

Supplement to the

Arizona Administrative Code

The official compilation of Arizona Rules

Arizona Secretary of State's Office

Public Services Division

1700 W. Washington Street, Fl 7.

Phoenix, AZ 85007

Replacement Check List

For rules filed within the

4th Calendar Quarter

October 1 - December 31, 2012

Code Release Number: Supp. 12-4

Within the stated calendar quarter, this Title contains all rules made, amended, repealed, renumbered, and recodified, or rules that have expired or were terminated due to an agency being eliminated under sunset law. These rules were either certified by the Governor's Regulatory Review Council or the Attorney General's Office, or exempt from the rulemaking process, and filed with the Office of the Secretary of State. Refer to the historical notes for more information. Please note that some rules you are about to remove may still be in effect after the publication date of this Supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

Follow the instructions to replace the updated Chapters.

TITLE 2. ADMINISTRATION

Chapter 5. Department of Administration - State Personnel System

Sections, Parts, Exhibits, Tables or Appendices modified

R2-5-101 through R2-5-105, R2-5-201 through R2-5-208, R2-5-211 through R2-5-213, R2-5-301 through R2-5-305, R2-5-401 through R2-5-415, R2-5-417, R2-5-501 through R2-5-503, R2-5-701 and R2-5-702, R2-5-801 through R2-5-803, R2-5-901 and R2-5-902, R2-5A-101 through R2-5A-105, R2-5A-201 through R2-5A-203, R2-5A-301 through R2-5A-308, R2-5A-401 through R2-5A-406, R2-5A-501 through R2-5A-504, R2-5A-A601, R2-5A-B601 through R2-5A-B611, R2-5A-C601 and R2-5A-C602, R2-5A-D601 through R2-5A-D604, R2-5A-701 and R2-5A-702, R2-5A-801 through R2-5A-803, R2-5A-901 and R2-5A-902, R2-5A-1001 and R2-5A-1002, R2-5B-101 and R2-5B-102, R2-5B-201 through R2-5B-205, R2-5B-301 through R2-5B-305, R2-5B-401 through R2-5B-403, R2-5B-501 through R2-5B-503, R2-5B-601 through R2-5B-603

REMOVE Supp. 11-2

Pages: 1 - 29

REPLACE with Supp. 12-4

Pages: 1 - 35

Chapter 5.1. State Personnel Board

Sections, Parts, Exhibits, Tables or Appendices modified

R2-5.1-101 and R2-5.1-103

REMOVE Supp. 02-4

Pages: 1 - 4

REPLACE with Supp. 12-4

Pages: 1 - 4

Chapter 7. Department of Administration - State Procurement Office

Sections, Parts, Exhibits, Tables or Appendices modified

R2-7-101, R2-7-B309, R2-7-C309, R2-7-C311, R2-7-C314 through R2-7-C316, R2-7-D303, R2-7-E301, R2-7-E303, R2-7-F307, R2-7-G301, R2-7-404, R2-7-501, R2-7-503 through R2-7-505, R2-7-511, R2-7-607, R2-7-608, R2-7-A902, R2-7-A908, R2-7-1301

REMOVE Supp. 06-1

Pages: 1 - 41

REPLACE with Supp. 12-4

Pages: 1 - 41

Chapter 8. State Retirement System Board

Sections, Parts, Exhibits, Tables or Appendices modified

R2-8-501 through R2-8-503, R2-8-513, R2-8-518

REMOVE Supp. 10-3

Pages: 1 - 33

REPLACE with Supp. 12-4

Pages: 1 - 33

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TITLE 2. ADMINISTRATION**CHAPTER 5. DEPARTMENT OF ADMINISTRATION
STATE PERSONNEL SYSTEM**

(Authority: A.R.S. § 41-761 et seq.)

Editor's Note: The Chapter Title was amended from Department of Administration, Personnel Administration to Department of Administration, State Personnel System. All Articles 1 through 9 repealed under exempt rulemaking at 18 A.A.R. 2782 effective September 29, 2012 (Supp. 12-4).

Editor's Note: Because the rules in this Chapter that were adopted under an exemption from the provisions of the Administrative Procedure Act (A.R.S. Title 41, Chapter 6) have been repealed, the Chapter is printed on white paper (Supp. 99-3).

Editor's Note: This Chapter contains rules which were repealed and adopted under an exemption from the provisions of the Administrative Procedure Act (A.R.S. Title 41, Chapter 6) pursuant to Laws 1997, Ch. 288, § 10. Exemption from A.R.S. Title 41, Chapter 6 means the Department of Administration did not submit these rules to the Governor's Regulatory Review Council for review; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the Department was not required to hold public hearings on these rules. Because this Chapter contains rules which are exempt from the regular rulemaking process, the Chapter is printed on blue paper.

Article 1 consisting of Sections R2-5-101 through R2-5-105; Article 2 consisting of Sections R2-5-201 through R2-5-210 and R2-5-213; Article 3 consisting of Sections R2-5-301 through R2-5-306; Article 4 consisting of Sections R2-5-401 through R2-5-411 and R2-5-413 through R2-5-418; Article 5 consisting of Sections R2-5-501 through R2-5-503; Article 6 consisting of Sections R2-5-601 through R2-5-605; Article 7 consisting of Sections R2-5-701 and R2-5-702; Article 8 consisting of Sections R2-5-801 through R2-5-803; and Article 9 consisting of Sections R2-5-901 and R2-5-902 adopted effective December 31, 1986 (Supp. 86-6).

Former Article 1 consisting of Sections R2-5-101 and R2-5-102; former Article 2 consisting of Sections R2-5-201 through R2-5-205; former Article 3 consisting of Sections R2-5-301 and R2-5-302; former Article 4 consisting of Sections R2-5-401 through R2-5-403; former Article 5 consisting of Sections R2-5-501 and R2-5-502; and former Article 6 consisting of Sections R2-5-601 through R2-5-605 repealed effective December 31, 1986 (Supp. 86-6).

ARTICLE 1. REPEALED

Article 1, consisting of Sections R2-5-101 through R2-5-105 repealed by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4)

R2-5-419.	Repealed
R2-5-420.	Repealed
R2-5-421.	Repealed
R2-5-422.	Repealed
R2-5-423.	Renumbered

ARTICLE 2. REPEALED**ARTICLE 5. REPEALED**

Article 5, consisting of Sections R2-5-501 through R2-5-503 repealed by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

ARTICLE 3. REPEALED**ARTICLE 6. REPEALED**

Section	
R2-5-301.	Repealed
R2-5-302.	Repealed
R2-5-303.	Repealed
R2-5-304.	Repealed
R2-5-305.	Repealed
R2-5-306.	Expired
R2-5-307.	Expired

Article 6, consisting of Sections R2-5-601 through R2-5-605, repealed by final rulemaking at 6 A.A.R. 4572, effective November 13, 2000 (Supp. 00-4).

ARTICLE 4. REPEALED**ARTICLE 7. REPEALED**

Section	
R2-5-401.	Repealed
R2-5-402.	Repealed
R2-5-403.	Repealed
R2-5-404.	Repealed
R2-5-405.	Repealed
R2-5-406.	Repealed
R2-5-407.	Repealed
R2-5-408.	Repealed
R2-5-409.	Repealed
R2-5-410.	Repealed
R2-5-411.	Repealed
R2-5-412.	Repealed
R2-5-413.	Repealed
R2-5-414.	Repealed
R2-5-415.	Repealed
R2-5-416.	Repealed
R2-5-417.	Repealed
R2-5-418.	Repealed

Article 7, consisting of Sections R2-5-701 through R2-5-702, repealed by final rulemaking at 6 A.A.R. 4572, effective November 13, 2000 (Supp. 00-4).

ARTICLE 8. REPEALED

Article 8, consisting of Sections R2-5-801 through R2-5-803, repealed by final rulemaking at 6 A.A.R. 4572, effective November 13, 2000 (Supp. 00-4).

ARTICLE 9. REPEALED

Section	
R2-5-901.	Repealed
R2-5-902.	Repealed
R2-5-903.	Repealed
R2-5-904.	Repealed

**SUBCHAPTER A. COVERED AND UNCOVERED
EMPLOYEES**

ARTICLE 1. GENERAL

- Section
- R2-5A-101. Definitions
 - R2-5A-102. General Provisions
 - R2-5A-103. Applicability
 - R2-5A-104. Prohibition Against Discrimination, Harassment and Retaliation
 - R2-5A-105. Records

ARTICLE 2. CLASSIFICATION SYSTEM

- Section
- R2-5A-201. Classification Plan
 - R2-5A-202. Change in Classification
 - R2-5A-203. Second Level Review

ARTICLE 3. RECRUITMENT, SELECTION AND APPOINTMENT

- Section
- R2-5A-301. General
 - R2-5A-302. Recruitment
 - R2-5A-303. Reference and Background Checks
 - R2-5A-304. Qualifications of Selected Candidate
 - R2-5A-305. Employment of Relatives
 - R2-5A-306. Hiring Requirements
 - R2-5A-307. Appointment
 - R2-5A-308. Applicant Complaint

ARTICLE 4. COMPENSATION SYSTEM

- Section
- R2-5A-401. Salary Plans
 - R2-5A-402. Salary Administration
 - R2-5A-403. Supplemental Pay
 - R2-5A-404. Overtime
 - R2-5A-405. Tuition Reimbursement for Education
 - R2-5A-406. Reimbursement for Relocation

ARTICLE 5. CONDITIONS OF EMPLOYMENT

- Section
- R2-5A-501. Standards of Conduct
 - R2-5A-502. Hours of Work
 - R2-5A-503. Outside Employment
 - R2-5A-504. Alcohol and Drug-free Workplace

ARTICLE 6. LEAVE**PART A. GENERAL**

- Section
- R2-5A-A601. Leave Administration

PART B. PAID LEAVE

- Section
- R2-5A-B601. Holidays
 - R2-5A-B602. Annual Leave
 - R2-5A-B603. Sick Leave
 - R2-5A-B604. Administrative Leave
 - R2-5A-B605. Bereavement Leave
 - R2-5A-B606. Civic Duty Leave
 - R2-5A-B607. Compensatory Leave
 - R2-5A-B608. Educational Leave
 - R2-5A-B609. Living Donor Leave
 - R2-5A-B610. Leave for National Disaster Medical System (NDMS) Training
 - R2-5A-B611. Meritorious Service Leave

PART C. UNPAID LEAVE

- Section
- R2-5A-C601. Furlough
 - R2-5A-C602. Leave Without Pay

PART D. LEAVE THAT COULD BE EITHER PAID OR UNPAID

- Section
- R2-5A-D601. Family and Medical Leave Act (FMLA) Leave
 - R2-5A-D602. Industrial Leave
 - R2-5A-D603. Military Leave
 - R2-5A-D604. Victim Leave

ARTICLE 7. PERFORMANCE MANAGEMENT

- Section
- R2-5A-701. General
 - R2-5A-702. Performance Management Process

ARTICLE 8. DISCIPLINARY ACTIONS

- Section
- R2-5A-801. General
 - R2-5A-802. Procedures for Review by the Director
 - R2-5A-803. Employee Request for Review of Disciplinary Action

ARTICLE 9. COMPLAINTS

- Section
- R2-5A-901. Complaint System
 - R2-5A-902. Complaint Procedures

ARTICLE 10. SEPARATIONS

- Section
- R2-5A-1001. Voluntary Separation
 - R2-5A-1002. Involuntary Separation

SUBCHAPTER B. COVERED EMPLOYEES**ARTICLE 1. GENERAL**

- Section
- R2-5B-101. Definitions
 - R2-5B-102. Applicability

ARTICLE 2. EMPLOYMENT STATUS

- Section
- R2-5B-201. Applicability
 - R2-5B-202. Original Probation
 - R2-5B-203. Promotional Probation
 - R2-5B-204. Permanent Status
 - R2-5B-205. Change from Covered to Uncovered Service

ARTICLE 3. DISCIPLINARY ACTIONS

- Section
- R2-5B-301. General
 - R2-5B-302. Reprimand
 - R2-5B-303. Suspension
 - R2-5B-304. Involuntary Demotion
 - R2-5B-305. Dismissal

ARTICLE 4. GRIEVANCES

- Section
- R2-5B-401. Applicability
 - R2-5B-402. Grievance System
 - R2-5B-403. Grievance Procedures

ARTICLE 5. APPEALS

Section

- R2-5B-501. Applicability
 R2-5B-502. General
 R2-5B-503. Full Authority Peace Officers

ARTICLE 6. REDUCTION IN FORCE

Section

- R2-5B-601. Applicability
 R2-5B-602. Reduction in Force Procedures
 R2-5B-603. Employee Request for Review

Editor's Note: Articles 1 through 9, under Chapter 5, Department of Administration, Personnel Administration repealed at 18 A.A.R. 2782 effective September 29, 2012 (Supp. 12-4).

ARTICLE 1. REPEALED**R2-5-101. Repealed****Historical Note**

Adopted effective December 31, 1986 (Supp. 86-6). Amended effective August 2, 1989 (Supp. 89-3). Subsection (48) corrected to read "without prejudice" (Supp. 95-2). Subsection (55) amended to correct a printing error (Supp. 99-3). Amended by final rulemaking at 9 A.A.R. 1040, effective May 4, 2003 (Supp. 03-1). Amended by final rulemaking at 11 A.A.R. 4357, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 1420, effective May 31, 2008 (Supp. 08-2). Amended by final rulemaking at 14 A.A.R. 2924, effective August 30, 2008 (Supp. 08-3). Amended by final rulemaking at 15 A.A.R. 207, effective March 7, 2009 (Supp. 09-1). Section repealed by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5-102. Repealed**Historical Note**

Adopted effective December 31, 1986 (Supp. 86-6). Correction to subsection (A) as certified effective December 31, 1986 (Supp. 87-3). Amended by final rulemaking at 9 A.A.R. 1040, effective May 4, 2003 (Supp. 03-1). Section repealed by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5-103. Repealed**Historical Note**

Adopted effective December 31, 1986 (Supp. 86-6). Amended by final rulemaking at 9 A.A.R. 1040, effective May 4, 2003 (Supp. 03-1). Section repealed by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5-104. Repealed**Historical Note**

Adopted effective December 31, 1986 (Supp. 86-6). Section heading amended by final rulemaking at 9 A.A.R. 1040, effective May 4, 2003 (Supp. 03-1). Section repealed by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5-105. Repealed**Historical Note**

Adopted effective December 31, 1986 (Supp. 86-6).

Amended effective August 2, 1989 (Supp. 89-3). Amended by final rulemaking at 9 A.A.R. 1040, effective May 4, 2003 (Supp. 03-1). Amended by final rulemaking at 16 A.A.R. 685, effective June 5, 2010 (Supp. 10-2). Section repealed by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

ARTICLE 2. REPEALED**R2-5-201. Repealed****Historical Note**

Adopted effective December 31, 1986 (Supp. 86-6). Amended effective September 15, 1994 (Supp. 94-3). Amended by final rulemaking at 6 A.A.R. 4572, effective November 13, 2000 (Supp. 00-4). Section repealed by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5-202. Repealed**Historical Note**

Adopted effective December 31, 1986 (Supp. 86-6). Amended by final rulemaking at 6 A.A.R. 4572, effective November 13, 2000 (Supp. 00-4). Section repealed by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5-203. Repealed**Historical Note**

Adopted effective December 31, 1986 (Supp. 86-6). Subsection (G) corrected to add omitted text following the word "error" (Supp. 95-2). Amended by final rulemaking at 6 A.A.R. 4572, effective November 13, 2000 (Supp. 00-4). Section repealed by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5-204. Repealed**Historical Note**

Adopted effective December 31, 1986 (Supp. 86-6). Section repealed by final rulemaking at 6 A.A.R. 4572, effective November 13, 2000 (Supp. 00-4). Section repealed by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5-205. Repealed**Historical Note**

Adopted effective December 31, 1986 (Supp. 86-6). Amended by final rulemaking at 6 A.A.R. 4572, effective November 13, 2000 (Supp. 00-4). Section repealed by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5-206. Repealed**Historical Note**

Adopted effective December 31, 1986 (Supp. 86-6). Amended effective September 15, 1994 (Supp. 94-3). Amended by final rulemaking at 6 A.A.R. 4572, effective November 13, 2000 (Supp. 00-4). Section repealed by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5-207. Repealed**Historical Note**

Adopted effective December 31, 1986 (Supp. 86-6). Amended effective August 2, 1989 (Supp. 89-3). Amended by final rulemaking at 6 A.A.R. 4572, effective November 13, 2000 (Supp. 00-4). Section repealed by

exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5-208. Repealed

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 4572, effective November 13, 2000 (Supp. 00-4). Section repealed by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5-209. Repealed

Historical Note

Adopted effective December 31, 1986 (Supp. 86-6).
Repealed effective August 2, 1989 (Supp. 89-3).

R2-5-210. Repealed

Historical Note

Adopted effective December 31, 1986 (Supp. 86-6). Section repealed by final rulemaking at 6 A.A.R. 4572, effective November 13, 2000 (Supp. 00-4).

R2-5-211. Repealed

Historical Note

Adopted effective August 2, 1989 (Supp. 89-3).
Amended effective September 15, 1994 (Supp. 94-3).
Amended by final rulemaking at 6 A.A.R. 4572, effective November 13, 2000 (Supp. 00-4). Section repealed by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5-212. Repealed

Historical Note

Reserved Section repealed by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5-213. Repealed

Historical Note

Adopted effective December 31, 1986 (Supp. 86-6). Subsection (C)(2) corrected to read “job-related” in line 2; Amended effective April 20, 1995 (Supp. 95-2).
Amended by final rulemaking at 6 A.A.R. 4572, effective November 13, 2000 (Supp. 00-4). Section repealed by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

ARTICLE 3. REPEALED

R2-5-301. Repealed

Historical Note

Adopted effective December 31, 1986 (Supp. 86-6).
Amended by final rulemaking at 7 A.A.R. 2724, effective June 6, 2001 (Supp. 01-2). Section repealed by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5-302. Repealed

Historical Note

Adopted effective December 31, 1986 (Supp. 86-6).
Amended by final rulemaking at 7 A.A.R. 2724, effective June 6, 2001 (Supp. 01-2). Section repealed by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5-303. Repealed

Historical Note

Adopted effective December 31, 1986 (Supp. 86-6).

Amended effective August 2, 1989 (Supp. 89-3).
Amended effective September 15, 1994 (Supp. 94-3).
Amended effective March 4, 1997 (Supp. 97-1).
Amended effective August 5, 1997 (Supp. 97-3).
Amended by final rulemaking at 7 A.A.R. 2724, effective June 6, 2001 (Supp. 01-2). Amended by final rulemaking at 16 A.A.R. 1129, effective August 7, 2010 (Supp. 10-2).
Section repealed by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5-304. Repealed

Historical Note

Adopted effective December 31, 1986 (Supp. 86-6).
Amended by final rulemaking at 5 A.A.R. 4417, effective November 2, 1999 (Supp. 99-4). Amended by final rulemaking at 7 A.A.R. 2724, effective June 6, 2001 (Supp. 01-2). Section repealed by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5-305. Repealed

Historical Note

Adopted effective December 31, 1986 (Supp. 86-6).
Amended effective April 20, 1995 (Supp. 95-2).
Amended by final rulemaking at 7 A.A.R. 2724, effective June 6, 2001 (Supp. 01-2). Section repealed by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5-306. Expired

Historical Note

Adopted effective December 31, 1986 (Supp. 86-6).
Amended by final rulemaking at 7 A.A.R. 2724, effective June 6, 2001 (Supp. 01-2). Section expired under A.R.S. § 41-1056(E) at 13 A.A.R. 1143, effective May 31, 2006 (Supp. 07-1).

R2-5-307. Expired

Historical Note

Adopted as an emergency effective February 22, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-1). Emergency expired. New Section adopted effective March 10, 1993 (Supp. 93-1). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 3483, effective July 19, 2002 (Supp. 02-3).

ARTICLE 4. REPEALED

R2-5-401. Repealed

Historical Note

Adopted effective December 31, 1986 (Supp. 86-6).
Amended by final rulemaking at 14 A.A.R. 4309, effective November 4, 2008 (Supp. 08-4). Section repealed by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5-402. Repealed

Historical Note

Adopted effective December 31, 1986 (Supp. 86-6).
Amended effective July 6, 1993 (Supp. 93-3). Amended effective April 20, 1995 (Supp. 95-2). Section repealed by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5-403. Repealed**Historical Note**

Adopted effective December 31, 1986 (Supp. 86-6). Amended as an emergency effective August 19, 1988 pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-3). Emergency expired. Amended effective September 12, 1989 (Supp. 89-3). Amended effective September 14, 1990 (Supp. 90-3). Amended effective August 5, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 4093, effective October 3, 2000 (Supp. 00-4). Amended by final rulemaking at 9 A.A.R. 2082, effective August 2, 2003 (Supp. 03-2). Amended by final rulemaking at 13 A.A.R. 1635, effective June 30, 2007 (Supp. 07-2). Amended by final rulemaking at 14 A.A.R. 4309, effective November 4, 2008 (Supp. 08-4). Section repealed by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5-404. Repealed**Historical Note**

Adopted effective December 31, 1986 (Supp. 86-6). Amended effective August 2, 1989 (Supp. 89-3). Amended effective September 15, 1994 (Supp. 94-3). Amended by final rulemaking at 14 A.A.R. 4309, effective November 4, 2008 (Supp. 08-4). Section repealed by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5-405. Repealed**Historical Note**

Adopted effective December 31, 1986 (Supp. 86-6). Amended effective April 20, 1995 (Supp. 95-2). Amended by final rulemaking at 6 A.A.R. 4093, effective October 3, 2000 (Supp. 00-4). Amended by final rulemaking at 14 A.A.R. 4309, effective November 4, 2008 (Supp. 08-4). Section repealed by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5-406. Repealed**Historical Note**

Adopted effective December 31, 1986 (Supp. 86-6). Section repealed by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5-407. Repealed**Historical Note**

Adopted effective December 31, 1986 (Supp. 86-6). Amended by final rulemaking at 6 A.A.R. 4093, effective October 3, 2000 (Supp. 00-4). Section repealed by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5-408. Repealed**Historical Note**

Adopted effective December 31, 1986 (Supp. 86-6). Section repealed by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5-409. Repealed**Historical Note**

Adopted effective December 31, 1986 (Supp. 86-6). Section repealed by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5-410. Repealed**Historical Note**

Adopted effective December 31, 1986 (Supp. 86-6). Amended effective August 2, 1989 (Supp. 89-3). Amended effective April 20, 1995 (Supp. 95-2). Amended by final rulemaking at 6 A.A.R. 4093, effective October 3, 2000 (Supp. 00-4). Amended by final rulemaking at 14 A.A.R. 4309, effective November 4, 2008 (Supp. 08-4). Section repealed by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5-411. Repealed**Historical Note**

Adopted effective December 31, 1986 (Supp. 86-6). Amended effective August 2, 1989 (Supp. 89-3). Amended effective April 20, 1995 (Supp. 95-2). Amended by final rulemaking at 6 A.A.R. 4093, effective October 3, 2000 (Supp. 00-4). Amended by final rulemaking at 14 A.A.R. 4309, effective November 4, 2008 (Supp. 08-4). Section repealed by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5-412. Repealed**Historical Note**

Adopted as an emergency effective August 19, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-3). Emergency expired. Amended and adopted as a permanent rule effective September 12, 1989 (Supp. 89-3). Rule citation in subsection (B) corrected (Supp. 95-2). Former Section R2-5-412 renumbered to R2-5-413; new Section R2-5-412 adopted by final rulemaking at 6 A.A.R. 4093, effective October 3, 2000 (Supp. 00-4). Section repealed by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5-413. Repealed**Historical Note**

Adopted effective December 31, 1986 (Supp. 86-6). Amended effective August 2, 1989 (Supp. 89-3). Amended effective April 20, 1995 (Supp. 95-2). Former Section R2-5-413 renumbered to R2-5-414; new Section R2-5-413 renumbered from R2-5-412 and amended by final rulemaking at 6 A.A.R. 4093, effective October 3, 2000 (Supp. 00-4). Amended by final rulemaking at 14 A.A.R. 4309, effective November 4, 2008 (Supp. 08-4). Section repealed by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5-414. Repealed**Historical Note**

Adopted effective December 31, 1986 (Supp. 86-6). Former Section R2-5-414 renumbered to R2-5-415; new Section R2-5-414 renumbered from R2-5-413 and amended by final rulemaking at 6 A.A.R. 4093, effective October 3, 2000 (Supp. 00-4). Amended by final rulemaking at 14 A.A.R. 4309, effective November 4, 2008 (Supp. 08-4). Section repealed by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5-415. Repealed**Historical Note**

Adopted effective December 31, 1986 (Supp. 86-6).

Amended effective August 2, 1989 (Supp. 89-3). Former Section R2-5-415 renumbered to R2-5-416; new Section R2-5-415 renumbered from R2-5-414 and amended by final rulemaking at 6 A.A.R. 4093, effective October 3, 2000 (Supp. 00-4). Section repealed; new Section R2-5-415 renumbered from R2-5-423 and amended by final rulemaking at 15 A.A.R. 207, effective March 7, 2009 (Supp. 09-1). Section repealed by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5-416. Repealed**Historical Note**

Adopted effective December 31, 1986 (Supp. 86-6). Amended effective August 2, 1989 (Supp. 89-3). Former Section R2-5-416 renumbered to R2-5-417; new Section R2-5-416 renumbered from R2-5-415 and amended by final rulemaking at 6 A.A.R. 4093, effective October 3, 2000 (Supp. 00-4). Amended by final rulemaking at 11 A.A.R. 4357, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 1420, effective May 31, 2008 (Supp. 08-2). Section repealed by final rulemaking at 15 A.A.R. 207, effective March 7, 2009 (Supp. 09-1).

R2-5-417. Repealed**Historical Note**

Adopted effective December 31, 1986 (Supp. 86-6). Amended effective August 2, 1989 and September 12, 1989 (Supp. 89-3). Former Section R2-5-417 renumbered to R2-5-418; new Section R2-5-417 renumbered from R2-5-416 and amended by final rulemaking at 6 A.A.R. 4093, effective October 3, 2000 (Supp. 00-4). Amended by final rulemaking at 11 A.A.R. 4357, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 1420, effective May 31, 2008 (Supp. 08-2). Section repealed by final rulemaking at 15 A.A.R. 207, effective March 7, 2009 (Supp. 09-1). New Section made by final rulemaking at 17 A.A.R. 650, effective June 4, 2011 (Supp. 11-2). Section repealed by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5-418. Repealed**Historical Note**

Adopted effective December 31, 1986 (Supp. 86-6). Amended effective August 2, 1989 (Supp. 89-3). Former Section R2-5-418 renumbered to R2-5-419; new Section R2-5-418 renumbered from R2-5-417 and amended by final rulemaking at 6 A.A.R. 4093, effective October 3, 2000 (Supp. 00-4). Amended by final rulemaking at 14 A.A.R. 1420, effective May 31, 2008 (Supp. 08-2). Section repealed by final rulemaking at 15 A.A.R. 207, effective March 7, 2009 (Supp. 09-1).

R2-5-419. Repealed**Historical Note**

Adopted effective August 2, 1989 (Supp. 89-3). Former Section R2-5-419 renumbered to R2-5-421; new Section R2-5-419 renumbered from R2-5-418 and amended by final rulemaking at 6 A.A.R. 4093, effective October 3, 2000 (Supp. 00-4). Amended by final rulemaking at 14 A.A.R. 1420, effective May 31, 2008 (Supp. 08-2). Section repealed by final rulemaking at 15 A.A.R. 207, effective March 7, 2009 (Supp. 09-1).

R2-5-420. Repealed**Historical Note**

Adopted effective August 2, 1989 (Supp. 89-3). Former Section R2-5-420 renumbered to R2-5-422; new Section R2-5-420 adopted by final rulemaking at 6 A.A.R. 4093, effective October 3, 2000 (Supp. 00-4). Section repealed by final rulemaking at 15 A.A.R. 207, effective March 7, 2009 (Supp. 09-1).

R2-5-421. Repealed**Historical Note**

Adopted effective February 28, 1991 (Supp. 91-1). Former Section R2-5-421 renumbered to R2-5-423; new Section R2-5-421 renumbered from R2-5-419 and amended by final rulemaking at 6 A.A.R. 4093, effective October 3, 2000 (Supp. 00-4). Amended by final rulemaking at 14 A.A.R. 1420, effective May 31, 2008 (Supp. 08-2). Section repealed by final rulemaking at 15 A.A.R. 207, effective March 7, 2009 (Supp. 09-1).

R2-5-422. Repealed**Historical Note**

New Section R2-5-422 renumbered from R2-5-420 and amended by final rulemaking at 6 A.A.R. 4093, effective October 3, 2000 (Supp. 00-4). Amended by final rulemaking at 14 A.A.R. 1420, effective May 31, 2008 (Supp. 08-2). Section repealed by final rulemaking at 15 A.A.R. 207, effective March 7, 2009 (Supp. 09-1).

R2-5-423. Renumbered**Historical Note**

New Section R2-5-423 renumbered from R2-5-421 and amended by final rulemaking at 6 A.A.R. 4093, effective October 3, 2000 (Supp. 00-4). Former R2-5-423 renumbered to R2-5-415 by final rulemaking at 15 A.A.R. 207, effective March 7, 2009 (Supp. 09-1).

ARTICLE 5. REPEALED**R2-5-501. Repealed****Historical Note**

Adopted effective December 31, 1986 (Supp. 86-6). Amended effective April 20, 1995 (Supp. 95-2). Amended by final rulemaking at 7 A.A.R. 5811, effective December 6, 2001 (Supp. 01-4). Section repealed by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5-502. Repealed**Historical Note**

Adopted effective December 31, 1986 (Supp. 86-6). Amended effective September 15, 1994 (Supp. 94-3). Amended by final rulemaking at 7 A.A.R. 5811, effective December 6, 2001 (Supp. 01-4). Amended by final rulemaking at 12 A.A.R. 1733, effective July 1, 2006 (Supp. 06-2). Section repealed by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5-503. Repealed**Historical Note**

Adopted effective December 31, 1986 (Supp. 86-6). Amended effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 7 A.A.R. 5811, effective December 6, 2001 (Supp. 01-4). Section repealed by

exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

ARTICLE 6. REPEALED

R2-5-601. Repealed

Historical Note

Adopted effective December 31, 1986 (Supp. 86-6). Section repealed by final rulemaking at 6 A.A.R. 4572, effective November 13, 2000 (Supp. 00-4).

R2-5-602. Repealed

Historical Note

Adopted effective December 31, 1986 (Supp. 86-6). Section repealed by final rulemaking at 6 A.A.R. 4572, effective November 13, 2000 (Supp. 00-4).

R2-5-603. Repealed

Historical Note

Adopted effective December 31, 1986 (Supp. 86-6). Section repealed by final rulemaking at 6 A.A.R. 4572, effective November 13, 2000 (Supp. 00-4).

R2-5-604. Repealed

Historical Note

Adopted effective December 31, 1986 (Supp. 86-6). Section repealed by final rulemaking at 6 A.A.R. 4572, effective November 13, 2000 (Supp. 00-4).

R2-5-605. Repealed

Historical Note

Adopted effective December 31, 1986 (Supp. 86-6). Section repealed by final rulemaking at 6 A.A.R. 4572, effective November 13, 2000 (Supp. 00-4).

ARTICLE 7. REPEALED

R2-5-701. Repealed

Historical Note

Adopted effective December 31, 1986 (Supp. 86-6). Amended effective September 15, 1994 (Supp. 94-3). Section repealed by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5-702. Repealed

Historical Note

Adopted effective December 31, 1986 (Supp. 86-6). Amended effective September 15, 1994 (Supp. 94-3). Section repealed by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

ARTICLE 8. REPEALED

R2-5-801. Repealed

Historical Note

Adopted effective December 31, 1986 (Supp. 86-6). Amended effective July 25, 1994 (Supp. 94-3). Section repealed by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5-802. Repealed

Historical Note

Adopted effective December 31, 1986 (Supp. 86-6). Section repealed by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5-803. Repealed

Historical Note

Adopted effective December 31, 1986 (Supp. 86-6). Section repealed by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

Editor's Note: Article 9 contained rules which were repealed and adopted under an exemption from the provisions of the Administrative Procedure Act (A.R.S. Title 41, Chapter 6) pursuant to Laws 1997, Ch. 288, § 10. Exemption from A.R.S. Title 41, Chapter 6 means the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the Department was not required to hold public hearings on these rules. Temporary rules repealed and adopted under these Sections are repealed from and after June 30, 1999 (Supp. 98-2). Temporary rules repealed and adopted pursuant to Laws 1997, Ch. 288, § 10 were repealed from and after June 30, 1999 and the rule in effect before the adoption of the temporary rules became effective again upon the repeal of the temporary rules (Supp. 99-3).

ARTICLE 9. REPEALED

R2-5-901. Repealed

Historical Note

Adopted effective December 31, 1986 (Supp. 86-6). Section repealed by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

Editor's Note: The following Section R2-5-902 was temporarily repealed and a new Section was temporarily adopted under an exemption from the provisions of the Administrative Procedure Act (A.R.S. Title 41, Chapter 6) pursuant to Laws 1997, Ch. 288, § 10. Exemption from A.R.S. Title 41, Chapter 6 means the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the Department was not required to hold public hearings on these rules. Temporary rules adopted are repealed effective June 30, 1999 (Supp. 98-2). The temporary rules were repealed from and after June 30, 1999, pursuant to Laws 1997, Ch. 288, § 10; the rule in effect before the adoption of the temporary rules became effective again upon the repeal of the temporary rules (Supp. 99-3). Section R2-5-902 was repealed and a new Section was adopted by final rulemaking (Supp. 99-4).

R2-5-902. Repealed

Historical Note

Adopted effective December 31, 1986 (Supp. 86-6). Section R2-5-902 temporarily repealed; new Section temporarily adopted effective April 23, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1997, Ch. 288, § 10. Rules adopted under this temporary Section are repealed effective June 30, 1999 (Supp. 98-2). Section repealed from and after June 30, 1999, pursuant to Laws 1997, Ch. 288, § 10; the rule in effect before the adoption of the temporary rules became effective again upon the repeal of the temporary rules (Supp. 99-3). Section repealed by final rulemaking at 5 A.A.R. 4529, effective November 2, 1999; new Section adopted by final rulemaking at 6 A.A.R. 20, effective December 7, 1999 (Supp. 99-4). Amended by final rulemaking at 13 A.A.R. 958, effective May 5, 2007 (Supp. 07-1). Amended by final rulemaking at 16 A.A.R.

2379, effective January 15, 2011 (Supp. 10-4). Section repealed by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5-903. Repealed

Historical Note

Emergency rule adopted effective January 4, 1996, pursuant to A.R.S. § 41-1026, in effect for a maximum of 180 days (Supp. 86-6). Adopted with changes effective June 7, 1996 (Supp. 96-2). Section repealed by final rulemaking at 17 A.A.R. 650, effective June 4, 2011 (Supp. 11-2).

Editor's Note: The following Section was temporarily adopted under an exemption from the provisions of the Administrative Procedure Act (A.R.S. Title 41, Chapter 6) pursuant to Laws 1997, Ch. 288, § 10. Exemption from A.R.S. Title 41, Chapter 6 means the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the Department was not required to hold public hearings on these rules. Temporary rules adopted are repealed effective June 30, 1999 (Supp. 98-2). Section repealed from and after June 30, 1999, pursuant to Laws 1997, Ch. 288, § 10 (Supp. 99-3). New Section R2-5-904 adopted by final rulemaking (99-4).

R2-5-904. Repealed

Historical Note

New Section adopted effective April 23, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1997, Ch. 288, § 10. This Section is automatically repealed effective June 30, 1999 (Supp. 98-2). Section repealed from and after June 30, 1999, pursuant to Laws 1997, Ch. 288, § 10 (Supp. 99-3). New Section adopted by final rulemaking at 6 A.A.R. 20, effective December 7, 1999 (Supp. 99-4). Formatting errors corrected (Supp. 08-3). Section repealed by final rulemaking at 16 A.A.R. 2379, effective January 15, 2011 (Supp. 10-4).

SUBCHAPTER A. COVERED AND UNCOVERED EMPLOYEES

ARTICLE 1. GENERAL

R2-5A-101. Definitions

In this subchapter, the following words and phrases have the defined meanings unless otherwise clearly indicated by the context:

“Agency head” means the chief executive officer of a state agency, or designee.

“Appeal” means a covered employee’s request for a review of a disciplinary action by the State Personnel Board under A.R.S. § 41-782 or the Law Enforcement Merit System Council under A.R.S. § 41-1830.16, as applicable.

“Applicant” means a person who seeks appointment to a position in state employment.

“Appointing authority” means the person or group of persons authorized by law or delegated authority to make appointments to fill positions. A.R.S. § 41-741(1)

“Appointment” means the offer to and the acceptance by a candidate of a position in a state agency.

“At will” means an employment relationship where either party to the relationship may sever the relationship at any time

for any reason other than an unlawful reason. A.R.S. § 41-741(2)

“Base salary” means an employee’s salary excluding supplemental pay provided by R2-5A-403, overtime pay or other pay allowance provided by law.

“Break in service” means a separation from state employment, regardless of the reason for separation. A.R.S. § 41-741(3)

“Business day” means the hours between 8:00 a.m. and 5:00 p.m., Monday through Friday, excluding observed state holidays.

“Candidate” means a person whose education, experience, competencies and other qualifications meet the requirements of a position and who may be considered for employment.

“Cause” means any of the reasons for disciplinary action provided by A.R.S. § 41-773 or these rules.

“Change in assignment” means movement of an employee to a different position in the same state agency or another state agency. A.R.S. § 41-741(4)

“Child” means, for purposes of R2-5A-B603, pertaining to sick leave, and R2-5A-B605 pertaining to bereavement leave, a natural child, adopted child, foster child, or stepchild.

“Class” means a group of positions with the same title and grade because each position in the group has similar duties, scope of discretion and responsibility, required qualifications, or other job-related characteristics.

“Class series” means a group of related classes as listed by the Arizona Department of Administration, Human Resources Division.

“Class specification” means a description of the type and level of duties and responsibilities of the positions assigned to a class.

“Competencies” means knowledge, skills, abilities, behaviors and other characteristics that contribute to successful job performance and the achievement of organizational results.

“Covered employee” means an employee who:

- (a) Before September 29, 2012, is in the state service, is not uncovered pursuant to section 41-742, subsection A, and has remained in covered status without a break in service since that date.
- (b) Before September 29, 2012, is in the state service, is employed as a Correctional Officer I, Correctional Officer II, Correctional Officer III or Community Corrections Officer and has remained in covered status without a break in service since that date.
- (c) Before September 29, 2012, is in the state service, is a full authority peace officer as certified by the Arizona Peace Officer Standards and Training Board and has remained in that status without a break in service since that date.
- (d) On or after September 29, 2012, is a Correctional Officer I, Correctional Officer II, Correctional Officer III or Community Corrections Officer and is appointed to a position in the covered service, but does not include a position in any other class in the correctional officer class series or the community correctional officer class series or in any other correctional class series.

- (e) *On or after September 29, 2012, is a full authority peace officer as certified by the Arizona Peace Officer Standards and Training Board and is appointed to a position that requires such a certification in the covered service.* A.R.S. § 41-741(5)

“Covered position” means a position in the covered service.

“Covered service” is defined in A.R.S. § 41-741 and means that employment status conferring rights of appeal as prescribed in A.R.S. §§ 41-782 and 41-783 or A.R.S. § 41-1830.16, as applicable.

“Days” means calendar days, unless otherwise stated.

“Demotion” means a change in the assignment of an employee from a position in one class to a position in another class that has a lower grade.

“Department” means the Arizona Department of Administration.

“Director” means the Director of the Arizona Department of Administration, or the Director’s designee, who is responsible for administering the state personnel system pursuant to applicable state and federal laws. A.R.S. § 41-741(7)

“Employee” means all officers and employees of this state, whether in covered service or uncovered service, unless otherwise prescribed. A.R.S. § 41-741(8)

“Employing agency” means the agency where the employee is employed or, if an applicant, the agency to which the person has applied.

“Essential job function” means a fundamental job duty of a position that an applicant or employee must be able to perform, with or without a reasonable accommodation.

“FLSA” means the federal Fair Labor Standards Act.

“FLSA exempt” means a position that is not entitled to overtime compensation under the FLSA.

“FLSA non-exempt” means a position that is entitled to overtime compensation under the FLSA.

“FMLA” means the federal Family and Medical Leave Act.

“Full authority peace officer” means a peace officer whose authority to enforce the laws of this state is not limited by the rules adopted by the Arizona Peace Officer Standards and Training Board. A.R.S. § 41-741(9)

“Grade” means the numeric identifier associated with one or more pay ranges, used to determine the internal worth of a class relative to other classes.

“Manifest error” means an act or failure to act that is, or clearly has caused, a mistake.

“Parent” means, for purposes of R2-5A-B602, pertaining to annual leave, R2-5A-B603, pertaining to sick leave, and R2-5A-B605, pertaining to bereavement leave, a birth parent, adoptive parent, stepparent, foster parent, grandparent, parent-in-law, or anyone who can be considered “in loco parentis.”

“Part-time” means employment scheduled for less than 40 hours per week.

“3/4 time” means employment regularly scheduled for at least 30 hours but fewer than 40 hours per week.

“1/2 time” means employment regularly scheduled for at least 20 hours but fewer than 30 hours per week.

“1/4 time” means employment regularly scheduled for at least 10 hours but fewer than 20 hours per week.

“Pay status” means an employee is receiving pay for work or for a compensated absence.

“Premium/contribution” means the amount paid in exchange for insurance coverage. Depending on the type of coverage, the premium/contribution is paid by the employee, the state, or a combination of both.

“Promotion” means a change in assignment of an employee from a position in one class to a position in another class that has a higher grade.

“Reallocation” means changing the allocation of a position to a different class if a material and permanent change in duties or responsibilities occurs.

“Reversion” means the return of a covered employee on promotional probation to a position in the class in which the employee held permanent status immediately before the promotion or to a similar position in another class at the same grade as the class the employee held permanent status if the employee possesses the qualifications for that position.

“Rules” means the rules adopted by the Department of Administration, Human Resources Division. A.R.S. § 41-741(13)

“Special assignment” means the temporary assignment, for up to six months, of the duties and responsibilities of another position to an employee in the same agency.

“State agency” means a department, board, office, authority, commission or other governmental budget unit of this state and includes an agency assigned to a department for administrative purposes. State agency does not include the legislative and judicial branches, the Arizona Board of Regents, state universities, the Arizona State Schools for the Deaf and the Blind, the Department of Public Safety, the Arizona Peace Officer Standards and Training Board, the Cotton Research and Protection Council or public corporations. A.R.S. § 41-741(14)

“State Personnel Board” is defined in A.R.S. § 41-741 and means the board established by A.R.S. Title 41, Chapter 4, Article 6.

“State Personnel System” is defined in A.R.S. § 41-741 and means all state agencies and employees of those agencies that are not exempted by the provisions of A.R.S. Title 41, Chapter 4, Article 4.

“State service” is defined in A.R.S. § 41-741 and means all offices and positions of employment in state government that, before September 29, 2012, were subject to the provisions of A.R.S. Title 41, Chapter 4, Articles 5 and 6 that were in effect before September 29, 2012.

“Supervisor” means a state employee who has one or more other state employees reporting directly to the person and, for those state employees, typically has the authority to:

- (a) *Approve sick or annual leave.*
- (b) *Recommend hiring, discipline or dismissal.*
- (c) *Assign or schedule daily work.*
- (d) *Complete a performance evaluation.* A.R.S. § 41-741(18)

“Temporary appointment” means an appointment made for a maximum of 1,500 hours worked in any agency in each calendar year.

“Transfer” means the movement of an employee from one position to another position in the same or an equivalent grade.

“Uncovered employee” means an employee in uncovered service. A.R.S. § 41-741(19)

“Uncovered service” means employment at will and includes all state employees except those in covered service. A.R.S. § 41-741(20)

“Working day” or “working hours” means a day or the hours an employee is regularly scheduled to work.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5A-102. General Provisions

A. Authority of Director.

1. The Director may approve, modify or deny a request, plan or proposal submitted by a state agency for review or when the Director’s approval is required by rule.
2. The Director may audit an agency’s personnel policies and procedures at any time. If the Director determines that the agency’s policies or procedures are inconsistent with these rules or are inconsistent with the procedures or guidelines issued by the Director, the Director may direct the agency head to modify them to achieve consistency or to discontinue them.

B. Delegation of authority.

1. The Director may, in writing, delegate authority to an agency head as consistent with legal requirements.
2. The Director may review or audit delegated authority to determine compliance with laws, rules, and policies.
3. Unless otherwise stated by law, or in these rules, an agency head may delegate authority granted to the agency head in these rules.

C. Availability of funds. The granting of any compensation under these rules is contingent upon the availability of funds, as determined by an agency head and the Director.

D. Service of notice. If a notice or document is to be given to a person or agency, the notice or document may be served personally or mailed to the last known residence or current business address of the person or agency. Unless otherwise provided by law or these rules, service is complete upon personal delivery or mailing.

E. Employee handbook. The Director may publish an employee handbook outlining pertinent rules and regulations and make the handbook available to all employees. If published, the employee handbook shall serve as the official handbook for all employees in the State Personnel System. An agency head may supplement the employee handbook with agency specific policies and directives.

F. Employment contracts. Unless otherwise provided by law, an appointing authority shall not execute an employment contract with any state employee.

G. Correction of errors. Only the Director, or designee, has authority to determine whether a manifest error exists and to correct the manifest error.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5A-103. Applicability

A. General. Except as provided in A.R.S., Title 41, Chapter 4, Article 4 and Article 5, or otherwise stated in rule, the rules in this subchapter are applicable to covered and uncovered positions, applicants for covered and uncovered positions and covered and uncovered employees in the State Personnel System.

An employee who violates or fails to comply with these rules may be disciplined or separated from state employment. Any such actions involving a covered employee shall be in accordance with the rules in Subchapter B, Article 3.

B. Temporary procedures. The Director may:

1. Unless otherwise prescribed by statute, waive any rule and implement temporary procedures if the Director determines that essential public services are being hampered or it is in the best interest of the state.
2. Implement a temporary pilot project to improve efficiency, productivity, or accountability in the State Personnel System. The project may include an activity or procedure that is not in accordance with these rules and shall not exceed two years in duration.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5A-104. Prohibition Against Discrimination, Harassment and Retaliation

A. General. Agencies shall comply with all federal and state anti-discrimination laws. Agencies shall not unlawfully discriminate against any individual with regard to the terms and conditions of employment, including hiring, pay, leave, insurance benefits, retention, and rehiring. The information provided in this rule is intended to serve as a summary of agencies’ and employees’ obligations with regard to compliance with applicable federal and state laws, rules and regulations. Nothing in these rules shall be construed as providing rights in excess of, or in addition to those authorized under federal laws and Arizona Revised Statutes.

B. Equal Employment Opportunity. Each agency shall provide equal employment opportunity for all individuals regardless of race, color, national origin, religion, age, disability, genetic information, sex, pregnancy, military or veteran status, or any other status protected by federal law, state law, or regulation. It is the policy of this state that all individuals are treated in a fair and non-discriminatory manner throughout the application and employment process.

C. Harassment Prohibited. Harassment of a sexual nature or harassment based on race, color, national origin, religion, age, disability, genetic information, sex, pregnancy, military or veteran status, or any other status protected by federal law, state law, or regulation is prohibited. An agency shall prohibit the unlawful harassment of any employee in the course of the employee’s work by supervisors, coworkers, or third parties, such as vendors or customers. Any employee who engages in unlawful harassment may be subject to disciplinary action, up to and including termination of employment.

D. Protection from Retaliation. The state prohibits retaliation against anyone for raising a concern about, assisting in an investigation of, or filing a complaint concerning unlawful discrimination or unlawful harassment.

E. Complaints.

1. An applicant for state employment who has a complaint alleging discrimination or harassment may file a complaint under the procedures in R2-5A-308.
2. It is every employee’s responsibility to promptly bring any allegation of discrimination, harassment or retaliation to the attention of the employing agency. Such complaints shall be filed under the procedures established under Article 9.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5A-105. Records

A. Definitions. For the purposes of this Section, “record” generally refers to a paper document; however, a document may be maintained electronically.

B. Application Materials.

1. An agency head shall maintain and keep confidential all resumés, applications, tests, test results, records, correspondence, and other documents used to seek state employment. The agency head shall not release any materials that the agency head determines would compromise the application process for future applicants and shall restrict the review of the applicant's application materials to:
 - a. The applicant,
 - b. An individual who has written authorization from the applicant,
 - c. State officials in the normal line of duty, or,
 - d. Officials acting in response to court orders or subpoenas.
2. The Director, or designee, shall ensure that when a person makes a public records request under A.R.S. Title 39, Chapter 1, Article 2 for applicant information:
 - a. Information shall only be provided if the position under recruitment is a high-level position and the public has a legitimate interest in the names of persons being seriously considered for the position, as determined by the Director; and
 - b. Only the names and resumés of the final candidates for the position as determined by the Director shall be released.

C. Official Personnel File.

1. An employee's official personnel file is the official record and documentation of the employee's employment.
2. An agency head shall, for each agency employee, maintain an official personnel file that contains:
 - a. A copy of the job application for the employee's current position;
 - b. A copy of all performance appraisals completed as required by Article 7;
 - c. Personnel action forms that authorize changes in employment status, position, classification, pay, or leave status;
 - d. Letters of commendation as established by agency policy; and
 - e. Correspondence consisting of:
 - i. Letters of reprimand, suspension, demotion or dismissal;
 - ii. Acknowledgments of receipt of letters of reprimand or other disciplinary communications; and
 - iii. Employee objections or responses to correspondence described in subsection (C)(2)(e)(i) that are not filed as complaints under Article 9 or grievances under Subchapter B, Article 4, if the objection or response is received within 30 calendar days of the date of the disciplinary action or letter of reprimand.
3. For the purpose of this subsection, an official is an individual who provides identification verifying that the individual is exercising powers and duties on behalf of the chief administrative head of a public body. An agency head shall limit access to an employee's official personnel file to:
 - a. The employee;

- b. The employee's attorney or an individual who has written authorization from the employee to review the personnel file;
- c. Agency personnel designated by the agency head as having a need for the information;
- d. A Department official in the normal line of duty;
- e. An official acting in response to a court order or subpoena;
- f. An official of an agency to which the employee has applied; and
- g. An official of an agency of the federal government, state government, or political subdivision, if the agency head of the employing agency deems access to the file to be appropriate.

4. When an employee moves from one state agency to another, the gaining agency shall request that the losing agency forward the employee's official personnel file to the gaining agency. The losing agency shall forward the file within 20 business days of the receipt of the request.

5. When a former employee returns to state employment within five years of the former employee's separation to an agency other than the agency in which the employee was last employed, the gaining agency shall request that the last agency forward the employee's official personnel file. The last agency shall forward the file within 20 business days of the receipt of the request.

D. Disclosure of information.

1. Definitions. For the purposes of this subsection:

- a. “Disciplinary actions” means letters of reprimand, suspension, demotion or dismissal.
- b. “Records that are reasonably necessary or appropriate to maintain an accurate knowledge of the employee's disciplinary actions” means the correspondence listed in subsection (D)(1)(a) and includes an official notice of charges of misconduct as applicable to covered employees, the final disciplinary letter, and any responses related to complaints, grievances or appeals upholding, amending, or overturning the discipline.
- c. “Employee responses” means any written documents, submitted and signed by the employee, either:
 - i. In response to an official notice of charges of misconduct;
 - ii. As a formal complaint filed under the provisions of Article 9 or a formal grievance under Subchapter B, Article 4, of these rules pertaining to a specific disciplinary action; or
 - iii. As an objection to a specific disciplinary action and contained in the employee's official personnel file under subsection (C)(2)(e)(iii).

2. Personnel records are confidential and an agency head shall ensure that except as provided in subsection (C)(3), only the following information about a current or former employee is provided to any person making a public records request under A.R.S. Title 39, Chapter 1, Article 2.

- a. Name of employee;
- b. Date of employment;
- c. Current and previous class titles and dates of appointment to the class;
- d. Current and previous agencies to which the employee has been assigned and the location of the main office for each agency;
- e. Current and previous salaries and dates of each change;

- f. Name of employee's current or last known supervisor; and
 - g. Records that are reasonably necessary or appropriate to maintain an accurate knowledge of the employee's disciplinary actions, including the employee responses to all disciplinary actions, unless providing this information is contrary to law.
- E.** Insurance and medical records. An agency head:
- 1. May maintain group insurance enrollment forms in an employee's official personnel file for an employee hired prior to September 29, 2012.
 - 2. Shall maintain in a separate file that is not part of the employee's official personnel file:
 - a. Medical records, and
 - b. Group insurance enrollment forms for an employee hired on or after September 29, 2012.
- F.** Employment eligibility records. An agency head shall retain I-9 forms and other documents required by law to prove employment eligibility in a separate file that is not part of the employee's official personnel file.
- G.** Employee access to files. An employee has the right to review only the employee's official personnel file.
- H.** Recordkeeping Requirements. An agency head shall ensure that agency recruitment and employee records are maintained in accordance with the General Records Retention Schedule for Human Resources/Personnel Records published by and on file with the Secretary of State, Arizona State Library, Archives and Public Records.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

ARTICLE 2. CLASSIFICATION SYSTEM**R2-5A-201. Classification Plan**

- A.** General. The Director shall group positions into classes based on similarities of duties and responsibilities. All positions are assigned a class specification with a specific title. An agency head may not appoint, transfer, promote, or demote an employee, or make any change in salary for any position until the position is allocated to a class.
- B.** Class title. An agency head shall use the class title of a position to designate the position in all budget estimates, payrolls, vouchers, and communications in connection with personnel processes.
- C.** Class specification. A class specification indicates the kinds of positions to be allocated to the class, as determined by the duties and responsibilities described for that class. Each class specification shall contain a statement of the minimum education, experience, competencies, and other qualifications required to perform the work. Required postsecondary education shall be attained in an institution that meets the standards established by an accrediting agency recognized by the U.S. Department of Education.
- D.** Position description. An agency head shall ensure that every position in the agency has a completed position description describing the current duties, responsibilities, and essential job functions specific to the position.
- E.** Allocation. The Director shall place every position in a class based on its duties and responsibilities.
- F.** Reallocation. Upon completion of a review of a position, the Director may determine that the position should be placed in a different class.
- G.** Regrade. Upon completion of a review of a classification, the Director may determine that the class should be placed in a different grade.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5A-202. Change in Classification

- A.** Change in classification plan. The Director may establish new classes and divide, combine, alter, or abolish existing classes, grades, or both, in consultation with affected agency heads.
- B.** Change in job duties.
 - 1. An employee in a position or the agency head may file a written request with the Director for review of the classification of the position. The request shall contain an updated position description, a specific explanation of how and when the position's duties and responsibilities have changed and the reasons why the current classification does not match these job duties.
 - 2. If a material and permanent change takes place in the duties and responsibilities of a position, the agency head shall report this change to the Director in an updated position description. The Director may order a reallocation of the position. The employee in the position at the time of reallocation shall continue to serve in the position.
- C.** Effective date. The effective date of a change in classification shall be the first day of the pay period immediately following the Director's determination, unless the Director authorizes an exception.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5A-203. Second Level Review

An employee in a position or the agency head may submit a written request for a second level review of a classification decision within 30 days of the initial determination. The request shall contain a concise and specific statement as to why the original decision was inappropriate. The Director may assign a different analyst to review the request and evaluate the proper classification of the position. The second level review shall be the final step in the classification review process.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

ARTICLE 3. RECRUITMENT, SELECTION AND APPOINTMENT**R2-5A-301. General**

An agency head shall follow the guidelines outlined in this Article to identify and appoint qualified candidates to fill vacancies. The Director shall establish and maintain a centralized employment system that includes a job board for announcing vacancies in state employment, applicant tracking and candidate identification. The Director shall establish procedures for state agencies to request approval for transportation or other travel expenses or moving expenses provided by A.R.S. § 35-196.01 for out of state candidates.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5A-302. Recruitment

- A.** Job posting.
 - 1. Unless exempted by A.R.S. Title 41, Chapter 4, Article 4, an appointing authority shall post an open position to the state's centralized job board. This includes recruitments open to only employees currently employed by the

agency, to state employees currently employed in any state agency, or the general public. An agency head may authorize an exception to the job posting requirement for a position in an individual case. Any exceptions shall be documented by the agency head and subject to audit by the Director.

2. In addition to posting to the state's centralized job board, an appointing authority may post an open position in a publication or to a commercial job posting board or both, in compliance with applicable procurement rules.

B. Application form.

1. A candidate for a position shall complete the standardized application form developed by the Director.
2. In addition to the standardized application form, an agency head may develop supplemental application procedures and forms specific to the agency or to a certain class or classes within the agency.

C. Preferences.

1. The state will provide preference to qualified veterans and disabled veterans seeking employment with the state.
2. For positions in the covered service, preference points authorized by A.R.S. § 38-492 shall be added to an applicant's grade on any assessment or evaluation that results in a numeric grade after the final grade is determined, if a passing grade is earned without the addition of preference points. Preference points shall not be applied to promotional examinations. If an evaluation does not result in a numeric grade, preference shall be given by granting applicable preference codes to qualified applicants.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5A-303. Reference and Background Checks

A candidate may be required to furnish, at the candidate's own expense, evidence of education or other qualification. The appointing authority is responsible for verifying education, work experience, applicable license or licenses and references provided by candidates on the application form and in interviews. An appointing authority shall not conduct a criminal background check or a credit check on a candidate unless the agency has statutory or executive order authority to conduct such a check.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5A-304. Qualifications of Selected Candidate

An agency head shall ensure that any candidate selected for hire meets the established qualifications for the position filled.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5A-305. Employment of Relatives

- A.** Relationship to supervisors. An individual shall not be employed in a position if the immediate supervisor of the individual is related within the third degree of affinity (marriage) or consanguinity (blood), or by adoption.
- B.** Relationship to other employees. An individual shall not be employed in a position if the individual is related within the third degree to an employee who currently occupies a position under the same immediate supervisor.
- C.** Exceptions. The Director may grant an exception to the prohibitions in subsections (A) and (B) if there is no other qualified person for the position at the location.

- D.** Relationship to subordinate employees. A supervisor or manager at any level shall not make an employment decision specifically benefitting any individual who is related within the third degree, unless an exception under subsection (C) has been granted.
- E.** Relationship to interviewer or interview panel members. An employee shall not interview or serve on an interview panel of any job candidate if the candidate is related within the third degree.
- F.** Definition. For the purpose of this Section, persons related within the third degree include a spouse, child, parent, grandchild, grandparent, sister, brother, great grandchild, great grandparent, aunt, uncle, niece, nephew or first cousin.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5A-306. Hiring Requirements

Agencies shall comply with federal and state law, including the verification of employment eligibility pursuant to A.R.S. § 23-214. An agency head shall ensure the completion of the Form I-9 and the employment eligibility verification process for all new hires.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5A-307. Appointment

- A.** General. Except as provided in A.R.S. Title 41, Chapter 4, Articles 4 and 5, all appointments shall be at will uncovered. An agency head may appoint a current state employee who accepts a change in assignment or an external candidate in accordance with these rules and the procedures established by the Director.
- B.** Types of Appointment.
 1. A regular appointment may be:
 - a. Full-time employment;
 - b. Part-time employment;
 - c. Subject to funding availability, such as federal or grant funding; or
 - d. To a trainee position.
 2. A temporary appointment may be made for a recurring period of time up to a maximum of 1500 hours in any one position per agency each calendar year. A temporary appointment employee may work full time for a portion of the year, intermittently, on a seasonal basis, or on an as needed basis. An employee in a pool classification is considered a temporary appointment.
 3. An agency head may place an employee on special assignment within the agency. A special assignment may be made non-competitively and for up to six months with the concurrence of the employee, the agency head of the employing agency and the Director. A special assignment shall not exceed six months unless extended by the Director. An agency head shall not make successive special assignments of the same person to the same class.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5A-308. Applicant Complaint

An applicant who has a complaint alleging discrimination or harassment relating to the procedures used in the selection or evaluation process shall submit the applicant complaint to the agency human resources representative within 90 days of the action giving rise to the complaint. The agency human resources representative

shall evaluate the complaint and notify the applicant of the final action to be taken.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

ARTICLE 4. COMPENSATION SYSTEM

R2-5A-401. Salary Plans

- A. General. The Director shall establish a salary plan. The salary plan shall allow for the following:
 1. Minimum and maximum rates of pay for classes outlined in the classification plan.
 2. Salary adjustments, including adjustments to base salary and pay supplements and incentives, including add-ons to base salary.
- B. Alternative salary plan. The Director may establish a special salary plan or pay practice determined to be the prevailing practice in the labor market and in the best interest of the state.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5A-402. Salary Administration

- A. General. The Director shall develop procedures for salary administration for use by all agencies when setting the salary of an employee. In setting an employee's salary, an agency head shall consider such factors as the employee's education, experience, skills, performance, and current or former salary, as well as the current salaries of employees in the same class in the agency and the relative experience and performance of those employees.
- B. Classes. The Director shall assign each class to a salary range and to a grade.
- C. Salary. The base salary of an employee shall be not less than the minimum nor more than the maximum of the salary range of the class to which the employee's position is allocated, except as provided by these rules.
- D. Salary adjustment. The salary used to compute a salary adjustment is the employee's base salary. Following an adjustment to the base salary, an agency shall add to the new rate of pay any special pay supplement still valid.
- E. New hire starting rate. An agency head may offer a salary to a new hire within the salary range of the class to which the employee is being appointed in accordance with the procedures and guidelines published by the Director, unless an exception is approved by the Director.
- F. Promotion. An employee who has a change in assignment from a position in one class to a position in another class having a higher grade shall receive a salary increase as determined by the agency head in accordance with the procedures and guidelines published by the Director, unless an exception is approved by the Director.
- G. Demotion.
 1. An employee who has a change in assignment from a position in one class to a position in another class having a lower grade, whether voluntary or involuntary, shall receive a salary decrease as determined by the agency head in accordance with the procedures and guidelines published by the Director, unless an exception is approved by the Director.
 2. If the employee's demotion is involuntary, the employee shall not be eligible for a salary increase for six months after the effective date of the demotion, other than a salary increase that is legislatively mandated. After six months, the employee may become eligible for a salary

increase only after a performance evaluation in the new position for which the employee received an overall rating of "meets expectations" or higher.

- H. Lateral transfer. An employee who has a change in assignment from a position in one class to a position in another class having the same grade shall receive no increase in salary, unless an exception is approved by the Director. The Director may approve a salary increase based upon documentation of recruitment difficulties to fill the position, specific needs identified by the agency, or the employee's qualifications. Transferred employees are not eligible for increases to base salary during their first six months in the new job unless approved by the Director. An employee who transfers to another agency may become eligible for a salary increase only after a performance evaluation in the new position for which the employee received an overall rating of "meets expectations" or higher.
- I. Reversion of covered employee. A covered employee who is reverted under the rules in Subchapter B shall be paid the same salary as that paid prior to the promotion, plus the percentage or dollar amount of increase of an intervening general salary adjustment for which the employee was eligible.
- J. Job reallocation.
 1. The base salary of an employee in a position that is reallocated to a class in a higher pay range may receive a salary increase in accordance with the procedures and guidelines published by the Director. If increasing the base salary of an employee would result in a salary level that is less than the minimum or greater than the maximum salary of the pay range, the employee's salary shall be the minimum or the maximum salary of the pay range, respectively.
 2. The base salary of an employee in a position that is reallocated to a class with the same or lower pay range shall remain the same provided that the employee's salary is within the pay range of the position. If the employee's salary is less than the minimum of the salary range or greater than the maximum salary of the new pay range, the employee's salary shall be the minimum salary or the maximum salary of the new pay range, respectively.
- K. Job regrade.
 1. The base salary of an employee in a class that is reassigned to a higher grade shall be adjusted by the amount determined by the Director. If adjusting the base salary of an employee would result in a salary level that is less than the minimum or greater than the maximum salary of the pay range, the employee's salary shall be the minimum or the maximum salary of the pay range, respectively.
 2. The base salary of an employee in a class that is reassigned to a lower grade shall remain the same provided that the employee's salary is at or above the minimum salary of the new pay range of the class, and may be greater than the maximum salary of the pay range. If the employee's salary is greater than the maximum, the employee is not eligible for an increase to base pay until the employee's salary is less than the maximum salary of the new pay range.
- L. Merit increases.
 1. The Director shall establish guidelines for merit increases to base pay.
 2. Merit increases shall be available:
 - a. To uncovered employees.
 - b. To covered employees only if such increases are legislatively appropriated.
 3. Subject to the guidelines established by the Director:
 - a. Merit increases may be implemented at the discretion of the agency head.

- b. Merit increases are subject to the availability of funding and must be within an agency's appropriation unless otherwise legislatively appropriated.
- 4. An agency head shall report to the Director on the utilization of merit increases pursuant to the reporting requirements in the guidelines established by the Director.
- M. Legislatively-appropriated salary adjustments. Subject to legislative appropriation, the Director shall determine employee eligibility and criteria for salary adjustments.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5A-403. Supplemental Pay

- A. General. Supplemental pay is in addition to an employee's base pay. The salary of an employee may exceed the maximum salary of the pay range for the employee's class if the excess amount is due to the receipt of supplemental pay.
- B. Shift differential. The Director may authorize a shift differential to be paid to an employee on other than a day shift. The Director shall establish a competitive shift differential rate periodically based on an annual survey of the market place. Employees in the same class in the same agency who work on the same shift shall receive the same shift differential pay.
- C. Special assignment. An employee on a special assignment shall remain in the employee's current position with no change to base salary. If the classification to which the employee is on a special assignment is a higher grade, the employee shall be provided a conditional pay supplement in an amount that, when added to the employee's base salary, would be within the range of the higher classification. If the classification to which the employee is on a special assignment is the same or a lower grade, the employee shall not be eligible for a conditional pay supplement while on special assignment. Any conditional pay supplement received by the employee for the special assignment shall be discontinued at the conclusion of the special assignment.
- D. Conditional pay supplements. The Director may establish conditional pay supplements. A conditional pay supplement provides additional compensation to an eligible employee and shall be discontinued when the qualifying conditions no longer apply. An employee may be awarded multiple conditional pay supplements. A conditional pay supplement does not:
 - 1. Change base salary;
 - 2. Provide a basis for the computation of a salary increase; or
 - 3. Provide a basis for the computation of pay upon an employee's promotion, demotion or transfer.
- E. Variable pay.
 - 1. The Director may establish variable pay strategies determined to be the prevailing practices in the market and in the best interest of the state.
 - 2. If the Director establishes variable pay strategies, the Director shall establish guidelines for the administration of variable pay.
 - 3. Variable pay shall be available only to uncovered employees, except for employees in covered positions classified as Correctional Officers I, II, or III, or Community Corrections Officers, as specified in the guidelines established by the Director.
 - 4. Subject to the guidelines established by the Director:
 - a. Variable pay strategies may be implemented at the discretion of the agency head.
 - b. Variable pay strategies are subject to the availability of funding and must be within an agency's appropriation unless otherwise legislatively appropriated.

- 5. An agency head shall report to the Director on the utilization of variable pay strategies pursuant to the reporting requirements in the guidelines established by the Director.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5A-404. Overtime

- A. Approval of overtime work. An agency head may require that an employee work overtime and:
 - 1. Shall approve in advance all work in excess of 40 hours per workweek or in excess of a work period as defined by the Fair Labor Standards Act (FLSA). FLSA Regulations 29 CFR 553 and 778 (July 2012), are incorporated by this reference and on file with the Department and available from the U.S. Government Printing Office, 732 North Capitol Street N.W., Washington, D.C. 20401. This incorporation by reference contains no future editions or amendments; and
 - 2. May assign an employee who volunteers for overtime before mandatory overtime is required.
- B. Exemptions. The Director shall determine exemptions from minimum wage and maximum hour requirements in accordance with the Fair Labor Standards Act, 29 U.S.C. 213, January 2004, incorporated by this reference and on file with the Department and available from the U.S. Government Printing Office, 732 North Capitol Street N.W., Washington, D.C. 20401. This incorporation by reference contains no future editions or amendments.
- C. Non-exempt employees.
 - 1. An agency shall compensate an employee in a non-exempt position who works in excess of 40 hours per workweek or in excess of a work period as defined by the FLSA by either:
 - a. Additional pay at the rate of 1 1/2 times the employee's regular rate for each excess hour worked, or
 - b. Compensatory leave at the rate of 1 1/2 hours for each excess hour worked.
 - 2. An employee shall select either overtime pay or compensatory leave for overtime compensation. If the employee selects both overtime pay and compensatory leave, the agency head shall determine which applies. If an employee's compensatory leave balance reaches the maximum allowed in subsection (E), the agency head shall compensate the employee by overtime pay.
- D. Exempt employees.
 - 1. Unless otherwise provided by statute or as specified in subsection (D)(2), an employee who is in a position that is exempt from the FLSA is excluded from receiving either overtime pay or compensatory leave.
 - 2. An employee who is in a position that is exempt from the FLSA who works in excess of 40 hours per workweek or in excess of an established work period shall receive for each hour of overtime worked, either one hour of additional pay or earn one hour of compensatory leave, at the option of the agency head, if the employee is either:
 - a. Engaged in law enforcement activities;
 - b. Engaged in firefighting activities; or
 - c. A full authority peace officer as certified by the Arizona Peace Officer Standards and Training Board, is in a position that requires such certification, and is in the covered service.
 - 3. An exempt employee may earn compensatory leave as provided by subsection (D)(2) until the employee's com-

persatory leave balance reaches the maximum allowed in subsection (E). When the maximum balance is reached, an agency head shall compensate the employee by overtime pay for excess hours worked.

4. For the purposes of this subsection, “engaged in law enforcement activities” has the same meaning as defined in A.R.S. Title 23, Chapter 2, Article 9.

E. Maximum accumulation. The maximum number of hours of accumulated compensatory leave is:

1. 480 hours for an employee who works in a public safety activity or an emergency response activity, or
2. 240 hours for an employee who works in any other activity.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5A-405. Tuition Reimbursement for Education

A. General. A state agency may assist an employee in the pursuit of educational goals by providing tuition reimbursement.

B. Procedures. Prior to granting tuition reimbursement, an agency shall establish a policy which shall include the following conditions:

1. The educational program will provide a benefit to the state.
2. The employee shall successfully complete the required course work or the educational requirements of the program in order to receive reimbursement.
3. Education assistance may not exceed \$5,250 per employee in any one calendar year unless approved in advance by the Director.
4. An employee who receives education assistance may be required to return all or a portion of the amount received if the employee does not remain employed with the agency for a defined period of time, as specified in the agency’s policy.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5A-406. Reimbursement for Relocation

An agency head may reimburse reasonable relocation expenses to a current employee for a management initiated geographical transfer of more than 50 miles from the employee’s current work site in accordance with the procedures established by the Director.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

ARTICLE 5. CONDITIONS OF EMPLOYMENT

R2-5A-501. Standards of Conduct

A. Required conduct. A state employee shall at all times:

1. Comply with federal and state laws and rules, and agency policies and directives;
2. Maintain high standards of honesty, integrity, and impartiality, free from personal considerations, or favoritism;
3. Be courteous, considerate, and prompt in interactions with and serving the public and other employees; and
4. Conduct himself or herself in a manner that will not bring discredit or embarrassment to the state.

B. Prohibited conduct. A state employee shall not:

1. Use his or her official position for personal gain, or attempt to use, or use, confidential information for personal advantage;

2. Permit himself or herself to be placed under any kind of personal obligation that could lead a person to expect official favors;

3. Perform an act in a private capacity that may be construed to be an official act;

4. Accept or solicit, directly or indirectly, anything of economic value as a gift, gratuity, favor, entertainment, or loan that is, or may appear to be, designed to influence the employee’s official conduct. This provision shall not prohibit acceptance by an employee of food, refreshments, or unsolicited advertising or promotional material of nominal value;

5. Directly or indirectly use or allow the use of state equipment or property of any kind, including equipment and property leased to the state, for other than official activities unless authorized by written agency policy or as otherwise allowed by these rules;

6. Inhibit a state employee from joining or refraining from joining an employee organization; or

7. Take disciplinary or punitive action against another employee that impedes or interferes with that employee’s exercise of any right granted under the law or these rules.

- C. Consequences of non-compliance.** An employee who violates the standards of conduct requirements listed in subsection (A) or (B) may be disciplined or separated from state employment. Any such actions involving a covered employee shall be in accordance with the rules in Subchapter B, Article 3.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5A-502. Hours of Work

- A. State work week.** The state work week is the period of seven consecutive days starting Saturday at 12:00 a.m. and ending Friday at 11:59 p.m. An agency head may apply to the Director for an exception from the work week period for all or part of an agency workforce. The Director may grant an exception from the work week period to promote efficiency in the State Personnel System.

B. Hours of employment.

1. An agency head shall determine the hours of employment in the work week for each agency employee.
2. An agency head may provide for breaks during the work period consistent with carrying out the duties of the agency.
3. An agency head may require an employee to work overtime.

- C. Flexible work options.** An agency head may offer a flexible 40-hour work week option to an employee if the agency head determines the agency’s services can be maintained.

- D. Attendance standards.** An agency head may establish a standard of attendance.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5A-503. Outside Employment

- A. General.** A state employee may seek employment and engage in a variety of activities outside of the employee’s work for the state; however, the employee shall not engage in other employment or other activity that is not compatible with the full and proper discharge of the duties and responsibilities of state employment, or that tends to impair the employee’s capacity to perform the employee’s duties and responsibilities in an acceptable manner.

- B. Definitions.** For the purposes of this Section:

1. "Other employment" includes, but is not limited to:
 - a. Working as an employee for any employer, including another state agency;
 - b. Owning a business;
 - c. Contracting to provide services for a fee; or
 - d. Serving as a consultant for a fee or being self-employed;
 - e. Holding any elected or appointed public office, whether federal, state, or local; or
 - f. Holding a position in a political party or organization.

2. "Primary agency" means the agency in which the employee is employed at the time of the employee's request to obtain outside employment with another agency.

3. "Secondary agency" means the agency in which the employee is requesting to be employed while remaining employed with the primary agency.

C. Notice requirement. An employee who desires to engage in other employment shall notify the employee's supervisor and abide by the policies of the employing agency. An employee engaged in outside employment, including consultant relationships, shall inform the supervisor of the nature of the employment and corresponding work hours. An employee shall also disclose actual or potential conflicts of interest related to outside employment activities as soon as the employee becomes aware of the conflict. The determination as to whether a conflict or potential conflict exists shall be made by the agency head.

D. Outside employment with another state agency. An employee who seeks outside employment with another state agency must request approval from both the employee's primary agency and prospective secondary agency before commencing employment with the secondary agency. The primary and secondary agencies must ensure that the request complies with state and federal guidelines. Such request, if approved shall be in writing and on file with both agencies. Employment records are to be maintained in accordance with the provisions of R2-5A-105.

E. Outside employment as a paid public official or in a political party or organization. All employees shall comply with A.R.S. § 41-752 pertaining to political activities.

F. Termination of outside employment. If an agency head determines that an employee's outside employment interferes with the employee's performance or creates a conflict of interest, the employee will be required to terminate the outside employment.

G. Consequences of non-compliance. An employee who fails to make required disclosures or to take action to resolve any conflict of interest may be disciplined or separated from state employment. Any such actions involving a covered employee shall be in accordance with the rules in Subchapter B, Article 3.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5A-504. Alcohol and Drug-free Workplace

State agencies shall prohibit the manufacture, distribution, dispensation, possession or use of alcohol, illegal drugs, unauthorized drugs, inhalants, or other unauthorized controlled substances during an employee's working hours or while on state premises or worksites, including state vehicles and property leased to the state. A state employee shall not be impaired by alcohol or drugs while on duty.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

ARTICLE 6. LEAVE

PART A. GENERAL

R2-5A-A601. Leave Administration

A. Leave plans. The Director shall adopt leave plans. Agency heads are responsible for administering leave for agency employees in accordance with the leave plans in this Article.

B. Eligibility for leave. All state employees, except temporary employees, are eligible for any type of leave with pay from the date of appointment. Temporary employees are eligible only for holidays subject to the provisions of R2-5A-B601, administrative leave, civic duty leave for the purpose of voting, living donor leave and military leave.

C. Amount of leave. Leave amounts are based on full-time employment and shall be pro-rated for part-time employees, even if not specified in an individual rule.

D. Family and Medical Leave Act (FMLA) leave. FMLA Regulations, 29 CFR 825.100 through 29 CFR 825.800 (July 2012), are incorporated by this reference and on file with the Department and available from the U.S. Government Printing Office, 732 N. Capitol Street N.W., Washington, D.C. 20401. This incorporation by reference contains no future editions or amendments. An employee who meets FMLA eligibility requirements and uses leave for any of the situations covered by the FMLA shall be subject to the following:

1. Counting FMLA leave. Periods of paid leave and periods of leave without pay shall count towards the employee's available FMLA leave.
2. Use of accrued paid leave. An employee shall use available paid leave for all or part of the employee's FMLA leave under the conditions in:
 - a. R2-5A-D602 for an employee on industrial leave,
 - b. R2-5A-D601 for an employee on FMLA leave for any other reason.

E. Insurance benefits continuation. An employee remains eligible for continued participation in the employee insurance plans while on leave pursuant to this Article.

F. Requests for leave. Except in an emergency, an employee shall obtain approval in advance and in writing before taking any leave.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

PART B. PAID LEAVE

R2-5A-B601. Holidays

A. State holidays.

1. January 1, "New Year's Day."
2. Third Monday in January, "Martin Luther King, Jr./Civil Rights Day."
3. Third Monday in February, "Lincoln/Washington Presidents' Day."
4. Last Monday in May, "Memorial Day."
5. July 4, "Independence Day."
6. First Monday in September, "Labor Day."
7. Second Monday in October, "Columbus Day."
8. November 11, "Veterans Day."
9. Fourth Thursday in November, "Thanksgiving Day."
10. December 25, "Christmas Day."

B. Employees scheduled to work. Unless required to work to maintain essential state services, an employee who is regularly scheduled to work on a day on which one of the holidays listed

in subsection (A) is observed is entitled to be absent with pay for the number of hours regularly scheduled to work, not to exceed eight hours, provided the employee is not on leave without pay on the employee's work days immediately preceding or following the day on which the holiday is observed.

1. Part-time employees who work 1/4 time, 1/2 time, or 3/4 time are entitled to a proportional amount of holiday pay. Part-time employees who work a percentage of full-time other than 1/4 time, 1/2 time, or 3/4 time are entitled to holiday pay at the next lower rate. An employee who works less than 1/4 time is not entitled to holiday pay.
 2. Temporary employees shall receive holiday pay provided they are in pay status the day before and the day after the holiday.
- C.** Employees not scheduled to work. An employee, excluding part-time and temporary employees, who is not scheduled to work on a day on which one of the holidays listed in subsection (A) above is observed shall receive holiday compensation for the number of hours normally worked per day, not to exceed eight, provided the employee is not on leave without pay on the employee's work days immediately preceding or following the day on which the holiday is observed.
- D.** Employees required to work. An employee who is required to work on a day on which a holiday listed in subsection (A) is observed shall receive:
1. Both holiday compensation and one hour of pay at the employee's current salary rate for each hour worked if the employee is in a position that is either:
 - a. FLSA non-exempt; or
 - b. Exempt from the FLSA, but meets the conditions in R2-5A-404(D)(2).
 2. No additional compensation if the employee is in a position that is exempt from the FLSA and is employed in any other capacity.
- E.** Holiday compensation.
1. Except as modified by subsection (E)(2), an employee who is eligible for holiday compensation pursuant to subsection (C) or (D) shall receive for each hour of holiday compensation authorized, at the option of the agency head, either:
 - a. One hour of additional pay at the current salary rate; or
 - b. One hour of annual leave; or
 - c. One hour time off with pay on an alternate work day specified by the agency head after the holiday and during the pay period in which the holiday is observed, or the succeeding pay period.
 2. Temporary employees do not accrue annual leave and shall receive either additional pay or time off as in subsection (E)(1)(c) above.
 3. An employee may not receive more than eight hours of holiday compensation for any holiday.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5A-B602. Annual Leave

A. Definitions. For the purposes of this Section:

1. "Annual leave" means a period of approved absence with pay that is not chargeable to another category of leave.
2. "Hire date" means the employee's first day of work upon hire or, if the employee has a break in service, rehire.

B. Accrual.

1. All employees, except temporary and part-time employees, shall accrue annual leave as follows:

- a. Covered employees shall accrue annual leave in accordance with the following schedule:

Credited Service	Hours Bi-weekly
Fewer than 3 years	3.70
3 years but fewer than 7 years	4.62
7 years but fewer than 15 years	5.54
15 years or more	6.47

- b. Except as provided in subsection (B)(1)(c), uncovered employees shall accrue leave based on the following schedule:

Credited Service	Hours Bi-weekly
Fewer than 3 years	4.00
3 years but fewer than 9 years	5.54
9 years or more	6.47

- c. An uncovered employee shall accrue annual leave at the rate of 6.47 hours bi-weekly if:
 - i. The employee's hire date is prior to September 29, 2012, the employee has remained employed without a break in service since that date, and the employee either was uncovered prior to September 29, 2012 or became uncovered in accordance with A.R.S. Title 41, Chapter 4, Article 4; or
 - ii. The employee is in a position listed in A.R.S. § 41-742(F).

2. Temporary employees shall not accrue annual leave.
3. Part-time employees who:
 - a. Work 1/4 time, 1/2 time, or 3/4 time shall accrue a proportional amount of annual leave;
 - b. Work a percentage of full-time other than 1/4 time, 1/2 time, or 3/4 time shall accrue annual leave at the next lower rate;
 - c. Work less than 1/4 time shall not accrue annual leave.
4. Except as provided by R2-5A-D602 for an employee on industrial leave, an eligible employee accrues annual leave each bi-weekly pay period if the employee is in pay status for at least one-half of the employee's scheduled work hours in that pay period.
5. An annual leave accrual is credited on the last day of the bi-weekly pay period in which the accrual is earned and is available for use on the first day of the following pay period.
 - a. Annual leave accrued during the last pay period that begins in a calendar year is not subject to forfeiture under subsection (D).
 - b. An employee who is separating from state employment is compensated in accordance with subsection (I) for annual leave accrued through the employee's last date of employment.
6. The effective date for change in the accrual rate is the first day of the pay period immediately following the attainment of the required credited service.

C. Credited service.

1. Credited service shall be calculated from the first day of the first complete pay period worked.
2. Credited service shall include:
 - a. A period of service as an employee of a state budget unit before a break in service of less than two years;
 - b. A period of leave without pay of 240 hours or less;
 - c. Family and Medical Leave Act (FMLA) leave;
 - d. Military leave taken under A.R.S. §§ 26-168, 26-171, or 38-610; and
 - e. Active military service of an employee who is restored to state employment under A.R.S. § 38-298.

D. Accumulation.

1. Except as provided in subsections (D)(2) and (3), an employee shall forfeit annual leave in excess of the accumulation limit as of the last day of the last pay period that begins in a calendar year. The accumulation limit is:
 - a. 240 hours for a covered employee.
 - b. 320 hours for an uncovered employee.
2. An agency head may request an exception to the accumulation limit contained in subsection (D)(1) for an employee in an individual case.
 - a. An agency head seeking an exception shall submit a written request to the Director that contains a plan to use the excess hours during the following calendar year, pay the employee for the excess hours, or a combination of both.
 - b. The Director may approve, modify, or deny the request.
3. Annual leave earned for working on a day on which a state holiday is observed is not included in the accumulation limit specified in subsection (D)(1) and shall not be forfeited.

E. Use of annual leave.

1. An employee may take annual leave at any time approved by the agency head.
2. An agency head shall not advance annual leave to an employee.

F. Donation of annual leave.

1. Definitions. For the purposes of this subsection:
 - a. *“Immediate family” means the recipient employee’s parent, spouse, or child, whether natural, adopted, foster, or step.* A.R.S. § 41-748(B)(1)
 - b. *“Family” means spouse, natural child, adopted child, foster child, stepchild, natural parent, step-parent, adoptive parent, grandparent, grandchild, brother, sister, sister-in-law, brother-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, aunt, uncle, nephew, or niece.* A.R.S. § 41-748(B)(2)
 - c. *“Disability that is caused by pregnancy or childbirth” means, as certified by a licensed health care practitioner:*
 - i. An employee is unable to work due to the employee’s pregnancy, childbirth, or medical care associated with the pregnancy or childbirth; or
 - ii. A member of the employee’s immediate family requires assistance to perform regular daily activities due to the immediate family member’s pregnancy, childbirth, or medical care associated with the pregnancy or childbirth.
 - d. *“Extended” means a period of at least three consecutive weeks.*
 - e. *“Seriously incapacitating” means a licensed health care practitioner certifies that an illness, injury, or disability that is caused by pregnancy or childbirth:*
 - i. Involves in-patient care, or
 - ii. Involves continuing treatment.
2. Eligibility to receive donation of annual leave. An employee who has exhausted all available leave balances is eligible to receive donations of annual leave if, as certified by a licensed health care practitioner:
 - a. The employee is unable to work due to:
 - i. A seriously incapacitating and extended illness or injury, or

- ii. A seriously incapacitating and extended disability that is caused by pregnancy or childbirth, or
- b. The employee needs to care for a member of the employee’s immediate family who has:
 - i. A seriously incapacitating and extended illness or injury, or
 - ii. A seriously incapacitating and extended disability that is caused by pregnancy or childbirth.
3. Eligibility to donate annual leave. An employee may donate annual leave to another employee who has exhausted all available leave balances if:
 - a. The recipient employee is employed in the same state agency as the donating employee, or
 - b. The recipient employee is a family member of the donating employee and employed in another state agency.
4. Exhaustion of available leave. Before using donated annual leave, a recipient employee:
 - a. Who has a qualifying illness, injury, or disability caused by pregnancy or childbirth shall exhaust all available sick leave, compensatory leave, annual leave earned for working on a day on which a state holiday is observed and accrued annual leave; or
 - b. Whose immediate family member has a qualifying illness, injury, or disability caused by pregnancy or childbirth shall exhaust sick leave granted in accordance with R2-5A-B603(A)(4), if available, and all available compensatory leave, annual leave earned for working on a day on which a state holiday is observed and accrued annual leave.
5. Calculation of hours donated. An agency head shall adjust the number of hours of annual leave donated in proportion to the hourly rate of pay of the donating employee and the recipient employee. To calculate the number of hours of donated annual leave:
 - a. Multiply the actual number of hours donated by the donating employee’s hourly rate of pay, and
 - b. Divide the result by the recipient employee’s hourly rate of pay.
6. Maximum duration. A recipient employee is limited to using donated annual leave to allow the employee to be absent from work for a maximum of six consecutive months, or if the leave is intermittent, 1040 hours (the employee’s available leave plus leave donated to the employee) for each qualifying occurrence. If the recipient employee has a seriously incapacitating and extended illness or injury, or a seriously incapacitating and extended disability that is caused by pregnancy or childbirth and the employee applies for Long-term Disability (LTD) by the end of the fifth month of the employee’s leave, the recipient employee may continue to use donated annual leave for up to 60 additional days or until LTD benefit payments begin, whichever is sooner.
7. Unused donated leave. If the recipient employee separates from state employment, recovers before using all donated leave, attains the maximum donation of annual leave as permitted under subsection (F)(6), or the need for the donated annual leave is otherwise abated, the agency head shall return unused donated leave to employees who donated leave on a pro-rata basis.

G. Payment of annual leave. Subject to funding availability:

1. An agency head may pay an employee at any time at the employee’s current rate of pay for all or any portion of

the employee's annual leave that was earned as the result of working on a day on which a state holiday is observed.

2. An agency head may request and the Director may approve pay to a non-separating employee for all or any portion of the employee's accumulated and unused annual leave at the employee's current rate of pay subject to the following:
 - a. Agency procedures. Before requesting approval to pay an employee under this subsection, an agency head shall develop written standards and procedures that provide for equal consideration of all employees similarly situated. The agency head shall submit proposed standards and procedures and any subsequent changes to the Director for approval. The agency's procedures shall include at minimum:
 - i. Request and approval procedures;
 - ii. Documentation required to support the request for payment;
 - iii. Any limitations, as applicable, including, but not limited to: the maximum number of times an employee may receive payment under this subsection; the maximum number of hours an employee may be paid per occurrence; the minimum number of hours of annual leave an employee must have used in the previous 12 months; and the minimum balance an employee is required to maintain after payout, if any.
 - b. Restrictions. If payment would reduce the employee's annual leave balance to fewer than 240 hours, the agency head shall obtain the employee's concurrence.

H. Movement.

1. To another state agency. If an employee moves from one agency to another state agency, the employee's accumulated and unused annual leave shall be transferred to the employee's annual leave account in the new state agency, unless:
 - a. The provisions of subsection (H)(2) apply; or
 - b. The employee's leave exceeds the accumulation limit contained in subsection (D)(1). An agency head may pay an employee who transfers to another state agency for all excess annual leave at the time of the transfer. An agency head may transfer part or all of the employee's excess annual leave accumulated by the employee who transfers to another agency with the gaining agency's concurrence. If the gaining agency does not concur, the losing agency shall pay all of the unused excess annual leave that the gaining agency will not accept.
2. To an employment status ineligible for leave accrual. If an employee becomes ineligible for accrual of annual leave under R2-5A-A601(B), the agency head or the agency head of the losing agency if the employee moves to another state agency, shall pay the employee for all unused and unforfeited annual leave at the employee's current rate of pay immediately before the change in status.

- I. Separation. An agency head shall pay an employee who separates from state employment for all unused and unforfeited annual leave at the employee's current rate of pay.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5A-B603. Sick Leave

- A. Definition. "Sick leave" is any approved period of paid absence granted an employee due to:
 1. Illness or injury that renders the employee unable to perform the duties of the employee's position.
 2. Disability of the employee that is caused by pregnancy, childbirth, miscarriage, or abortion.
 3. Examination or treatment of the employee by a licensed health care practitioner.
 4. Illness, injury, disability caused by pregnancy or childbirth, or examination or treatment by a licensed health care practitioner of an employee's spouse, dependent child, or parent. Sick leave granted for this purpose shall be charged to the employee's sick leave account and shall not exceed 40 hours per calendar year. For the purposes of this Section:
 - a. The term "dependent child" means a natural child, an adopted child, a foster child, or a stepchild, more than one-half of whose support is received from the employee.
 - b. The term "parent" means a birth parent, adoptive parent, stepparent, foster parent, grandparent, parent-in-law, or an individual who stood "in loco parentis."

B. Accrual.

1. All state employees, except temporary and part-time employees, shall accrue sick leave at the rate of 3.70 hours bi-weekly.
2. Temporary employees shall not accrue sick leave.
3. Part-time employees who:
 - a. Work 1/4 time, 1/2 time, or 3/4 time shall accrue a proportional amount of sick leave;
 - b. Work a percentage of full-time other than 1/4 time, 1/2 time, or 3/4 time will accrue sick leave at the next lower rate;
 - c. Work less than 1/4 time shall not accrue sick leave.
4. Except as provided by R2-5A-D602 for an employee on industrial leave, an eligible employee accrues sick leave each bi-weekly pay period if the employee has been in a pay status for at least one-half of the employee's scheduled work hours in that pay period or month.
5. A sick leave accrual is credited on the last day of the bi-weekly pay period or month in which the accrual is earned and is available for use on the first day of the following pay period or month. An employee who is separating from state employment accrues leave through the employee's last date of employment for the purpose of determining the employee's accumulated sick leave at the time of the employee's separation pursuant to subsection (F).

- C. Accumulation. Sick leave accumulates without limit.

D. Use of sick leave.

1. Sick leave may be taken when approved by the agency head.
2. The agency head may require submission of evidence substantiating the need for sick leave. If the agency head determines the evidence is inadequate, the absence shall be charged to another category of leave or considered absence without leave.
3. An agency head may require an employee to be examined by a licensed health care practitioner designated by the agency head.
 - a. If the licensed health care practitioner determines that the employee should not work due to illness or injury, the agency head may place the employee on sick leave or, if the employee's sick leave is

exhausted, charge the absence to another category of leave or leave without pay.

- b. The agency head may require the employee to obtain approval from the licensed health care practitioner before returning to work.
- c. The agency shall pay for all examinations required pursuant to this subsection. The employee shall not be charged any leave while participating in or traveling to or from any examination required pursuant to this subsection.

- E. Movement to another state agency. An employee who moves to another state agency shall transfer all accumulated and unused sick leave to the employee's sick leave account in the new state agency.
- F. Separation. All sick leave credits are forfeited upon separation from state employment except as provided in A.R.S. § 38-615 or otherwise provided by law. However, an employee who returns to state employment within two years after separation shall be credited with all unused sick leave accumulated at the time of separation if the employee was not paid for accumulated sick leave pursuant to A.R.S. § 38-615.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5A-B604. Administrative Leave

- A. General. An agency head may authorize an employee to be absent with pay on administrative leave during a state of emergency declared by the Governor or:
 1. In other emergency situations such as extreme weather conditions, fire, flood, or malfunction of publicly-owned or controlled machinery or equipment.
 2. To relieve an employee of duties temporarily during the investigation of alleged wrongdoing by the employee or during a disciplinary process, subject to the requirements outlined in subsections (B) and (C).
- B. Reporting administrative leave. If an employee's administrative leave totals 80 consecutive hours, the agency head shall submit a report to the Director and for each week thereafter, until the employee's administrative leave is terminated. The report shall include:
 1. The name of the agency,
 2. The employee identification number (EIN) of the employee,
 3. The name of the employee,
 4. The employment status of the employee,
 5. The date the employee was placed on administrative leave,
 6. The number of hours the employee has been on administrative leave as of the date of the report, and
 7. A brief description as to why the employee is on administrative leave.
- C. Approval of Director. If an employee's administrative leave is anticipated to exceed 240 consecutive working hours, the agency head shall obtain the approval of the Director.
 1. An agency head requesting approval to continue an employee's administrative leave for more than 240 working hours shall submit a request to the Director for approval at least five business days before the employee's administrative leave will total 240 working hours. If circumstances beyond the agency's control do not permit at least five business days' notice, the agency head shall submit the request as soon as the agency head is aware of the necessity for the request. The request shall include all of the information listed in subsection (B), the reason the administrative leave will extend beyond 240 working

hours and the anticipated date the administrative leave will be terminated.

2. The Director shall review the request and approve, modify or deny the request within three business days of receipt.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5A-B605. Bereavement Leave

- A. General. An employee may be absent with pay due to the death or funeral of a spouse, natural child, adopted child, foster child, stepchild, natural parent, stepparent, adoptive parent, an individual who stood "in loco parentis," grandparent, grandchild, brother, sister, brother-in-law, sister-in-law, mother-in-law, father-in-law, son-in-law, or daughter-in-law.
- B. Amount of bereavement leave.
 1. A full-time employee may be absent with pay for up to 24 regularly scheduled work hours. An agency head may extend the bereavement leave for up to 16 additional work hours if the employee travels out-of-state for the funeral.
 2. A part-time employee who works 1/4 time, 1/2 time, or 3/4 time may be absent with pay for a proportional amount of bereavement leave. A part-time employee who works a percentage of full-time other than 1/4 time, 1/2 time, or 3/4 time may be absent with pay at the next lower rate. An employee who works less than 1/4 time is not entitled to bereavement leave.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5A-B606. Civic Duty Leave

- A. General. Upon substantiated application, an employee shall receive absence with pay as civic duty leave while serving as a juror, complying with a subpoena, voting, or serving as a member of a governmental board, commission, or similarly constituted governmental body, subject to the conditions set forth in this rule and the limitations in R2-5A-A601(B).
- B. Use of civic duty leave. Except for voting pursuant to A.R.S. § 16-401 (primary elections) or A.R.S. § 16-402 (general elections), an employee granted civic duty leave shall report for duty with the employing agency whenever the employee's presence is not required for the civic duty, unless:
 1. The distance to the work location would preclude timely reporting for the civic duty, or
 2. The employee cannot return to work at least one hour before the end of the work shift.
- C. Appearance as a witness. An employee who is subpoenaed as a witness by any court or administrative, executive, or judicial body in this state may be absent with pay unless the testimony or evidence to be given relates to the employee's commercial, business, or personal matters.
- D. Jury and witness fees. Employees who are granted civic duty leave when called for jury duty or subpoenaed as a witness shall remit any fees to the employing agency, except for mileage allowance.
- E. Membership on a public service body. An employee serving as a member of a governmental board, commission, or similarly constituted governmental body may be absent with pay while performing official duties with the body.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5A-B607. Compensatory Leave

- A.** General. Compensatory leave is leave that has been earned by an employee under the provisions of R2-5A-404.
- B.** Use of compensatory leave. An agency head:
1. Shall approve an employee's request for earned compensatory time off within a reasonable time after the employee makes the request if the use of such time off would not unduly disrupt agency operations.
 2. May require an employee to use the employee's available compensatory leave during a period specified by the agency head.
- C.** Payment. Subject to funding availability, an agency head may pay an employee at any time for all or any portion of the employee's earned compensatory leave balance at the employee's regular rate of pay.
- D.** Movement.
1. To another state agency. An agency head may pay an employee who transfers to another state agency for all unused compensatory leave at the time of the transfer. An agency head may transfer part or all of the compensatory leave earned by an employee who transfers to another agency with the gaining agency's concurrence. If the gaining agency does not concur, the losing agency shall pay all of the unused compensatory leave that the gaining agency will not accept.
 2. To an employment status or a position ineligible for compensatory leave. If an employee has a change in employment status or position that results in the employee being ineligible to earn compensatory leave, the agency head or the agency head of the losing agency if the employee moves to another state agency, shall pay the employee for all unused compensatory leave at the employee's regular rate of pay immediately before the employee's change in status or position.
- E.** Separation. An agency head shall pay an employee who separates from state employment for all unused compensatory leave at a rate of compensation not less than the higher of:
1. The average regular rate received by such employee during the last three years of the employee's employment, or
 2. The final regular rate received by such employee.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5A-B608. Educational Leave

- A.** General. An employee may be sent with pay to participate in a formal educational or training course of study at a college, university, or technical school with the approval of the agency head and the Director, based on the determination that the leave is in the best interest of the state.
- B.** Application. The approved application shall be accompanied by a written agreement signed by the agency head and the employee containing the following provisions at a minimum:
1. A statement of the payments, if any, to be provided to the employee and the manner of their payment.
 2. An agreement by the employee to return to or continue in state employment upon the completion of the educational or training course of study for a period of time specified by the agency head.
 3. A statement by the employee that failure to successfully complete the course, to complete the specified state employment, or to fulfill all of the terms of the agreement, shall result in the employee's being required to repay all or a proportionate part of the salary and other payments received, if any.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5A-B609. Living Donor Leave

An employee who requests absence with pay for living donor leave under A.R.S. § 41-706 shall submit written verification that the employee is to serve as a donor. An employee may be absent with pay for the time specified for the following purposes:

1. Up to 40 working hours to serve as a bone marrow donor.
2. Up to 240 working hours to serve as an organ donor.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5A-B610. Leave for National Disaster Medical System (NDMS) Training

An employee who requests absence with pay on national disaster medical system leave under A.R.S. § 38-610 is entitled to be absent with pay for the number of hours regularly scheduled to work on all days the employee is on training duty.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5A-B611. Meritorious Service Leave

- A.** The Director shall establish guidelines for meritorious service leave.
- B.** Except for employees in covered positions classified as Correctional Officers I, II, or III, or Community Corrections Officers, meritorious service leave is only available to uncovered employees.
- C.** The guidelines established by the Director shall include at a minimum:
1. The maximum number of hours of meritorious service leave that may be awarded to an employee per calendar year;
 2. The maximum percentage of agency employees eligible for meritorious service leave;
 3. A requirement that an employee shall use meritorious service leave within 12 months of receipt of the leave;
 4. A requirement that if the employee does not use the meritorious service leave within 12 months of receipt, that the leave is forfeited; and
 5. A statement that unused meritorious service leave is forfeited upon separation from state employment.
- D.** Subject to the guidelines established by the Director, a meritorious service leave program may be implemented at the discretion of the agency head.
- E.** An agency head shall report to the Director on the utilization of meritorious service leave pursuant to the reporting requirements in the guidelines established by the Director.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

PART C. UNPAID LEAVE**R2-5A-C601. Furlough**

- A.** Definition. A furlough is the involuntary placement of an employee on leave of absence without pay for budgetary reasons.
- B.** Types of furloughs. A furlough may be authorized by legislative action. In addition, the Director may approve:
1. A reduction of funding furlough that allows an agency head to place employees on furlough for any combination of consecutive or non-consecutive days. There is no maximum number of days an employee may be placed on fur-

lough, but consecutive furlough days shall not exceed five consecutive days or more than one-half the employee's regularly scheduled hours in a pay period, whichever is less; and

2. A suspension of funding furlough that allows an agency head to place employees on furlough indefinitely until funding is restored.

C. General.

1. The total number of days an employee is placed on furlough may vary based on the amount of the reduction or length of suspension of funding.
2. A furlough day equals eight hours for full-time employees and is pro-rated for part-time employees. Furlough hours for part-time employees are calculated by multiplying the number of hours the employee is scheduled to work in a week by 0.2. If the calculation results in a fraction, the furlough hours shall be rounded to the nearest whole hour, as follows:
 - a. 0.5 or above is rounded up, and
 - b. Less than 0.5 is rounded down.
3. A furlough is unpaid.
4. Unless a work emergency occurs under subsection (D)(5)(d), while on furlough, an employee shall not conduct state work or volunteer to conduct state work, either with or without compensation.
5. Paid leave shall not be substituted for furlough days.
6. All state employees within the scope of the furlough shall be subject to the furlough in the same manner. Exceptions may be granted when an agency head determines certain employees within the scope of the furlough have unique knowledge or skills or are considered mission critical and need to be excluded from the furlough.
7. Unless the employee is in a physician or attorney position, an employee who is in a position that has been determined to be exempt from the provisions of the Fair Labor Standards Act (FLSA) will lose the exemption for any work week in which the employee is furloughed for less than the full work week.
8. A furlough shall not adversely affect an employee's service anniversary date or create a break in service.
9. Upon conclusion of the furlough period, an agency head shall return an employee to the employee's status and position held prior to the furlough, unless a personnel action taken in accordance with State Personnel System rules authorizes a change to the employee's record.
10. An employee's failure or inability to return to work upon conclusion of the furlough period may, in accordance with applicable State Personnel System rules:
 - a. Result in the employee being placed on leave,
 - b. Be considered a resignation,
 - c. Result in separation without prejudice, or
 - d. Be cause for dismissal of a covered employee.

D. Reduction of funding furlough.

1. An agency head shall submit to the Director a furlough plan for approval if the agency head determines a furlough is necessary due to a reduction of funding. An agency head is not required to implement or exhaust other cost-savings measures prior to initiating a furlough plan.
2. The agency head shall submit the furlough plan for approval at least 30 business days prior to the proposed implementation date of the furlough. If circumstances beyond the agency head's control do not permit at least 30 business days' notice, the agency head shall submit the furlough plan as soon as the agency head is aware of the necessity for the furlough and provide a written explanation of why the 30 business day requirement was not met.

nation of why the 30 business day requirement was not met.

3. An agency head shall include all of the following in the furlough plan:
 - a. The proposed scope of the furlough plan, which shall be either agency-wide or limited to:
 - i. Agency operations in one or more geographic areas,
 - ii. One or more organizational units of the agency,
 - iii. One or more funding sources,
 - iv. One or more job classes,
 - v. One or more class series, or
 - vi. Any combination of the above.
 - b. If the furlough will not be conducted on an agency-wide basis, each affected:
 - i. Geographic location,
 - ii. Organizational unit,
 - iii. Funding source,
 - iv. Job class, and
 - v. Class series.
 - c. For each affected geographical location, organizational unit, funding source, job class, and class series specified in the furlough plan, the total number of employees scheduled for furlough;
 - d. If requesting any exceptions within the scope of the furlough under subsection (C)(6), the total number of employees within the scope of the furlough, the number of employees for whom an exception is requested, and the reason for the request;
 - e. The number of days and date ranges for the furlough;
 - f. The anticipated cost savings due to the furlough;
 - g. The agency's procedures for scheduling furloughs; and
 - h. The procedures for notifying employees of the furlough.
4. The Director shall review and provide written notification of approval, modification, or denial of an agency's furlough plan within 20 business days of receipt.
5. Upon approval of the Director to conduct a reduction of funding furlough, an agency head:
 - a. May place an employee on furlough for any combination of consecutive or non-consecutive days, subject to the limits in subsection (B)(1);
 - b. Shall determine the scheduling of furloughs that provide for the continuation of any agency operations required by law;
 - c. May cancel or rescind any approved paid or unpaid leave in progress or scheduled for an employee who is designated for furlough and shall notify the affected employee in writing of the cancellation of the approved leave for the duration of the furlough. If the previously approved leave was scheduled to extend beyond the furlough, the employee may return to paid leave status, if available, following the furlough period. If the agency head cancels an employee's paid leave and:
 - i. The employee is on leave pursuant to the provisions of the federal Family and Medical Leave Act (FMLA) during a scheduled furlough day, the furlough day shall not count against the employee's FMLA entitlement and the employee's leave balance shall not be charged for the furlough day; or
 - ii. The employee is on military leave during a scheduled furlough day, the furlough day shall

- not count against the employee's military leave and the employee's leave balance shall not be charged for the furlough day; and
- d. Shall prohibit an employee from working during the period of the furlough, unless a work emergency arises. In the event of a work emergency, an agency head may revoke the furlough for an employee in an individual case. An employee whose furlough is revoked due to an emergency shall be paid for time required to work and shall be required to take the furlough on another day, unless otherwise exempted.
- E. Suspension of funding furlough - agency head request.**
1. An agency head shall submit to the Director for approval a furlough plan if the agency head determines a furlough is required due to a suspension of funding to pay employees.
 2. The agency head shall submit the furlough plan for approval at least 15 business days prior to the proposed implementation date of the furlough. If circumstances beyond the agency head's control do not permit at least 15 business days' notice, the agency head shall submit the furlough plan as soon as the agency head is aware of the necessity for the furlough and provide a written explanation of why the 15 business day requirement was not met.
 3. An agency head shall include all of the following in the furlough plan:
 - a. The proposed scope of the furlough plan, which shall be either agency-wide or limited to:
 - i. Agency operations in one or more geographic areas,
 - ii. One or more organizational units of the agency,
 - iii. One or more funding sources,
 - iv. One or more job classes,
 - v. One or more class series, or
 - vi. Any combination of the above.
 - b. If the furlough will not be conducted on an agency-wide basis, each affected:
 - i. Geographic location,
 - ii. Organizational unit,
 - iii. Funding source,
 - iv. Job class, and
 - v. Class series.
 - c. For each affected geographical location, organizational unit, funding source, job class, and class series specified in the furlough plan, the total number of employees scheduled for furlough;
 - d. If requesting any exceptions within the scope of the furlough under subsection (C)(6), the total number of employees within the scope of the furlough, the number of employees for whom an exception is requested, and the reason for the request;
 - e. The procedures for notifying employees of the furlough; and
 - f. The procedures for notifying employees of restoration of funding and when to return to work.
 4. The Director shall review and provide written notification of approval, modification, or denial of an agency's furlough plan within 10 business days of receipt.
 5. Upon approval of the Director to conduct a suspension of funding furlough, an agency head:
 - a. Shall freeze all personnel actions except for those actions that would accomplish, or assist in accomplishing the purpose of the furlough;
 - b. May place employees on furlough indefinitely until the reason for the furlough is abated;
 - c. Shall notify affected employees of the furlough and that while on furlough, an employee:
 - i. Shall not report to work or work from any location until notified to return to work; and
 - ii. Will not receive pay for any unused and unforfeited annual leave, should the employee resign or be terminated, until funding is restored;
 - d. May cancel or rescind any approved paid or unpaid leave in progress or scheduled for an employee who is designated for furlough and shall notify the affected employee in writing of the cancellation of the approved leave for the duration of the furlough. If the previously approved leave was scheduled to extend beyond the furlough, the employee may return to paid leave status, if available, following the furlough period; and
 - e. Shall notify employees upon restoration of funding and when to return to work.
- F. Suspension of funding furlough - failure to pass state budget.** If the state fails to pass a budget and funds are not appropriated for the following fiscal year, the Director may authorize an agency head to implement a suspension of funding furlough. Upon such notification by the Director, an agency head:
1. Shall freeze all personnel actions except for those actions that would accomplish, or assist in accomplishing the purpose of the furlough;
 2. Unless an exception has been authorized as provided in subsection (F)(4), shall place all employees on furlough indefinitely until the reason for the furlough is abated;
 3. Shall require all employees to be subject to the furlough in the same manner;
 4. May establish exceptions when only a portion of the employees in a particular class are necessary to perform mission critical services;
 5. Shall notify affected employees of the furlough and that while on furlough, an employee:
 - a. Shall not report to work or work from any location until notified to return to work; and
 - b. Will not receive pay for any unused and unforfeited annual leave, should the employee resign or be terminated, until funding is restored;
 6. Shall cancel or rescind any approved paid or unpaid leave in progress or scheduled for an employee who is designated for furlough and shall notify the affected employee in writing of the cancellation of the approved leave for the duration of the furlough. If the previously approved leave was scheduled to extend beyond the furlough, the employee may return to paid leave status, if available, following the furlough period; and
 7. Shall notify employees upon restoration of funding and when to return to work.
- G. Employee request for review.**
1. An employee may submit a request for review of the employee's placement on furlough. The employee shall make the request for review in writing to the agency head no later than three business days after the employee's receipt of a furlough notice. The employee shall limit the request for review to the determination resulting in the employee's furlough and include a proposed resolution.
 2. The agency head shall provide a written response to the employee with a final decision within:
 - a. Five business days after receipt of the request if a reduction of funding furlough, or
 - b. Fifteen business days after the employee returns to work if a suspension of funding furlough.

3. A request for review shall not delay implementation of the furlough.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5A-C602. Leave Without Pay

- A. Approval. All leave without pay requires a written request by an employee in advance, including the reason for the employee's request, and approval by the agency head.
- B. Use of leave. Except for military leave, an agency head shall not grant leave without pay in excess of 80 consecutive hours until all annual leave earned for working on a day on which a state holiday is observed, all accrued annual leave and, if the leave without pay is for medical reasons, sick leave are exhausted.
- C. Return to work.
 1. An employee who returns to work after an authorized period of leave without pay of 80 consecutive hours or less shall return to the same position occupied at the start of the leave without pay.
 2. Except as provided in subsection (C)(4), an employee who returns to work after a period of leave without pay in excess of 80 consecutive hours may return to a position in the class held at the start of the leave without pay, if a position is available and funded, and if the leave without pay is terminated in one of the following ways:
 - a. Expiration of its term and the employee's return to work;
 - b. Rescission of the leave without pay by the agency head before its scheduled expiration due to an unforeseen need that results in an insufficient number of employees available to provide service and for which:
 - i. The agency head provides written notice of the rescission to the employee's last known address at least 15 days before the date the employee is directed to return to work; or
 - ii. If circumstances beyond the agency's control do not permit at least a 15-day notice, the agency head provides notice as soon as possible after becoming aware of the need for the employee to return to work; or
 - c. Curtailment of the leave without pay before its scheduled expiration date upon request of the employee and with approval of the agency head.
 3. An agency head may consider the failure or inability of an employee to return to work on the first work day after an approved leave without pay as a resignation.
 4. An employee returning to work from leave without pay granted:
 - a. For industrial illness or injury for up to six months shall return to the position occupied at the start of the leave without pay. If this position or a position in the same class is not available and funded, the agency head shall conduct a layoff or, if the employee is covered, a reduction in force in accordance with Subchapter B.
 - b. As military leave is subject to the provisions of the USERRA regulations incorporated by reference in R2-5A-D603.
 - c. As FMLA leave is subject to the provisions of the FMLA regulations incorporated by reference in R2-5A-D601.

- D. Insurance benefits continuation. An employee who is on leave without pay may continue to participate in the employee insurance plans as follows:
 1. Health benefit plan participation.

- a. An employee who is on FMLA leave is eligible to continue to participate in the health benefit plan for the duration of the FMLA leave by paying the employee premium/contribution. An agency head may recover the state's portion of premium/contributions paid to maintain health coverage for an employee if the employee fails to return from FMLA leave under certain circumstances, in accordance with FMLA regulations incorporated by reference in R2-5A-D601.
 - b. An employee who is on leave without pay for a health-related reason that is not an industrial illness or injury and who either does not meet FMLA eligibility requirements or has exhausted FMLA leave and remains absent from work may continue to participate in the health benefit plan by paying both the state and employee premium/contribution. Authority to continue participation in the health benefit plan shall terminate on the earliest of:
 - i. Receipt of long-term disability benefits for which there is eligibility to continue health benefit plan participation under a state-sponsored retirement plan,
 - ii. A determination of eligibility for Medicare coverage, or
 - iii. 30 months after the incapacity began.
 - c. An employee who is on leave without pay for reasons other than those outlined in subsection (D)(1)(a), (b), or R2-5A-D602 pertaining to industrial leave, may continue to participate in the health benefit plan for a maximum of six months by paying both the state and employee premiums/contributions.
2. Life insurance plan participation.
 - a. An employee who is on FMLA leave continues to participate in the Basic Life and Accidental Death and Dismemberment Insurance Plan and may continue to participate in the supplemental life and dependent life insurance coverage by paying the full premium/contribution.
 - b. An employee who is on leave without pay for a health-related reason that is not an industrial illness or injury and who either does not meet FMLA eligibility requirements or has exhausted FMLA leave and remains absent from work may continue to participate in the basic life insurance plan by paying the state premium/contribution. An employee who elects to continue to participate in the basic plan may also continue any supplemental or dependent life coverage that is in force at the beginning of the leave without pay by continuing to pay the premium/contribution. Authority to continue in the life insurance plan shall terminate in accordance with the time limits specified in subsection (D)(1)(b).
 - c. An employee who is on leave without pay for reasons other than those outlined in subsection (D)(1)(a), (b), or R2-5A-D602 pertaining to industrial leave, may continue to participate in the basic life insurance plan by paying the state premium/contribution. An employee who elects to continue to participate in the basic plan may also continue any supplemental or dependent life coverage that is in

force at the beginning of the leave without pay by continuing to pay the premium/contribution. Authority to continue in the life insurance plan shall be available for a maximum of six months.

3. Termination of insurance. The insurance coverage of an individual on leave without pay who fails to pay insurance premiums/contributions when due shall terminate at 11:59 p.m. on the last day of the period covered by the last premium/contribution paid.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

PART D. LEAVE THAT COULD BE EITHER PAID OR UNPAID

R2-5A-D601. Family and Medical Leave Act (FMLA) Leave

- A. General. All state agencies are responsible for complying with the federal Family and Medical Leave Act (FMLA) of 1993 and all applicable revisions. FMLA Regulations, 29 CFR 825.100 through 29 CFR 825.800 (July 2012), are incorporated by this reference and on file with the Department and available from the U.S. Government Printing Office, 732 North Capitol Street N.W., Washington, D.C. 20401. This incorporation by reference contains no future editions or amendments. Any interference with, restraint of, or denial of an employee's rights provided by the FMLA is strictly prohibited.
- B. Eligible employee.
 1. An eligible employee for the purposes of the FMLA is an employee who:
 - a. Is an employee of the state of Arizona;
 - b. Has been employed by the state of Arizona for at least 12 months; and
 - c. Worked for at least 1,250 hours of service during the 12 months immediately preceding commencement of the leave.
 2. An agency head shall not extend FMLA benefits to an ineligible employee.
- C. Situations covered by the FMLA. A state agency shall grant an eligible employee FMLA leave when the employee takes leave for one or more of the following reasons:
 1. The birth of a child or placement of a child with the employee for adoption or foster care, provided the leave concludes within 12 months of the birth or placement.
 2. To care for the employee's spouse, child or parent with a serious health condition.
 3. The employee is unable to work because of the employee's own serious health condition.
 4. Any qualifying exigency arising out of the fact that the employee's spouse, child or parent is a covered military member on active duty or call to active duty status in support of a contingency operation.
 5. To care for a covered service member with a serious injury or illness when the covered service member is the employee's spouse, child, parent or next of kin.
- D. Amount of FMLA leave.
 1. An employee who takes FMLA leave for any of the situations described in subsections (C)(1), (2), (3) or (4) may take a maximum of 12 workweeks of leave during any rolling 12-month period, measured backward from the first day of each approved period of FMLA leave.
 2. An employee who takes FMLA leave for the situation described in subsection (C)(5) may take up to 26 workweeks of leave in a single 12-month period.
 3. During a 12-month period, an eligible employee is able to take no more than 12 workweeks of leave for any of the situations described in subsections (C)(1), (2), (3) or (4) and a combined total of 26 workweeks of leave if the leave includes the situation described in subsection (C)(5).
- E. Designation of FMLA leave. An employee need not specifically request FMLA leave to be placed on FMLA leave. If an eligible employee takes leave for any reason covered by the FMLA and has not already exhausted the employee's available FMLA leave, the agency head shall designate the employee's leave as FMLA leave.
- F. Use of paid leave. Except for portions of industrial leave, an employee on FMLA leave shall be required to use the employee's available paid leave while on FMLA leave as follows and in the following order:
 1. Sick leave or, as applicable, family sick leave subject to the provisions of R2-5A-B603.
 2. Compensatory leave subject to the provisions of R2-5A-B607.
 3. Annual leave subject to the provisions of R2-5A-B602.
 4. Leave without pay subject to the provisions of R2-5A-C602.
- G. Insurance benefits continuation. An employee who is using leave with pay remains eligible for continued participation in the employee insurance plans and the employee's share of premiums/contributions is paid through payroll deduction. An employee who is on leave without pay while on FMLA leave may continue to participate in the employee insurance plans as follows:
 1. Health benefit plan participation. An employee is eligible to continue to participate in the health benefit plan for the duration of the FMLA leave by paying the employee premium/contribution. An agency head may recover the state's portion of premium/contributions paid to maintain health coverage for an employee if the employee fails to return from FMLA leave under certain circumstances, in accordance with FMLA regulations incorporated by reference in subsection (A).
 2. Life insurance plan participation. An employee continues to participate in the Basic Life and Accidental Death and Dismemberment Insurance Plan and may continue to participate in the supplemental life and dependent life insurance coverage by paying the full premium/contribution.
 3. Termination of insurance. The insurance coverage of an employee on leave without pay who fails to pay insurance premiums/contributions when due shall terminate at 11:59 p.m. on the last day of the period covered by the last premium/contribution paid.
- H. Return from FMLA leave. An agency head shall restore an employee returning from FMLA leave to the employee's original job, or to an equivalent job with equivalent pay, benefits, and other terms and conditions of employment. The provisions of the FMLA, not the provisions of R2-5A-C602(C), shall govern return to work from leave without pay granted to complete an FMLA-qualified leave.
- I. Employee responsibilities. An employee is required to adhere to the employing agency's call-in procedures, give the agency 30 days' notice in the event of a foreseeable leave, provide

requested documentation, and periodic updates of the employee's status and intent to return to work as requested by the agency.

- J. Agency rights. Nothing in the FMLA or this rule should be construed as limiting an agency's right to manage, discipline or terminate an employee, including an employee's failure to comply with the agency's request for appropriate documentation to substantiate the employee's need for the leave. However, an employee's use of FMLA leave cannot be considered as a negative factor in any employment decision.
- K. Conflict. If there is a conflict between the provisions of these rules and the FMLA, the provisions of the FMLA govern.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5A-D602. Industrial Leave

- A. Use of leave.
 1. An agency head shall place an employee who sustains a job-related illness or injury that is compensable under the Workers' Compensation Law, A.R.S. Title 23, Chapter 6 on sick leave.
 2. If an employee who is on leave under the Worker's Compensation laws meets Family and Medical Leave Act (FMLA) eligibility requirements and the leave qualifies for FMLA leave, an agency head shall count it as FMLA leave. An agency head shall apply industrial leave and FMLA concurrently.
 3. An employee shall use leave in an amount necessary to receive total payments (leave payments plus Workers' Compensation payments) that do not exceed the gross salary of the employee.
 4. If an employee exhausts all sick leave, compensatory leave and annual leave, an agency head shall place the employee on leave without pay.
- B. Payments. If an employee receives a retroactive Workers' Compensation payment for any period of industrial illness or injury for which leave payments were received, the employee shall reimburse the agency for Workers' Compensation payments that exceed 100% of the employee's base pay before the illness or injury, and the agency head shall restore the equivalent value of leave to the employee's appropriate leave account.
- C. Light duty. If an employee has a job-related illness or injury that impairs performance on the former job, the agency head shall make every effort to place the employee in a suitable position within the agency, including a light duty assignment.
- D. Restriction. An agency head shall not grant sick leave or leave without pay to an employee who fails to accept compensation available under the industrial injury and disease provisions of A.R.S. §§ 23-901 to 23-1091.
- E. Insurance benefits continuation. An employee who is using leave with pay in accordance with subsection (A) remains eligible for continued participation in the employee insurance plans and the employee's share of premiums/contributions is paid through payroll deduction. An employee who is on leave without pay due to an industrial illness or injury may continue to participate in the employee insurance plans as follows:
 1. Health benefit plan participation.
 - a. An employee may continue to participate in the health benefit plan for a maximum of six months from the date of illness or injury by paying the employee premium/contribution.
 - b. At the end of the six-month period, an employee who remains on leave without pay due to industrial illness or injury may continue to participate in the

health benefit plan by paying both the state and employee premiums/contributions, until the employee returns to work or is determined to be eligible for Medicare coverage or Long-term Disability, whichever occurs first.

2. Life insurance plan participation. An employee who is on leave without pay continues to participate in the basic life and accidental death and dismemberment insurance plan without cost for six months after the month in which the illness or injury occurs. During this six-month period, the employee may continue supplemental life and dependent life coverages that were in effect at the start of the leave by paying the applicable premium/contribution.
 3. Termination of insurance. The insurance coverage of an employee on leave without pay who fails to pay insurance premiums/contributions when due shall terminate at 11:59 p.m. on the last day of the period covered by the last premium/contribution paid.
- F. Accrual of leave. An employee shall continue to receive full leave accrual as long as the employee uses two or more hours of paid leave each day.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5A-D603. Military Leave

An employee who requests absence with pay on military leave under A.R.S. § 26-168, 26-171, or 38-610 shall submit a copy of the orders for duty with the request for military leave. An employee may be absent with pay for military purposes for up to thirty days in any two consecutive federal fiscal years. All state agencies are responsible for complying with the federal Uniformed Services Employment and Reemployment Rights Act (USERRA) of 1994 and all applicable revisions. USERRA Regulations, 20 CFR 1002.1 through 20 CFR 1002.314 (April 2012), are incorporated by this reference and on file with the Department and available from the U.S. Government Printing Office, 732 North Capitol Street N.W., Washington, D.C. 20401. This incorporation by reference contains no future editions or amendments.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5A-D604. Victim Leave

An employee who is a victim of a juvenile offense or a crime and who requests absence from work to attend court-related proceedings under A.R.S. § 8-420 or 13-4439 shall submit a copy of the form provided to the employee by the law enforcement agency or a copy of the information the law enforcement agency provided to the employee with the request for victim leave. An employee shall use the employee's available sick leave, compensatory leave or annual leave for such absence. If an employee exhausts all sick leave, compensatory leave and annual leave, an agency head shall place the employee on leave without pay.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

ARTICLE 7. PERFORMANCE MANAGEMENT

R2-5A-701. General

- A. Performance management system. The Director shall establish a performance management system to evaluate the job performance of state employees. The performance management system established by the Director shall contain performance rating levels and shall contain numerical points to apply to each performance rating level established.

- B.** Administration. The Director shall develop an administrative manual and training on the performance management system.
- C.** Exceptions. The performance management system may be used:
1. As determined by the appointing authority for the agency head, to evaluate the job performance of the agency head.
 2. As determined by the agency head, to evaluate the job performance of:
 - a. Each deputy director, or equivalent, of the agency.
 - b. Each assistant director, or equivalent, of the agency.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5A-702. Performance Management Process

- A.** Performance plan. For the purposes of this subsection, “performance plan” means a document prepared by an employee’s supervisor that outlines what is expected of the employee and how the employee’s performance will be measured. Subject to review by agency management, a supervisor:
1. Shall administer a performance plan for each employee within 30 days of becoming the employee’s supervisor.
 2. May modify a performance plan at any time during a performance period.
 3. Shall modify a performance plan when significant responsibilities or expectations are added to or removed from a position.
 4. Shall notify the affected employee of any modifications made to a performance plan under subsection (A)(2) or (3).
- B.** Performance evaluation requirements.
1. Informal evaluation. A supervisor shall:
 - a. Monitor and evaluate an employee’s performance throughout the rating period,
 - b. Provide feedback to the employee on a regular basis, and
 - c. Attempt to correct inadequate performance where possible and appropriate.
 2. Formal evaluation. A supervisor shall:
 - a. Formally evaluate, document and rate the performance of each employee at least annually.
 - b. Submit the evaluation to agency management for review prior to the evaluation being administered to the employee.
 3. Covered probationary employees. Prior to granting a covered probationary employee permanent status, a supervisor shall evaluate a probationary employee at least once prior to the end of the employee’s probationary period.
- C.** Responsibilities.
1. An employee shall comply with the performance plan established by the supervisor.
 2. A supervisor shall comply with performance evaluation requirements.
 3. An agency head shall ensure that all performance evaluations are completed as required by this Section.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

ARTICLE 8. DISCIPLINARY ACTIONS

R2-5A-801. General

- A.** Authority. An agency head has the primary authority and responsibility for managing the conduct of all employees within an agency. A covered employee may be disciplined only for cause. An agency head shall discipline a covered employee in accordance with this Article and the rules in Sub-

chapter B of this Chapter. An uncovered employee serves at the pleasure of the appointing authority and may be dismissed at will. Except for an employee who is in a position listed in A.R.S. § 41-742(F), any action that involves a suspension greater than 80 working hours, an involuntary demotion, or a dismissal requires review by the Director prior to the agency head administering such action.

B. Level of discipline.

1. If an agency head deems it necessary to discipline an employee, the agency head may determine the level of discipline to be imposed, up to and including dismissal, subject to review by the Director, if applicable.
2. In determining the level of discipline to be imposed, the agency head may consider the following factors:
 - a. Consistent application of rules and standards,
 - i. Unless otherwise prescribed by statute, the agency head need only consider those cases decided under the administration of the current agency head. Decisions in cases prior to the administration of the current agency head are not binding upon the current agency head and are not relevant in determining consistent application of rules and standards.
 - ii. In determining consistent application of rules and standards, the disciplinary actions imposed by one agency may not be binding upon any other agency and may not be used for comparison purposes in hearings wherein the consistent application of rules and standards is at issue.
 - b. Prior knowledge of rules and standards,
 - c. The severity of the infraction,
 - d. The repeated nature of violations,
 - e. Prior corrective or disciplinary actions,
 - f. Previous oral discussions,
 - g. The employee’s past work record,
 - h. The effect on agency operations,
 - i. The potential of the violations for causing damage to persons or property.

C. Limitations.

1. Except as otherwise provided by statute or rule, suspensions shall not exceed a total of 30 working days during any 12-month period. The 12-month period begins with the first day of the first suspension.
2. An employee who is involuntarily demoted must possess the qualifications for the position and:
 - a. A covered employee who has attained permanent status may be involuntarily demoted only to a regular position in the covered service.
 - b. An uncovered employee may be involuntarily demoted only to a position in the uncovered service.

D. Review by Director.

1. Letters of reprimand and suspensions without pay of 80 working hours or less are not subject to review by the Director.
2. Prior to imposing a suspension greater than 80 working hours, an involuntary demotion, or dismissal, the agency head shall submit the proposed action to the Director for review as prescribed in R2-5A-802, unless the employee is in a position listed in A.R.S. § 41-742(F). If the employee is in a position listed in A.R.S. § 41-742(F), a review by the Director is not required.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5A-802. Procedures for Review by the Director

- A. Prior to administering any action requiring review by the Director, the agency head shall submit the proposed letter to the Director prior to the date the agency head intends to issue the letter to the employee.
- B. The Director shall review the agency head's proposed action and provide notification of concurrence or recommend modification to the proposed action.
- C. When the agency head administers the action to an employee, the agency head shall also send a copy of the employee's letter to the Director. If the agency head determines that no action will be taken, the agency head shall notify the Director.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5A-803. Employee Request for Review of Disciplinary Action

- A. A covered employee who is issued a disciplinary action may have grievance or appeal rights, as applicable.
- B. An uncovered employee does not have grievance rights or the right of appeal to a state merit board or council.
- C. A covered employee who files a complaint on a disciplinary action alleging discrimination or harassment is precluded from also filing a grievance through the agency's grievance procedure on the same disciplinary action that is the subject of the employee's complaint.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

ARTICLE 9. COMPLAINTS**R2-5A-901. Complaint System**

- A. General. Each agency head shall:
 - 1. Adopt a procedure to address employee complaints concerning discrimination or harassment in compliance with this rule.
 - 2. Designate an employee of the agency to serve as the agency's complaint coordinator, who shall be responsible for receiving complaints, determining applicability under the complaint system, investigating or assigning the complaint to the appropriate individual within the agency for review or investigation, and tracking the processing of complaints.
- B. Matters subject to the complaint system. The adopted complaint procedure shall require the complainant to file the complaint with the agency complaint coordinator within 180 days of the action giving rise to the complaint and to clearly outline the allegations to be addressed, including whether the basis of the complaint is based on:
 - 1. Unlawful discrimination based on race, color, religion, sex (including pregnancy), age, national origin, genetic information or on the basis of a disability.
 - 2. Allegation of sexual harassment or other form of harassment.
 - 3. Retaliation for filing a complaint.
 - 4. Retaliation or intimidation for exercising any right under state or federal law.
- C. Preparation. A complainant shall not be allowed the use of state time or state property to prepare a complaint, prepare for a meeting with agency management or to meet with a representative. Subject to supervisory approval, a complainant may request available compensatory or annual leave for this purpose.
- D. Multiple complaints. Multiple complaints by an employee may be consolidated into a single complaint. Separate complaints filed by two or more employees regarding the same

issue or issues may be consolidated into a group complaint. Employees having a common complaint may submit one group complaint, identifying one complainant as the selected spokesperson for the group. Employees who choose to file a group complaint are prohibited from filing separate complaints on the same issue.

- E. Amendments. Once a complaint is submitted to the agency complaint coordinator, it may not be amended. If additional documentation is submitted by the complainant after the initiation of the complaint, the reviewing or investigating official may remand the complaint to the complainant for reconsideration and resubmission.
- F. Approval. Each agency will submit its proposed complaint procedure and any subsequent changes to the Director for approval.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5A-902. Complaint Procedures

- A. Content. Each agency complaint procedure shall include as a minimum that:
 - 1. The agency head be notified of all verbal or written complaints of discrimination or harassment reported by an employee immediately upon receipt of a complaint.
 - 2. Employees who are told or otherwise become aware that discrimination or harassment is occurring must immediately report the allegation or complaint to the agency's complaint coordinator.
 - 3. The complaint include all facts and circumstances involved in the alleged violation, including:
 - a. Description of the incident(s),
 - b. Name(s) of individual(s) involved,
 - c. Name(s) of witness(es),
 - d. The date(s) the discrimination or harassment occurred (if known),
 - e. Resolution sought,
 - f. Federal or state law alleged to have been violated.
 - 4. The agency complaint coordinator shall acknowledge receipt of the complaint in writing to the complainant not later than five business days after receipt of the written complaint.
 - 5. The agency complaint coordinator shall initiate an investigation into the alleged complaint or assign the complaint to the appropriate individual within the agency for review or investigation within 10 business days and the review or investigation shall be completed within 60 business days of receipt of the written complaint. If extenuating circumstances exist, an extension shall be requested through the agency complaint coordinator.
 - 6. Barring resolution of the complaint by agreement of the parties, the agency complaint coordinator shall forward a written recommendation to the agency head, or designee, within 10 business days of completion of the review or investigation.
 - 7. The agency head, or designee, shall review the findings and recommendations and issue a decision in writing to the complainant.
 - 8. A statement advising that retaliation against an employee for filing a complaint in good faith will not be tolerated or permitted.
 - 9. A statement specifying that a grievance filed by a covered employee under R2-5B-403 that includes an allegation of discrimination or harassment shall be reviewed or investigated under the provisions of this Article, and not the grievance system.

B. Review by Director.

1. An employee, other than a Department of Administration employee, who is not satisfied with the agency head's response to a complaint alleging discrimination or harassment, may elevate the complaint to the Director within five business days after the receipt of the agency head's response. The Director will furnish a copy of the final decision to the agency head and the complainant within 20 business days following receipt of the complaint by the Director. The 20 business days may be extended by the Director with the concurrence of the complainant. The decision of the Director is the final step in the complaint procedure.
2. A complainant who is a Department of Administration employee and who is not satisfied with the Director's decision on a complaint alleging discrimination or harassment may resubmit the complaint to the Director within five business days after receipt of the Director's decision. The Director will appoint an individual who is not an employee of the Department of Administration and who serves in a position that is assigned to manage an agency's employee relations or investigations work unit to investigate the resubmitted complaint. The investigator shall conduct an investigation and furnish a copy of the findings and final decision to the Director and the complainant within 20 business days following receipt of the complaint by the investigator. The 20 business days may be extended by the investigator with the concurrence of the complainant. The decision of the investigator is the final step in the complaint procedure.
3. The response will refer the employee to the appropriate entity if the employee is dissatisfied with the final step of the complaint procedure.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

ARTICLE 10. SEPARATIONS**R2-5A-1001. Voluntary Separation**

- A.** Resignation. An employee may terminate employment with the state by submitting a written resignation to the agency head. An employee should submit a resignation at least 10 business days prior to the effective date of the resignation. If an employee resigns orally, the agency head shall confirm the resignation in writing. An agency head may refuse to accept a resignation and separate the employee pursuant to R2-5A-1002.
- B.** Job abandonment. An agency head may consider an employee to have voluntarily resigned from employment with the agency when the employee is absent from duty for three consecutive workdays or equivalent without proper authorization.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5A-1002. Involuntary Separation

- A.** General. An agency head may terminate an employee as deemed necessary to meet the needs of the agency and in keeping with federal and state laws and regulations. A covered employee may be dismissed only for cause. An agency head shall dismiss a covered employee in accordance with Article 8 and the rules in Subchapter B of this Chapter.
- B.** Staff reduction. At times, a staff reduction is necessary due to lack of work, lack of funds, economic slowdowns, technological or structural changes in the agency's operations, or because

a staff reduction is determined to be necessary to ensure the financial health and viability of the agency.

1. Except for an employee who is in a position listed in A.R.S. § 41-742(F), a staff reduction of an uncovered employee requires review by the Director prior to the agency head administering such action.
2. An agency head shall conduct staff reductions of covered employees in accordance with Subchapter B, Article 6, Reduction in Force.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

SUBCHAPTER B. COVERED EMPLOYEES**ARTICLE 1. GENERAL****R2-5B-101. Definitions**

In addition to the definitions provided in Subchapter A of this Chapter, the following definitions apply to this Subchapter:

"Limited appointment employee" means an employee who, before September 29, 2012, was subject to the provisions of A.R.S. Title 41, Chapter 4, Articles 5 and 6 that were in effect before September 29, 2012, was appointed to a position that was based on the duration of funding, and was not eligible to acquire reduction in force rights.

"Original probationary period" means the specified period following initial appointment to covered service. A.R.S. § 41-741(10)

"Permanent status" means the standing a covered employee achieves after the completion of an original probation or a promotional probation.

"Probationary period" means a working test period of employment in a covered service position for evaluation of the employee's work. A.R.S. § 41-741(11)

"Promotional probation" means the specified period of employment following promotion of a permanent status employee to another covered position that has a higher pay grade. A.R.S. § 41-741(12)

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5B-102. Applicability

- A.** The rules in this Subchapter are applicable to covered positions, applicants for covered positions and covered employees in the State Personnel System.
- B.** Covered service is limited to the following:
 1. An employee who was in the state service as either a probationary or permanent status employee, was not required to become at will uncovered in accordance with A.R.S. Title 41, Chapter 4, Article 4, and who does not:
 - a. Voluntarily elect to become uncovered at will.
 - b. Voluntarily accept a change in assignment.
 - c. Have a break in service.
 2. A newly hired employee who is appointed to:
 - a. A position in the Arizona Department of Corrections that is classified as a Correctional Officer I, Correctional Officer II, Correctional Officer III, or a Community Corrections Officer; or
 - b. A position in any state agency that requires certification as a full authority peace officer by the Arizona Peace Officer Standards and Training Board, provided the position is not in the uncovered service.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

ARTICLE 2. EMPLOYMENT STATUS**R2-5B-201. Applicability**

The rules under this Article are applicable only to positions in the covered service and covered employees.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5B-202. Original Probation

A. General. A new employee hired into a position in the covered service shall serve an original probation period of one year.

B. Extension of probation.

1. An agency head may extend an employee's original probation up to six additional months for employment-related reasons.
2. The probationary period shall be extended for any period for which a probationary employee is on leave without pay for more than 80 consecutive working hours. If original probation is extended for this reason, the employee's probation may exceed 18 months.

C. Completion of original probation.

1. In accordance with the rules in Subchapter 5A, Article 7, a supervisor shall evaluate an original probationary employee and submit a report to the agency head before expiration of the employee's probationary period. If the agency head takes no action to extend the probationary period or to terminate the employee, the agency head shall grant permanent status to the employee upon completion of the probationary period.
2. If an agency head determines at any time during an original probationary period that the services of a probationary employee are no longer required in that position for any reason or for no reason, the agency head may:
 - a. Dismiss the employee without a stated reason and without the right of appeal, providing the employee a letter of dismissal; or
 - b. Offer the employee another position for which the employee possesses the qualifications. An employee who accepts a position that is not in the covered service is an at will uncovered employee.

D. Change in position. An original probation employee who is selected for another position in the covered service shall serve an original probation period in the new position.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5B-203. Promotional Probation

A. General. A permanent-status employee who is promoted to a position in the covered service shall serve a promotional probation period of six months.

B. Extension of probation.

1. An agency head may extend an employee's promotional probation up to six additional months for employment-related reasons.
2. The probationary period shall be extended for any period for which a probationary employee is on leave without pay for more than 80 consecutive working hours. If promotional probation is extended for this reason, the employee's probation may exceed one year.

C. Completion of promotional probation.

1. In accordance with the rules in Subchapter 5A, Article 7, a supervisor shall evaluate a promotional probationary employee and submit a report to the agency head before expiration of the employee's probationary period. If the agency head takes no action to extend the probationary period, to revert or separate the employee, or offer the employee another position, the agency head shall grant permanent status to the employee upon completion of the probationary period.
 2. If an employee fails to complete a promotional probation successfully the agency head may revert the employee in the current employing agency to:
 - a. A vacant position in the class in which the employee held permanent status immediately before promotion, or
 - b. A similar position in another class at the same grade as the class that the employee holds permanent status if the employee possesses the qualifications for that position.
- D.** Discipline. Neither subsection (C)(2)(a) nor (b) shall preclude the imposition of disciplinary action.
- E.** Failure to complete promotional probation. An employee who is reverted shall not have the right to appeal.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5B-204. Permanent Status

A covered employee who has successfully completed the employee's probationary period shall attain permanent status in the position.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5B-205. Change from Covered to Uncovered Service

- A.** Voluntary election. A covered employee may voluntarily elect to become an at will uncovered employee without a change in assignment. Such an election is subject to the approval of the head of the employing agency and the Director. If approved, the effective date of the employee's change to uncovered service shall be the first day of the pay period immediately following the Director's approval.
- B.** Change in assignment. Except for a special assignment, a covered employee who voluntarily accepts a change in assignment to a position that is not in the covered service, regardless of whether the voluntary change in assignment is a promotion, demotion, or lateral transfer, is an at will uncovered employee. The effective date of the employee's change to uncovered service shall be the same as the effective date of the change in assignment.
- C.** Return to state employment. A covered employee who has a break in service and returns to employment in an agency in the State Personnel System in any capacity shall be an at will uncovered employee, unless the appointment is to a position in the covered service.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

ARTICLE 3. DISCIPLINARY ACTIONS**R2-5B-301. General**

A. Applicability. The rules under this Article are applicable only to covered employees.

- B.** Review by Director. Disciplinary actions for covered employees are subject to the review requirements outlined in R2-5A-801(D) and R2-5A-802.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5B-302. Reprimand

- A.** Authority. An agency head may issue a written reprimand to an employee for cause.
- B.** Reprimand Procedures. The agency head shall provide the employee with a written statement of the reasons for the reprimand and the employee's grievance rights.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5B-303. Suspension

- A.** Authority. An agency head may suspend an employee without pay for cause.
- B.** Limitation. Except as otherwise provided by statute or rule, suspensions shall not exceed a total of 30 working days during any 12-month period. The 12-month period begins with the first day of the first suspension.
- C.** Pre-suspension procedures for suspensions exceeding 80 working hours. Before an employee with permanent status can be suspended for more than 80 working hours, the agency head shall submit the proposed action to the Director for review as prescribed in R2-5A-802, give the employee written notice of the charges, a summary of the agency head's basis for the charges, and an opportunity for the employee to present a written response. The employee's response shall be made not later than three business days after the employee receives notice of the charges, unless extended in writing by the agency head.
- D.** Suspension procedures. The agency head shall provide the employee with a written statement of the reasons for the suspension. The statement shall specify the period of suspension and the employee's grievance or appeal rights.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5B-304. Involuntary Demotion

- A.** Authority. An agency head may involuntarily demote a permanent status employee for cause to any covered position in the employing agency, provided the employee possesses the qualifications for such position.
- B.** Pre-demotion procedures. Before an employee with permanent status can be involuntarily demoted, the agency head shall submit the proposed action to the Director for review as prescribed in R2-5A-802, give the employee written notice of the charges, a summary of the agency head's basis for the charges, and an opportunity for the employee to present a written response. The employee's response shall be made not later than three business days after the employee receives notice of the charges, unless extended in writing by the agency head.
- C.** Involuntary demotion procedures. Prior to the effective date of the involuntary demotion, a written notice containing specific reasons for the demotion and the employee's right of appeal shall be provided to the employee and the Director.
- D.** Probation. Except as otherwise provided in these rules, an employee who is involuntarily demoted shall not be required to serve a probationary period in the position to which demoted.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5B-305. Dismissal

- A.** Relief from duty. Nothing in this rule shall preclude the agency head from immediately placing an employee on administrative leave pending implementation of procedures under this Section, but no pay shall be withheld for such period.
- B.** Dismissal during original probation. An employee on original probation may be dismissed without a stated reason and without the right of appeal.
- C.** Pre-dismissal procedures. Before an employee with permanent status can be dismissed, the agency head shall submit the proposed action to the Director for review as prescribed in R2-5A-802, give the employee written notice of the charges, a summary of the agency head's basis for the charges, and an opportunity for the employee to present a written response. The employee's response shall be made not later than three business days after the employee receives notice of the charges, unless extended in writing by the agency head.
- D.** Dismissal procedures. The agency head may dismiss an employee with permanent status only for cause but not before attempting to serve the employee personally or by registered or certified mail, return receipt requested (addressee only), with written notice of the specific reasons for dismissal in sufficient detail to inform the employee of the facts, with a copy to the Director. The agency head shall include a statement of the employee's right to appeal.
- E.** Effective date of dismissal. The dismissal action is not effective until one of the following occurs:
1. The employee signs for receipt of the dismissal letter personally served or served by mail;
 2. Three business days have passed since the letter was mailed to the employee; or
 3. An attempt is made to personally serve the dismissal letter, but the employee refuses to sign for the letter. Such attempt to personally serve the letter shall be witnessed.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

ARTICLE 4. GRIEVANCES

R2-5B-401. Applicability

The rules under this Article are applicable only to covered employees.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5B-402. Grievance System

- A.** General. Each agency that has one or more covered employees shall:
1. Adopt a grievance procedure which will afford each covered employee a systematic means of resolving an employee's disagreement with the receipt of a disciplinary action that is either:
 - a. A written reprimand, or
 - b. A suspension of:
 - i. 40 working hours or less if the employee is a full authority peace officer, or
 - ii. 80 working hours or less if the employee is a covered employee in any other capacity.
 2. Designate an employee of the agency to serve as the agency's grievance coordinator, who shall be responsible

for receiving grievances, determining applicability under the grievance system, forwarding the grievance to the appropriate individual within the agency for review or investigation, and tracking the processing of grievances.

B. Non-applicable matters. The adopted grievance procedure shall not apply to any matter for which another method of review is provided, including but not limited to:

1. Retirement, Life Insurance, or Health Insurance;
2. Any classification action;
3. Any recruitment, selection, or appointment;
4. Any compensation action;
5. A disciplinary action that is either:
 - a. A suspension of:
 - i. More than 40 working hours if the employee is a full authority peace officer, or
 - ii. More than 80 working hours if the employee is a covered employee in any other capacity,
 - b. A demotion, or
 - c. A dismissal.
6. A complaint alleging discrimination or harassment; or
7. Any reduction in force action.

C. Restrictions. An employee may not submit a grievance challenging the following management rights:

1. An agency head's right to direct agency employees.
2. An agency head's right to hire, promote, transfer, assign, and retain employees.
3. An agency head's right to maintain efficiency of government operations and to determine the methods, means, and personnel by which these operations are to be conducted.

D. Preparation. A grievant shall not be allowed the use of state time or state property to prepare a grievance, prepare for a meeting with agency management or to meet with a representative. Subject to supervisory approval, a grievant may request available compensatory or annual leave for this purpose.

E. Steps. An agency's grievance procedure shall have two steps for review.

1. As determined by the agency head, the first step in the grievance procedure shall be:
 - a. The employee's second line supervisor,
 - b. The assistant director or equivalent, or
 - c. Any level of management between (a) and (b).
2. The final step in the grievance procedure shall be the agency head, or designee.
3. An agency head may choose to incorporate an additional step in the agency grievance procedure after the first step review.

F. Amendments. Once a grievance is submitted to the first step, it may not be amended. If additional documentation is submitted by the grievant after the initiation of the grievance, the reviewing official may remand the grievance to the appropriate previous level for reconsideration.

G. Approval. Each agency head will submit the agency's proposed grievance procedure and any subsequent changes to the Director for approval.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5B-403. Grievance Procedures

Content. The grievance procedure established in each state agency shall include as a minimum:

1. An initial statement that any complaint alleging unlawful discrimination or unlawful harassment will be reviewed or investigated according to the provisions of the separate

complaint process outlined in Subchapter A, Article 9, and not the grievance system.

2. A requirement that the grievant have an oral discussion with the immediate supervisor in an attempt to resolve the employee's disagreement with the disciplinary action, prior to initiating the written grievance procedure.
3. A requirement that the employee file the grievance in writing with the agency grievance coordinator, within 10 business days after the occurrence of the action being grieved. The date of occurrence of a:
 - a. Reprimand is the date the reprimand was issued to the employee.
 - b. Suspension is the first day of suspension.
4. A requirement that the grievance contain a complete statement of all the facts and circumstances involved and the specific redress sought.
5. A provision that the grievant may select a representative at any step in the procedure after the oral discussion with the immediate supervisor.
6. A requirement that another state employee who serves as the representative of a grievant must receive approval for annual or compensatory leave to represent the grievant.
7. A requirement that the grievant must have a minimum of five business days after receipt of a response to forward the grievance at any step, must sign the grievance at each step, and must state the reasons why the response at the previous step was unsatisfactory.
8. A requirement that the agency head will respond to the grievant not later than 30 business days after receipt of the grievance at the first step. Within the 30 business day period, the time for any step may be extended by the agency head with the concurrence of the grievant.
9. A statement that the decision of the agency head is the final step in the grievance process.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

ARTICLE 5. APPEALS

R2-5B-501. Applicability

The rules under this Article are applicable only to covered employees who have attained permanent status.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5B-502. General

A. Except for an employee who is a full authority peace officer, an employee may file an appeal on the receipt of a disciplinary action that is either:

1. A suspension for more than 80 working hours,
2. An involuntary demotion, or
3. A dismissal.

B. Such appeals shall be filed with the State Personnel Board and in accordance with the rules established by the Board.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5B-503. Full Authority Peace Officers

A. A full authority peace officer may file an appeal on the receipt of a disciplinary action that is either:

1. A suspension for more than 40 working hours,
2. An involuntary demotion, or
3. A dismissal.

- B.** Such appeals shall be filed with the Law Enforcement Merit System Council and in accordance with the rules established by the Council.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

ARTICLE 6. REDUCTION IN FORCE

R2-5B-601. Applicability

The rules under this Article are applicable only to covered positions and covered employees.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5B-602. Reduction in Force Procedures

A. General.

1. An agency head shall submit to the Director a proposal to conduct a reduction in force if required for one or more of the following reasons:
 - a. Lack of funds or work,
 - b. Abolition of one or more covered positions,
 - c. Material change in job duties or agency organization, or
 - d. Introduction of a cost reduction initiative.
2. An agency head shall submit the proposal for a reduction in force at least 30 business days before the proposed effective date of the reduction in force. If circumstances beyond the agency's control do not permit at least 30 business days' notice, the agency head shall submit the proposal as soon as the agency head is aware of the necessity for a reduction in force.
3. An agency head shall include all of the following in the proposal for a reduction in force:
 - a. The reason for the reduction in force;
 - b. The proposed scope of the reduction in force, which shall be limited to either:
 - i. The agency,
 - ii. An organizational unit of the agency, or
 - iii. Agency operations within a geographic area,
 - c. Each specific covered position proposed for elimination and an organization chart identifying each position, and
 - d. The proposed effective date of the reduction in force.
4. An agency head shall submit a proposal that is consistent with A.R.S. § 41-772 and this Section.
5. An agency head shall not approve a personnel action that would have an effect on the reduction in force after the agency head has submitted a proposal for a reduction in force.
6. An agency head shall not re-establish a position that was abolished as a result of a reduction in force for two years if the position was filled when the reduction in force occurred, unless the position was abolished due to fiscal constraints, legislative action, or court order.

- B.** Administration of reduction in force. The Director shall review and approve, modify or deny a reduction in force within 20 business days of receipt. Upon approval of the Director to conduct a reduction in force:

1. An agency head shall separate a covered employee who is not a permanent status employee in the class affected by the reduction in force in the following order before any reduction in force action is taken that affects a permanent status employee, provided the separation of the non-per-

manent status employee will accomplish, or assist in accomplishing, the purpose of the reduction in force:

- a. Temporary employee,
- b. Original probationary employee, and
- c. Limited appointment employee.

2. An agency head shall use retention points to identify a permanent status employee within a class series affected by a reduction in force for retention in the employee's current position, transfer, reduction, or separation based on the employee's relative standing on the retention point list.
3. An agency head shall base retention points upon performance calculated in accordance with the instructions in subsections (C) and (D).
4. An employee on promotional probation or special assignment shall compete for retention in the employee's permanent status class.
5. An employee in an underfill position shall compete for retention in the employee's permanent status class.
6. A permanent part-time employee shall compete for retention against another permanent part-time employee in the same class.

- C.** Calculation of retention points. An agency head shall compute the average score of a maximum of the three most recent performance evaluations in the 24 months concluded before the date of proposal for a reduction in force. An employee's average score shall be the employee's retention points. If an employee has not had a performance evaluation in the past 24 months, the employee shall receive 3.0 retention points.

- D.** Resolution of ties. An agency head shall break any tie in total retention points in the following manner and order:

1. The employee with the highest most recent performance evaluation shall be given preference.
2. If a tie continues to exist, the agency head shall break the tie by lot.

- E.** Offer of position.

1. An agency head shall provide written notice at least five business days in advance to each employee identified for transfer, reduction, or separation. If circumstances beyond the agency's control do not permit at least five business days' notice, the agency head shall provide notice as soon as the agency head is aware of the necessity to transfer, reduce, or separate the employee.
2. The notice shall include:
 - a. The reason for and effective date of the action;
 - b. A job offer, if any, including the salary, location of the position, and supervisor's name;
 - c. The availability of reduction in force procedures and records for review, with references to relevant statutes and rules; and
 - d. The employee's right to request a review of the determination as provided in R2-5B-603.
3. An agency head shall offer a position to an employee identified for transfer, reduction, or separation with the highest number of points on the retention point list in descending order as follows:
 - a. If a vacant covered position exists and an employee possesses the required qualifications for the position, an agency head shall make the single best offer, in terms of pay range, within the agency of:
 - i. A regular position at the same or lower pay range in the same class series as the employee's present permanent status position;
 - ii. A regular position at the same or lower pay range in any class series in which the employee

- has held permanent status during the past five years; or
- iii. If both positions described in subsections (E)(3)(a)(i) and (ii) are available, the position described in subsection (E)(3)(a)(i).
 - b. If the offer under subsection (E)(3)(a) is a position at a lower pay range, the agency head shall provide the employee the option of accepting a vacant covered:
 - i. Funded, regular position at the employee's present pay range in a class series in which the employee has never held permanent status for which the employee is qualified; or
 - ii. Temporary or part-time position at the employee's present pay range for which the employee is qualified.
 4. An employee shall possess the qualifications required when the position was last filled, unless the Director grants an exception.
 5. Any job offer shall contain a time period of not less than three business days in which the employee may accept the offer. Failure of an employee to reply in writing within the stated time period, or failure to accept the job offer, shall constitute a resignation. An employee may accept a job offer and retain the right to request a review of the determination.
 6. If no position exists, the agency head shall separate an employee without prejudice.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

R2-5B-603. Employee Request for Review

- A. An employee may request a review of the following determinations made during a reduction in force:
 1. Calculation of the employee's retention points,
 2. A job offer resulting in the employee's transfer or reduction, and
 3. Notification of the employee's separation.
- B. Within three business days of receipt of a determination notice, unless a longer period is authorized by an agency head, an employee may submit a written request to the agency head for a review of the determination. The request for review shall be based upon an error, contain specific information concerning the error involved, and include a proposed resolution of the problem.
- C. The agency head shall review the request and respond to the employee within five business days after receipt of the request.
- D. An agency head may postpone any portion of a reduction in force until completion of an employee request for review.

Historical Note

Section made by exempt rulemaking at 18 A.A.R. 2782, effective September 29, 2012 (Supp. 12-4).

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TITLE 2. ADMINISTRATION

CHAPTER 5.1. STATE PERSONNEL BOARD

(Authority: A.R.S. § 41-781 et seq.)

Laws 1983, Ch. 98, § 162 limited authority of the Personnel Board. Prior rules and regulations for the Board were found in A.C.R.R. Title 2, Chapter 5, now consisting of rules and regulations of Personnel Administration, Department of Administration.

ARTICLE 1. GENERAL PROVISIONS

Section

- R2-5.1-101. Definitions
- R2-5.1-102. Personnel Board Procedures
- R2-5.1-103. Appeal Procedures
- R2-5.1-104. Complaint Procedures

ARTICLE 1. GENERAL PROVISIONS

R2-5.1-101. Definitions

Unless the context requires otherwise, the following definitions govern in this Chapter:

1. "Agency," for purposes of appeal from a disciplinary action, means an employing state entity that takes an appealable disciplinary action against a covered employee in covered service as defined by A.R.S. § 41-741.
2. "Appeal" means a written request filed with the Board by a permanent covered employee in covered service seeking relief from dismissal, involuntary demotion, or suspension of more than 80 working hours.
3. "Appellant" means a permanent covered employee in covered service who files an appeal with the Board.
4. "Complainant" means an employee or former employee as defined in A.R.S. § 38-531 who files a complaint with the Board.
5. "Complaint" means a written request for relief under A.R.S. § 38-532 filed with the Board by an employee or former employee who believes a prohibited personnel action was taken against the employee or former employee as a result of the employee's or former employee's disclosure of information under A.R.S. § 38-532.
6. "Day" means a calendar day, unless otherwise stated.
7. "Deposition" means a form of discovery in which testimony of a witness is given under oath or affirmation, subject to cross-examination, and recorded in writing, before a hearing.
8. "Hearing" means an administrative proceeding at which the appellant or complainant and the respondent are given the opportunity to be heard by oral or written presentation of evidence.
9. "Hearing officer" means a person employed or appointed by the Board, the Board's chair, or any member of the Board designated by the Board's chair acting as the trier of fact.
10. "Respondent" means an agency or individual whose interests are adverse to those of an appellant or complainant or who will be directly affected by the Board's decision.
11. "Subpoena" means a formal legal document issued under authority of the Board to compel the appearance of a witness at a hearing.

Historical Note

Adopted effective November 10, 1983 (Supp. 83-6). Former Section R2-5.1-101 renumbered to R2-5.1-102; new Section R2-5.1-101 adopted by final rulemaking at 7 A.A.R. 44, effective December 13, 2000 (Supp. 00-4). Amended by final rulemaking at 9 A.A.R. 22, effective

February 7, 2003 (Supp. 02-4). Amended by exempt rulemaking at 18 A.A.R. 2926, effective October 29, 2012 (Supp. 12-4).

R2-5.1-102. Personnel Board Procedures

- A. Regular meetings. At each public meeting, the Board shall announce the time and place of its next regular monthly meeting. The Board shall give notice as required by law.
- B. Special meetings. The chair of the Board may call special meetings of the Board. The Board shall give notice as required by law.
- C. Emergency meetings. In the case of an emergency, the chair or vice chair of the Board may call a meeting. The Board shall give notice as required by law.
- D. Agenda. The Board shall consider only matters placed on the agenda. The agenda shall be mailed to each member of the Board at least five business days before the meeting.
- E. Notice to agencies. At least five business days before a meeting, the Board shall mail a copy of the agenda to a state agency indicating an interest in receiving the agenda. The Board's failure to mail the agenda, or failure of an agency to receive the agenda, does not affect the validity of the meeting or of any action taken by the Board at the meeting.
- F. Notice to parties. The Board shall give notice of a meeting as required by law to all parties in a matter scheduled for a Board meeting.
- G. Minutes. The Board shall record in the Board's minutes the time and place of each meeting of the Board, names of the Board members present, all official acts of the Board, the votes of each Board member except when the acts are unanimous, and, when requested by a member, a member's dissent with the member's reasons. Board staff shall write the minutes and shall present the minutes for approval by the Board members at the next regular meeting. The Board shall provide copies of the approved minutes to the appellant and respondent within seven days of the regular meeting at which the minutes are approved.

Historical Note

Adopted effective November 10, 1983 (Supp. 83-6). Amended subsection (B)(2) effective March 3, 1988 (Supp. 88-1). Corrections to subsections (B)(2) and (4) from revised format edition published February 1991 (Supp. 96-1). Former Section R2-5.1-102 renumbered to R2-5.1-103; new Section R2-5.1-102 renumbered from R2-5.1-101 and amended by final rulemaking at 7 A.A.R. 44, effective December 13, 2000 (Supp. 00-4). Manifest typographical error corrected in Section heading (Supp. 01-2). Amended by final rulemaking at 9 A.A.R. 22, effective February 7, 2003 (Supp. 02-4).

R2-5.1-103. Appeal Procedures

- A. Appeal. A permanent status covered employee who wishes to appeal a disciplinary action shall, no later than 10 business days from the effective date of the action, file a written appeal with the Board in accordance with A.R.S. § 41-783. The appeal shall include:
 1. The appellant's name, address, and telephone number;
 2. The name of the agency taking the disciplinary action being appealed;

3. The name, address, and telephone number of the appellant's representative, if applicable;
 4. The action requested of the Board; and
 5. A specific response to the causes for disciplinary action upon which the appeal is based.
- B.** Change of address. A party shall notify the Board of a change of address or telephone number.
- C.** Routing of appeal. The Board shall provide a copy of an appeal to the respondent at the respondent's last known address within five business days from the date of filing.
- D.** Hearing officer. The Board or the Board's chair may assign an appeal or may direct staff administratively to assign an appeal to a hearing officer for hearing. When an appeal is assigned to a hearing officer, the hearing officer is the authorized representative of the Board and is fully empowered to grant or refuse extensions of time, to set proceedings for hearing, to conduct the hearing, and to take any action in connection with the proceedings that the Board is authorized by law to take other than making the final findings of fact, conclusions of law, and order. The assignment of an appeal to a hearing officer does not preclude the Board or the Board's chair from withdrawing the assignment and conducting the hearing itself or from reassigning the appeal to another hearing officer.
- E.** Hearing officer report. The hearing officer conducting the hearing shall write proposed findings of fact, conclusions of law, and a recommendation, as well as a brief statement of reasons for the hearing officer's findings and conclusions and shall submit to the Board the proposed findings of fact, conclusions of law, and recommendation within 30 days of the last date of the hearing.
- F.** Conclusion of hearing. The Board shall consider the hearing concluded when it receives a copy of the hearing officer's proposed findings of fact, conclusions of law, and recommendation or, if objections are filed, on the date the objections are filed. At the discretion of the Board, the hearing officer may be, but need not be, present during the consideration of the appeal by the Board, and, if requested, shall assist and advise the Board.
- G.** Time for hearing. The Board shall hold a hearing on an appeal within 30 days from receipt by the Board of an appeal unless the Board finds good cause to extend the time.
- H.** Notice of hearing. The Board shall provide the appellant and respondent with written notice of the time, date, and place of hearing of an appeal, and the name of the hearing officer at least 20 days before the date of the hearing.
- I.** Nature of hearing; rules of evidence. Every hearing shall be open to the public unless the appellant requests a confidential hearing. If the hearing involves evidence the state is precluded by law from disclosing, the Board or the Board's hearing officer shall grant a request for a confidential hearing by the respondent. The appellant, respondent, or hearing officer may request that portions of the record be sealed or adequately protected if testimony of a witness is of a sensitive nature. Any party may be self-represented or may designate a representative as provided by law. Every hearing shall be conducted in an impartial manner as a quasi-judicial proceeding. All witnesses shall testify under oath or by affirmation, and a record of the proceeding shall be made and kept by the Board for three years. Hearings shall be conducted in a manner that ascertains the substantial rights of the parties. The Board, a Board member, or a hearing officer is not bound by common law, statutory rules of evidence, or technical or formal rules of procedure, except the rule of privilege as recognized by law.
- J.** Prehearing conference. The Board or the Board's hearing officer may require the appellant and respondent to attend a prehearing conference. Any agreements reached at that conference shall be binding at the hearing.
- K.** Exhibits. A party introducing an exhibit shall furnish the Board or the Board's hearing officer and the opposing party with a copy of the exhibit before or at the beginning of the hearing.
- L.** Exclusion of witnesses. Upon the motion of an appellant or respondent, the hearing officer, in the hearing officer's discretion, may exclude from the hearing room any witness who is not under examination. The hearing officer shall not exclude a party to the hearing or a party's representative.
- M.** Witness fees. Witnesses, other than state employees, when subpoenaed to attend a hearing are entitled to the same fee as is allowed witnesses in civil cases in the Arizona Superior Court. If the hearing officer, on the hearing officer's own motion, subpoenas a witness, fees and mileage shall be paid from funds of the Board upon presentation of a duly executed claim. If the appellant or respondent subpoenas a witness, the fees and mileage shall be paid by the party requesting the witness. Reimbursement to state employees subpoenaed as witnesses is limited to payment of mileage by the party requesting the witness. Mileage shall be paid at the current Arizona Department of Administration reimbursement rate.
- N.** Enforcement of subpoenas. If enforcement of a subpoena for appearance of a witness is necessary, enforcement proceedings shall be taken to Superior Court by the party requesting enforcement, and enforcement shall be determined by the Superior Court and not the Board. The party requesting enforcement shall name the Board as a party to any proceedings. The Board shall follow any orders entered by the court.
- O.** Depositions. Either party may request that a witness' deposition be used as evidence if the presence of a witness cannot be procured at the time of hearing. The hearing officer shall grant or deny the request.
- P.** Proposed findings of fact. Both appellant and respondent may file with the Board proposed findings of fact and conclusions of law for the benefit of the hearing officer. If either the appellant or the respondent chooses to file proposed findings of fact and conclusions of law, the filing shall take place before the conclusion of the hearing as defined in subsection (F).
- Q.** Objections to findings. The Board shall send a copy of the hearing officer's proposed findings of fact, conclusions of law, and recommendation to the appellant and respondent. The appellant or respondent may file written objections, but not post-hearing evidence, to the hearing officer's proposed findings of fact or conclusions of law with the Board within 15 days from receipt of the hearing officer's proposed findings of fact and conclusions of law and shall serve copies of the objections upon the other party and the Board. The Board shall not consider untimely objections.
- R.** Personnel Board decision. Within the time required by law, the Board shall notify the appellant and respondent of the time and place of the Board meeting at which the appeal will be decided. The Board may affirm, reverse, adopt, modify, supplement, or reject the hearing officer's proposed findings of fact and conclusions of law in whole or in part, may recommit the matter to the hearing officer with instructions, may convene itself as a hearing body, or may make any other disposition of the appeal allowed by law. The Board shall make a decision on the appeal in an open meeting within 45 days after the conclusion of the hearing and shall send a copy of the decision to the appellant and respondent by certified mail, return receipt requested. If the Board orders the respondent to reinstate the appellant, it may also order the respondent to reinstate the appellant with or without back pay in the amount and for the period the Board determines to be proper.

State Personnel Board

- S. Appeal of Board decision in court. The appellant or respondent may appeal the Board's decision to the Superior Court as provided in A.R.S. § 41-783.

Historical Note

New Section renumbered from R2-5.1-103 renumbered from R2-5.1-102 and amended by final rulemaking at 7 A.A.R. 44, effective December 13, 2000 (Supp. 00-4). Amended by final rulemaking at 9 A.A.R. 22, effective February 7, 2003 (Supp. 02-4). Amended by exempt rulemaking at 18 A.A.R. 2926, effective October 29, 2012 (Supp. 12-4).

R2-5.1-104. Complaint Procedures

- A. Complaint. A state employee or former employee who wishes to file a complaint shall, no later than ten days from the effective date of the alleged prohibited personnel practice that is the subject of the complaint, file a written complaint with the Board in accordance with A.R.S. § 38-532. The complaint shall include:
1. The complainant's name, address, and telephone number;
 2. A clear and concise statement of the facts constituting the alleged prohibited personnel practice;
 3. The name of the state agency or state employee believed to have knowingly committed the prohibited personnel practice;
 4. The date and place of the alleged prohibited personnel practice; and
 5. The name, address, and telephone number of the complainant's representative, if applicable.
- B. Change of address. A party shall notify the Board of a change of address or telephone number.
- C. Routing of complaint. The Board shall provide a copy of a complaint to the respondent at the respondent's last known address within five business days from the date of filing.
- D. Amending a complaint. A complainant may move to amend a complaint. An amendment shall relate only to the facts and circumstances under the original complaint and shall not relate to new causes of action. The hearing officer shall grant or deny the motion or shall refer the motion to the Board for disposition.
- E. Hearing officer. The Board or the Board's chair may assign a complaint or may direct staff administratively to assign a complaint to a hearing officer for hearing. When a complaint is assigned to a hearing officer, the hearing officer is the authorized representative of the Board and is fully empowered to grant or refuse extensions of time, to set proceedings for hearing, to conduct the hearing, and to take any action in connection with the proceedings that the Board is authorized by law to take other than making the final findings of fact, conclusions of law, and order. The assignment of a complaint to a hearing officer does not preclude the Board or the Board's chair from withdrawing the assignment and conducting the hearing itself or from reassigning the complaint to another hearing officer.
- F. Hearing officer report. The hearing officer conducting the hearing shall write proposed findings of fact, conclusions of law, and a recommendation, as well as a brief statement of reasons for the hearing officer's findings and conclusions and shall submit to the Board the proposed findings of fact, conclusions of law, and recommendation within 30 days of the last date of hearing.
- G. Conclusion of hearing. The Board shall consider the hearing concluded when it receives a copy of the hearing officer's proposed findings of fact, conclusions of law, and recommendation or, if objections are filed, on the date the objections are filed. At the discretion of the Board, the hearing officer may be, but need not be, present during the consideration of the complaint by the Board, and, if requested, shall assist and advise the Board.
- H. Time for hearing. The Board shall hold a hearing on a complaint within 30 days from receipt by the Board of a complaint unless the Board finds good cause to extend the time.
- I. Notice of hearing. The Board shall provide the complainant and respondent with written notice of the time, date, and place of hearing of a complaint, and the name of the hearing officer at least 20 days before the date of the hearing.
- J. Nature of hearing; rules of evidence. Every hearing shall be open to the public unless the complainant requests a confidential hearing. If the hearing involves evidence the state is precluded by law from disclosing, the Board or the Board's hearing officer shall grant a request for a confidential hearing by the respondent. The complainant, respondent, or hearing officer may request that portions of the record be sealed or adequately protected if testimony of a witness is of a sensitive nature. Any party may be self-represented or may designate a representative as provided by law. Every hearing shall be conducted in an impartial manner as a quasi-judicial proceeding. All witnesses shall testify under oath or by affirmation, and a record of the proceeding shall be made and kept by the Board for three years. Hearings shall be conducted in a manner that ascertains the substantial rights of the parties. The Board, a Board member, or a hearing officer is not bound by common law, statutory rules of evidence, or technical or formal rules of procedure, except the rule of privilege as recognized by law.
- K. Prehearing conference. The Board or the Board's hearing officer may require the complainant and respondent to attend a prehearing conference. Any agreements reached at that conference shall be binding at the hearing.
- L. Exhibits. A party introducing an exhibit shall furnish the Board or the Board's hearing officer and the opposing party with a copy of the exhibit before or at the beginning of the hearing.
- M. Exclusion of witnesses. Upon the motion of a complainant or respondent, the hearing officer, in the hearing officer's discretion, may exclude from the hearing room any witness who is not under examination. The hearing officer shall not exclude a party to the hearing or a party's representative.
- N. Witness fees. Witnesses, other than state employees, when subpoenaed to attend a hearing are entitled to the same fee as is allowed witnesses in civil cases in the Arizona Superior Court. If the hearing officer, on the hearing officer's own motion, subpoenas a witness, fees and mileage shall be paid from funds of the Board upon presentation of a duly executed claim. If the complainant or respondent subpoenas a witness, the fees and mileage shall be paid by the party requesting the witness. Reimbursement to state employees subpoenaed as witnesses is limited to payment of mileage by the party requesting the witness. Mileage shall be paid at the current Arizona Department of Administration reimbursement rate.
- O. Enforcement of subpoenas. If enforcement of a subpoena for appearance of a witness is necessary, enforcement proceedings shall be taken to Superior Court by the party requesting enforcement, and enforcement shall be determined by the Superior Court and not the Board. The party requesting enforcement shall name the Board as a party to any proceedings. The Board shall follow any orders entered by the court.
- P. Depositions. Either party may request that a witness' deposition be used as evidence if the presence of a witness cannot be procured at the time of hearing. The hearing officer shall grant or deny the request.
- Q. Proposed findings of fact. Both complainant and respondent may file with the Board proposed findings of fact and conclu-

sions of law for the benefit of the hearing officer. If either the complainant or the respondent chooses to file proposed findings of fact and conclusions of law, the filing shall take place before the conclusion of the hearing as defined in subsection (G).

- R. Objections to findings. The Board shall send a copy of the hearing officer's proposed findings of fact, conclusions of law, and recommendation to the complainant and respondent. The complainant or respondent may file written objections, but not post-hearing evidence, to the hearing officer's proposed findings of fact or conclusions of law with the Board within 15 days from receipt of the hearing officer's proposed findings of fact and conclusions of law and shall serve copies of the objections upon the other party and the Board. The Board shall not consider untimely objections.
- S. Personnel Board decision. Within the time required by law, the Board shall notify the complainant and respondent of the time

and place of the Board meeting at which the complaint will be decided. The Board shall determine the validity of the complaint and whether a prohibited personnel practice was committed against the employee or former employee as a result of the employee or former employee's disclosure of information of a matter of public concern. If the Board determines a prohibited personnel practice was committed as a result of disclosure of information by the employee or former employee, the Board shall act in accordance with the requirements of A.R.S. § 38-532.

- T. Appeal of Board decision in court. The complainant or respondent may appeal the Board's decision to the Superior Court as provided in A.R.S. § 38-532.

Historical Note

New Section made by final rulemaking at 9 A.A.R. 22, effective February 7, 2003 (Supp. 02-4).

TITLE 2. ADMINISTRATION**CHAPTER 7. DEPARTMENT OF ADMINISTRATION
STATE PROCUREMENT OFFICE**

(Authority: A.R.S. § 41-2511 et seq.)

Chapter 7 consisting of Article 1, Sections R2-7-101 thru R2-7-104; Article 2, Sections R2-7-201 thru R2-7-203; Article 3, Sections R2-7-301 thru R2-7-334, R2-7-336 thru R2-7-370; Article 4, Sections R2-7-401 thru R2-7-405, R2-7-407 thru R2-7-411; Article 5, Sections R2-7-501, R2-7-503 thru R2-7-515; Article 7, Section R2-7-701; Article 8, Sections R2-7-801 thru R2-7-810; Article 9, Sections R2-7-901 thru R2-7-937; Article 10, Sections R2-7-1001 thru R2-7-1008 adopted effective April 3, 1985 (Supp. 85-2).

ARTICLE 1. GENERAL PROVISIONS

Section

R2-7-101.	Definitions
R2-7-102.	Written Determinations
R2-7-103.	Confidential Information
R2-7-104.	Repealed
R2-7-105.	Repealed

R2-7-330.	Repealed
R2-7-331.	Repealed
R2-7-332.	Repealed
R2-7-333.	Repealed
R2-7-334.	Repealed
R2-7-335.	Repealed
R2-7-336.	Repealed
R2-7-337.	Repealed

ARTICLE 2. PROCUREMENT ORGANIZATION

Section

R2-7-201.	State Procurement Administrator: Duties and Qualifications
R2-7-202.	Delegation of Procurement Authority to State Governmental Units
R2-7-203.	Agency Chief Procurement Officer
R2-7-204.	State Employee or Public Officer Use of State Contracts
R2-7-205.	Procurement Requests by Purchasing Agencies
R2-7-206.	Authorized Procurement Officers
R2-7-207.	Resolution of Intra-agency Procurement Disputes
R2-7-208.	Authorization of Electronic Transactions
R2-7-209.	Prospective Suppliers List

R2-7-338.	Repealed
R2-7-339.	Repealed
R2-7-340.	Repealed
R2-7-341.	Repealed
R2-7-342.	Repealed
R2-7-343.	Repealed
R2-7-344.	Repealed
R2-7-345.	Repealed
R2-7-346.	Repealed
R2-7-347.	Repealed
R2-7-348.	Repealed
R2-7-349.	Repealed
R2-7-350.	Repealed
R2-7-351.	Repealed
R2-7-352.	Repealed
R2-7-353.	Repealed
R2-7-354.	Repealed
R2-7-355.	Repealed
R2-7-356.	Repealed
R2-7-357.	Repealed
R2-7-358.	Repealed
R2-7-359.	Repealed
R2-7-360.	Repealed
R2-7-361.	Repealed
R2-7-362.	Repealed
R2-7-363.	Repealed
R2-7-364.	Repealed
R2-7-365.	Repealed
R2-7-366.	Repealed
R2-7-367.	Repealed
R2-7-368.	Repealed
R2-7-369.	Repealed
R2-7-370.	Repealed

**ARTICLE 3. SOURCE SELECTION AND CONTRACT
FORMATION**

Section

R2-7-301.	Repealed
R2-7-302.	Repealed
R2-7-303.	Repealed
R2-7-304.	Repealed
R2-7-305.	Repealed
R2-7-306.	Repealed
R2-7-307.	Repealed
R2-7-308.	Repealed
R2-7-309.	Repealed
R2-7-310.	Repealed
R2-7-311.	Repealed
R2-7-312.	Repealed
R2-7-313.	Repealed
R2-7-314.	Repealed
R2-7-315.	Repealed
R2-7-316.	Repealed
R2-7-317.	Repealed
R2-7-318.	Repealed
R2-7-319.	Repealed
R2-7-320.	Repealed
R2-7-321.	Repealed
R2-7-322.	Repealed
R2-7-323.	Repealed
R2-7-324.	Repealed
R2-7-325.	Repealed
R2-7-326.	Repealed
R2-7-327.	Repealed
R2-7-328.	Repealed
R2-7-329.	Repealed

PART A. GENERAL PROVISIONS

Section

R2-7-A301.	Source Selection Method: Determination Factors
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PART B. COMPETITIVE SEALED BIDDING

Section

R2-7-B301.	Solicitation
R2-7-B302.	Pre-offer Conferences
R2-7-B303.	Solicitation Amendment
R2-7-B304.	Modification or Withdrawal of Offer Before Offer Due Date and Time
R2-7-B305.	Cancellation of a Solicitation Before Offer Due Date and Time
R2-7-B306.	Receipt, Opening, and Recording of Offers

- R2-7-B307. Late Offers, Modifications, Withdrawals
- R2-7-B308. Cancellation of Solicitation After Receipt of Offers and Before Award
- R2-7-B309. One Offer Received
- R2-7-B310. Offer Mistakes Discovered After Offer Opening and Before Award
- R2-7-B311. Extension of Offer Acceptance Period
- R2-7-B312. Bid Evaluation
- R2-7-B313. Responsibility Determinations
- R2-7-B314. Contract Award
- R2-7-B315. Mistakes Discovered After Award
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- R2-7-F304. Cancellation of Solicitation
- R2-7-F305. Receipt, Opening, and Recording of Offers
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ARTICLE 4. SPECIFICATIONS

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- R2-7-405. Repealed
- R2-7-406. Reserved
- R2-7-407. Repealed
- R2-7-408. Repealed
- R2-7-409. Repealed
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Section

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- R2-7-508. Performance and Payment Bonds
- R2-7-509. Conditions for Use of Substitute Security in Lieu of Retention
- R2-7-510. The Form of Substitute Security in Lieu of Retention
- R2-7-511. Individual Job Order Contracting
- R2-7-512. Repealed
- R2-7-513. Repealed
- R2-7-514. Repealed
- R2-7-515. Repealed

ARTICLE 6. CONTRACT CLAUSES

Section

- R2-7-601. Contract Clauses
- R2-7-602. Assignment of Rights and Duties
- R2-7-603. Change of Name
- R2-7-604. Contract Change Orders and Amendments
- R2-7-605. Multi-term Contracts
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- R2-7-608. Multiple Source Contracts

ARTICLE 7. COST PRINCIPLES

Section

- R2-7-701. Cost principles

Department of Administration - State Procurement Office

R2-7-702.	Determination of Fair and Reasonable Price
R2-7-703.	Submission and Certification of Cost or Pricing Data
R2-7-704.	Refusal to Submit Cost or Pricing Data
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ARTICLE 8. TRANSFERRED

Article 8, consisting of Sections R2-7-801 through R2-7-810, transferred to Title 2, Chapter 15, Article 3, Sections R2-15-301 through R2-15-310, Department of Administration, General Services Division (Supp. 91-3).

ARTICLE 9. LEGAL AND CONTRACTUAL REMEDIES

Section	
R2-7-901.	Repealed
R2-7-902.	Repealed
R2-7-903.	Repealed
R2-7-904.	Repealed
R2-7-905.	Repealed
R2-7-906.	Repealed
R2-7-907.	Repealed
R2-7-908.	Repealed
R2-7-909.	Repealed
R2-7-910.	Repealed
R2-7-911.	Repealed
R2-7-912.	Repealed
R2-7-913.	Repealed
R2-7-914.	Repealed
R2-7-915.	Repealed
R2-7-916.	Repealed
R2-7-917.	Repealed
R2-7-918.	Repealed
R2-7-919.	Repealed
R2-7-920.	Repealed
R2-7-921.	Repealed
R2-7-922.	Repealed
R2-7-923.	Repealed
R2-7-924.	Repealed
R2-7-925.	Repealed
R2-7-926.	Repealed
R2-7-927.	Repealed
R2-7-928.	Repealed
R2-7-929.	Repealed
R2-7-930.	Repealed
R2-7-931.	Repealed
R2-7-932.	Repealed
R2-7-933.	Repealed
R2-7-934.	Repealed
R2-7-935.	Repealed
R2-7-936.	Repealed
R2-7-937.	Repealed

PART A. PROTEST OF SOLICITATIONS AND CONTRACT AWARDS

Section	
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R2-7-A902.	Stay of Procurements During the Protest
R2-7-A903.	Resolution of Solicitation and Contract Award Protests
R2-7-A904.	Remedies by the Agency Chief Procurement Officer
R2-7-A905.	Appeals to the Director
R2-7-A906.	Notice of Appeal to the Director
R2-7-A907.	Stay of Procurement During Appeal to Director
R2-7-A908.	Agency Report
R2-7-A909.	Remedies by the Director
R2-7-A910.	Dismissal Before Hearing
R2-7-A911.	Hearing

PART B. CONTRACT CLAIMS

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R2-7-B903.	Issuance of a Timely Decision
R2-7-B904.	Appeals and Reports to the Director
R2-7-B905.	Controversies Involving State Claims Against the Contractor

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R2-7-C901.	Authority to Debar or Suspend
R2-7-C902.	Initiation of Debarment
R2-7-C903.	Period of Debarment
R2-7-C904.	Notice of Debarment and Hearing
R2-7-C905.	Imputed Knowledge
R2-7-C906.	Reinstatement
R2-7-C907.	Limited Participation
R2-7-C908.	Suspension
R2-7-C909.	Period and Scope of Suspension
R2-7-C910.	Notice, Hearing, Determination, and Appeal
R2-7-C911.	Master List

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R2-7-1002.	Cooperative Purchasing Agreement Administered by an Agency Chief Procurement Officer
R2-7-1003.	Establishment of a Committee as Required by A.R.S. § 41-2636
R2-7-1004.	Certification as Non-Profit Agency for Disabled Individuals
R2-7-1005.	Application for Approval as Required by A.R.S. § 41-2636 to Become a Certified Non-Profit Agency for Disabled Individuals
R2-7-1006.	Approval of Specific Materials or Services for Set-aside Use
R2-7-1007.	Contract Awards Directed by the Committee
R2-7-1008.	Contract Awards Initiated by an Agency Chief Procurement Officer or Local Public Procurement Unit
R2-7-1009.	Set-aside Application Dispute Process
R2-7-1010.	Renumbered

ARTICLE 11. RESERVED**ARTICLE 12. RESERVED****ARTICLE 13. REPEALED**

Section	
R2-7-1301.	Repealed

ARTICLE 1. GENERAL PROVISIONS**R2-7-101. Definitions**

In this Chapter, unless the context otherwise requires:

1. "Affiliate" means any person whose governing instruments require it to be bound by the decision of another person or whose governing board includes enough voting representatives of the other person to cause or prevent action, whether or not the power is exercised. The term

- applies to persons doing business under a variety of names, persons in a parent-subsidiary relationship, or persons that are similarly affiliated.
2. "Agency chief procurement officer" means the procurement officer within a state governmental unit, who is acting under specific, written authority from the state procurement administrator in accordance with R2-7-202 or any person delegated that authority, in writing, under R2-7-203. The term does not include any other person within a state governmental unit who does not have this written delegation of authority.
 3. "Aggregate dollar amount" means purchase price, including taxes and delivery charges, for the term of the contract and accounting for all allowable extensions and options.
 4. "Alternate project delivery methods" means design-build, construction-management-at-risk, and job-order-contracting construction services.
 5. "Arizona Procurement Code" means A.R.S. Title 41, Chapter 23 and this Chapter.
 6. "Arizona state contract" means a contract established or authorized by the state procurement administrator for use by state governmental units and eligible procurement units.
 7. "Award" means a determination by the state that it is entering into a contract with one or more offerors.
 8. "Bid" means an offer in response to solicitation.
 9. "Bidder" means "offeror" as defined in R2-7-101(36).
 10. "Brand name or equal specification" means a written description that uses one or more manufacturers' product name or catalog item, to describe the standard of quality, performance, and other characteristics that meet state requirements and provides for submission of equivalent products or services.
 11. "Brand name specification" means a written description limited to a list of one or more items by manufacturers' product name or catalog item to describe the standard of quality, performance, and other characteristics that meet state requirements.
 12. "Clergy" includes the same persons described in A.R.S. § 32-3272(3).
 13. "Competitive range" is a range determined by the procurement officer on the basis of the criteria stated in the solicitation and an initial review of the proposals submitted. Those proposals that are susceptible for award after the initial review of all original proposals in accordance with the evaluation criteria and a comparison and ranking of original proposals shall be in the competitive range. Those proposals that have no reasonable chance for award when compared on a relative basis with more highly ranked proposals will not be in the competitive range. Proposals to be considered within the competitive range must, at a minimum, demonstrate the following:
 - a. Affirmative compliance with mandatory requirements designated in the solicitation.
 - b. An ability to deliver goods or services on terms advantageous to the state sufficient to be entitled to continue in the competition.
 - c. That the proposal is technically acceptable as submitted.
 14. "Component" means a part of a manufactured product.
 15. "Contract amendment" means a written modification of a contract under A.R.S. § 41-2503(8) or a unilateral exercise of a right contained in the contract.
 16. "Cost data" means information concerning the actual or estimated cost of labor, material, overhead, and other cost elements that have been incurred or will be incurred by the offeror or contractor in performing the contract.
 17. "Cost-plus-a-percentage-of-cost contract" means the parties to a contract agree that the fee will be a predetermined percentage of the cost of work performed and the contract does not limit the cost and fee before authorization of performance.
 18. "Day" means a calendar day and time is computed under A.R.S. § 1-243, unless otherwise specified in the solicitation or contract.
 19. "Debarment" means an action taken by the director under R2-7-C901 that prohibits a person from participating in the state procurement process.
 20. "Defective data" means data that is inaccurate, incomplete, or outdated.
 21. "Dentist" means a person licensed under A.R.S. Title 32, Chapter 11.
 22. "Descriptive literature" means information available in the ordinary course of business that shows the characteristics, construction, or operation of an item or service offered.
 23. "Discussion" means "negotiation" as defined in R2-7-101(34).
 24. "Eligible procurement unit" means a local public procurement unit, any other state or agency of the United States, or a nonprofit educational or public health institution, including any certified non-profit agency for disabled individuals as defined in A.R.S. § 41-2631, that is eligible under a cooperative agreement to use Arizona state contracts.
 25. "Enterprise Procurement Services" means state procurement office as defined in R2-7-101(50).
 26. "Filed" means delivery to an agency chief procurement officer or to the director, whichever is applicable, in a manner specified by the Arizona Procurement Code or a solicitation.
 27. "Finished goods" means units of a manufactured product awaiting sale.
 28. "Force account" as used in A.R.S. § 41-2572, means work performed by the state's regularly employed personnel.
 29. "Governing instruments" means legal documents that establish the existence of an organization and define its powers, including articles of incorporation or association, constitution, charter, by-laws, or similar documents.
 30. "In writing" has the same meaning as "written" or "writing" in A.R.S. § 47-1201, which includes printing, type-writing, electronic transmission, facsimile, or any other intentional reduction to tangible form.
 31. "Interested party" means an offeror or prospective offeror whose economic interest is affected substantially and directly by issuance of a solicitation, an award or loss of an award. Whether an offeror or prospective offeror has an economic interest depends upon the circumstances of each case.
 32. "Legal counsel" means a person licensed as an attorney by the Arizona Supreme Court.
 33. "May" means something is permissive.
 34. "Negotiation" means an exchange or series of exchanges between the state and an offeror or contractor that allows the state or the offeror or contractor to revise an offer or contract, unless revision is specifically prohibited by this Chapter.
 35. "Offer" means a response to a solicitation.
 36. "Offeror" means a person who responds to a solicitation.

37. "Physician" means a person licensed under A.R.S. Title 32, Chapters 7, 8, 13, 14, 15.1, 16, or 17.
38. "Price data" means information concerning prices, including profit, for materials, services, or construction substantially similar to the materials, services, or construction to be procured under a contract or subcontract. In this definition, "prices" refers to offered selling prices, historical selling prices, or current selling prices of the items to be purchased.
39. "Procurement file" means the official records file of the director whether located in the office of the director or at a public procurement unit. The procurement file shall include (electronic or paper) the following:
 - a. List of notified vendors;
 - b. Final solicitation;
 - c. Solicitation amendments;
 - d. Bids and offers;
 - e. Final proposal revisions;
 - f. Discussions;
 - g. Clarifications;
 - h. Final evaluation reports; and
 - i. Additional information, if requested by the agency chief procurement officer and approved by the state procurement administrator.
40. "Procurement request" means the document that initiates a procurement.
41. "Proposal" means an offer submitted in response to a solicitation.
42. "Prospective offeror" means a person that expresses an interest in a specific solicitation.
43. "Raw materials" means goods, excluding equipment and machinery, purchased for use in manufacturing a product.
44. "Reverse auction" means a procurement method in which offerors are invited to bid on specified goods or services through online bidding and real-time electronic bidding. During an electronic bidding process, offerors' prices or relative ranking are available to competing offerors and offerors may modify their offer prices until the closing date and time.
45. "Shall" means something is mandatory.
46. "Small business" means a for-profit or not-for-profit organization, including its affiliates, with fewer than 100 full-time employees or gross annual receipts of less than \$4 million for the last complete fiscal year.
47. "Solicitation" means an invitation for bids, a request for technical offers, a request for proposals, a request for quotations, or any other invitation or request issued by the purchasing agency to invite a person to submit an offer.
48. "Source selection method" means a process that is approved by an agency chief procurement officer and used to select a person to enter into a contract for procurement.
49. "State procurement administrator" means the individual appointed by the director as a chief procurement officer for a state, or a state procurement administrator's authorized designee. A different title may be used for this position.
50. "State procurement office" means an office that acts under the authority delegated to the state procurement administrator.
51. "Suspension" means an action taken by the director under R2-7-C901 that temporarily disqualifies a person from participating in a state procurement process.
52. "Trade secret" means information, including a formula, pattern, device, compilation, program, method, tech-

nique, or process, that is the subject of reasonable efforts to maintain its secrecy and that derives independent economic value, actual or potential, as a result of not being generally known to and not being readily ascertainable by legal means.

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Amended effective April 2, 1993 (Supp. 93-2). Section repealed; new Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1). Amended by final rulemaking at 18 A.A.R. 3118, effective January 7, 2013 (Supp. 12-4).

R2-7-102. Written Determinations

- A. If a written determination is required under applicable law, an agency chief procurement officer shall include the basis for the action taken in the written determination.
- B. The agency chief procurement officer shall place the written determination into the purchasing agency's procurement file.
- C. A procurement file located at a state agency is considered the official records file of the director as required by A.R.S. § 41-2502, if the file is maintained by an agency chief procurement officer.

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Amended effective April 2, 1993 (Supp. 93-2). Section repealed; new Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-103. Confidential Information

- A. If a person wants to assert that a person's offer, specification, or protest contains a trade secret or other proprietary information, a person shall include with the submission a statement supporting this assertion. A person shall clearly designate any trade secret and other proprietary information, using the term "confidential". Contract terms and conditions, pricing, and information generally available to the public are not considered confidential information under this Section.
- B. Until a final determination is made under subsection (C), an agency chief procurement officer shall not disclose information designated as confidential under subsection (A) except to those individuals deemed by an agency chief procurement officer to have a legitimate state interest.
- C. Upon receipt of a submission, an agency chief procurement officer shall make one of the following written determinations:
 1. The designated information is confidential and the agency chief procurement officer shall not disclose the information except to those individuals deemed by the agency chief procurement officer to have a legitimate state interest;
 2. The designated information is not confidential; or
 3. Additional information is required before a final confidentiality determination can be made.
- D. If an agency chief procurement officer determines that information submitted is not confidential, a person who made the submission shall be notified in writing. The notice shall include a time period for requesting a review of the determination by the state procurement administrator.
- E. An agency chief procurement officer may release information designated as confidential under subsection (A) if:

1. A request for review is not received by the state procurement administrator within the time period specified in the notice; or
2. The state procurement administrator, after review, makes a written determination that the designated information is not confidential.

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Section repealed; new Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-104. Repealed**Historical Note**

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Amended effective April 2, 1993 (Supp. 93-2). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-105. Repealed**Historical Note**

Adopted effective April 2, 1993 (Supp. 93-2). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

ARTICLE 2. PROCUREMENT ORGANIZATION**R2-7-201. State Procurement Administrator: Duties and Qualifications**

- A. The director shall hire a state procurement administrator with executive and organizational skills and relevant, recent experience in public procurement.
- B. The state procurement administrator shall:
 1. Administer the procurement of materials, services, and construction needed by the state;
 2. Establish procurement policy and procedure;
 3. Establish procurement training standards;
 4. Designate if an Arizona state contract is mandatory;
 5. Delegate procurement authority under R2-7-202; and
 6. Monitor compliance of state governmental units with state procurement laws.
- C. The state procurement administrator shall maintain a record of each contract awarded under A.R.S. §§ 41-2536 (sole source procurement) and 41-2537 (emergency procurement) that exceeds the amount prescribed in A.R.S. § 41-2535(A). The record shall be maintained for a minimum of five years. The state procurement administrator shall ensure that the record is available for public inspection and contains all of the following:
 1. Each contractor's name;
 2. The estimated amount of each contract; and
 3. A description of the item or service procured.

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Amended effective April 2, 1993 (Supp. 93-2). Section repealed; new Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-202. Delegation of Procurement Authority to State Governmental Units

- A. The state procurement administrator shall delegate procurement authority to a state governmental unit based upon the following criteria:
 1. The procurement expertise, knowledge, experience, and performance of the state governmental unit's agency chief procurement officer, as identified by the state governmental unit; and
 2. The impact of the delegation on procurement efficiency and effectiveness.
- B. The state procurement administrator shall delegate procurement authority in a written document that specifies all of the following:
 1. The agency chief procurement officer,
 2. The specific authority delegated,
 3. Any limits or restrictions upon the delegated authority,
 4. Whether the authority may be further delegated, and
 5. The duration of the delegation.
- C. The head of a purchasing agency shall immediately report any significant change regarding the criteria considered under subsection (A) to the state procurement administrator.
- D. A purchasing agency shall exercise delegated authority according to A.R.S. Title 41, Chapter 23 and A.A.C. Title 2, Chapter 7.
- E. An agency chief procurement officer shall submit to the state procurement administrator any procurement that exceeds the agency's delegated authority.
- F. The state procurement administrator may revoke, suspend, or modify delegated authority for failure to comply with A.R.S. Title 41, Chapter 23 or A.A.C. Title 2, Chapter 7, or a significant change regarding the criteria considered under subsection (A).
- G. The state procurement administrator retains all authorities and duties delegated to an agency chief procurement officer at a state governmental unit.

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Amended effective April 2, 1993 (Supp. 93-2). Section repealed; new Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-203. Agency Chief Procurement Officer

- A. An agency chief procurement officer may further delegate procurement authority within the purchasing agency, within the limits specified by the state procurement administrator.
- B. The agency chief procurement officer shall notify the state procurement administrator in writing of employees who have delegated procurement authority.

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Amended effective April 2, 1993 (Supp. 93-2). Section repealed; new Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-204. State Employee or Public Officer Use of State Contracts

State employees and public officers shall not purchase materials or services for their own personal or business use from contracts entered into by the state unless authorized in writing by the director.

The determination shall state how the purchase will further the interests of the state.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-205. Procurement Requests by Purchasing Agencies

If a purchasing agency determines that a procurement is necessary, the purchasing agency shall submit a procurement request, in writing, to the procurement officer. The procurement request shall be submitted in a manner expressly approved by the agency chief procurement officer.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-206. Authorized Procurement Officers

A procurement officer shall perform all procurement duties in accordance with the Arizona Procurement Code and within the authority delegated to the procurement officer in accordance with this Chapter.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-207. Resolution of Intra-agency Procurement Disputes

Procurement disputes between a purchasing agency and its agency chief procurement officer shall be resolved by the state procurement administrator.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-208. Authorization of Electronic Transactions

- A. An electronic media transaction, involving an electronic record or electronic signature, is authorized if the transaction is consistent with state law.
- B. The state procurement administrator may limit the use of electronic transactions, based on consideration of the best interest of the state.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-209. Prospective Suppliers List

- A. The state procurement administrator shall compile and maintain a prospective suppliers list. To be included on the prospective suppliers list, a person shall register with the state procurement office.
- B. The state procurement administrator may remove suppliers from the prospective suppliers list if a notice sent to the supplier is returned. The state procurement administrator shall maintain a record of the date and reason for removal of a supplier from the prospective suppliers list.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

ARTICLE 3. SOURCE SELECTION AND CONTRACT FORMATION

R2-7-301. Repealed

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Amended effective April 2, 1993 (Supp. 93-2). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Amended effective April 2, 1993 (Supp. 93-2). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-302. Repealed

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Amended effective April 2, 1993 (Supp. 93-2). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-303. Repealed

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Amended effective April 2, 1993 (Supp. 93-2). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-304. Repealed

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Amended effective April 2, 1993 (Supp. 93-2). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-305. Repealed

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-306. Repealed

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Amended effective April 2, 1993 (Supp. 93-2). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-307. Repealed

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-308. Repealed

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-335. Repealed**Historical Note**

Adopted effective July 6, 1994 (Supp. 94-3). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-336. Repealed**Historical Note**

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Amended effective April 2, 1993 (Supp. 93-2). Amended effective July 6, 1994 (Supp. 94-3). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-337. Repealed**Historical Note**

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Amended effective April 2, 1993 (Supp. 93-2). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-338. Repealed**Historical Note**

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Amended effective April 2, 1993 (Supp. 93-2). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-339. Repealed**Historical Note**

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Amended effective April 2, 1993 (Supp. 93-2). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-340. Repealed**Historical Note**

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Amended effective April 2, 1993 (Supp. 93-2). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-341. Repealed**Historical Note**

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-1). Amended effective April 2, 1993 (Supp. 93-2). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-342. Repealed**Historical Note**

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-1). Amended effective April 2, 1993 (Supp. 93-2). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-343. Repealed

The Request for Proposals shall be in accordance with R2-7-326. The Requests for Proposals shall also be distributed to persons who have submitted statements of qualifications under R2-7-342 for the particular services sought.

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-1). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-344. Repealed**Historical Note**

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-1). Amended effective April 2, 1993 (Supp. 93-2). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-345. Repealed**Historical Note**

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-1). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-346. Repealed**Historical Note**

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-1). Amended effective April 2, 1993 (Supp. 93-2). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-347. Repealed**Historical Note**

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-1). Amended effective April 2, 1993 (Supp. 93-2). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-348. Repealed**Historical Note**

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp.

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-1). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-362. Repealed**Historical Note**

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-1). Amended effective April 2, 1993 (Supp. 93-2). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-363. Repealed**Historical Note**

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-1). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-364. Repealed**Historical Note**

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-1). Amended effective April 2, 1993 (Supp. 93-2). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-365. Repealed**Historical Note**

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-1). Amended effective April 2, 1993 (Supp. 93-2). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-366. Repealed**Historical Note**

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-1). Amended effective April 2, 1993 (Supp. 93-2). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-367. Repealed**Historical Note**

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-1). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-368. Repealed**Historical Note**

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-1). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-369. Repealed**Historical Note**

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-1). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-370. Repealed**Historical Note**

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-1). Amended effective April 2, 1993 (Supp. 93-2). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

PART A. GENERAL PROVISIONS**R2-7-A301. Source Selection Method: Determination Factors**

- A. A state governmental unit shall use any existing Arizona state contract designated as mandatory to satisfy requirements for those materials and services covered by such contracts.
- B. If a state governmental unit believes that an Arizona state contract, designated as mandatory, does not satisfy its requirements, the state governmental unit may only procure the material or service from another source with the written approval of the state procurement administrator and in conformance with the applicable source selection method.
- C. The agency chief procurement officer shall determine the applicable source selection method for a procurement, estimating the aggregate dollar amount of the contract and ensuring that the procurement is not artificially divided, fragmented, or combined to circumvent the Arizona Procurement Code.
- D. The agency chief procurement officer shall not award a contract or incur an obligation on behalf of the state unless sufficient funds are available for the procurement, consistent with A.R.S. § 35-154. If it is reasonable to believe that sufficient funds will become available for a procurement, the agency chief procurement officer may issue a notice with the solicitation indicating that funds are not currently available and that any contract awarded will be conditioned upon the availability of funds.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

PART B. COMPETITIVE SEALED BIDDING**R2-7-B301. Solicitation**

- A. An agency chief procurement officer shall issue an invitation for bids at least 14 days before the offer due date and time, unless the agency chief procurement officer determines a shorter time is necessary for a particular procurement. If a shorter time is necessary, the agency chief procurement officer shall document the specific reasons in the procurement file.
- B. An agency chief procurement officer shall:
 1. Advertise the procurement in accordance with A.R.S. § 41-2533(C); and
 2. At a minimum, provide written notice to the prospective suppliers that have registered with the state procurement office for the specific material, service, or construction solicited.
- C. An agency chief procurement officer shall include the following in the solicitation:

1. Instruction to offerors, including:
 - a. Instructions and information to offerors concerning the offer submission requirements, offer due date and time, the location where offers or other documents will be received, and the offer acceptance period;
 - b. The deadline date for requesting a substitution or exception to the solicitation;
 - c. The manner by which the offeror is required to acknowledge amendments;
 - d. The minimum required information in the offer;
 - e. The specific requirements for designating trade secrets and other proprietary information as confidential;
 - f. Any specific responsibility criteria;
 - g. Whether the offeror is required to submit samples, descriptive literature, or technical data with the offer;
 - h. Any evaluation criteria;
 - i. A statement of where documents incorporated by reference are available for inspection and copying;
 - j. A statement that the agency may cancel the solicitation or reject an offer in whole or in part;
 - k. Certification by the offeror that submission of the offer did not involve collusion or other anticompetitive practices;
 - l. Certification by the offeror of compliance with A.R.S. § 41-3532 when offering electronics or information technology products, services, or maintenance;
 - m. That the offeror is required to declare whether the offeror has been debarred, suspended, or otherwise lawfully prohibited from participating in any public procurement activity, including, but not limited to, being disapproved as a subcontractor of any public procurement unit or other governmental body;
 - n. Any bid security required;
 - o. The means required for submission of an offer. The solicitation shall specifically indicate whether hand delivery, U.S. mail, electronic mail, facsimile, or other means are acceptable methods of submission;
 - p. Any designation of the specific bid items and amounts to be recorded at offer opening; and
 - q. Any other offer submission requirements;
2. Specifications, including:
 - a. Any purchase description, specifications, delivery or performance schedule, and inspection and acceptance requirements;
 - b. If a brand name or equal specification is used, instructions that use of a brand name is for the purpose of describing the standard of quality, performance, and characteristics desired and is not intended to limit or restrict competition. The solicitation shall state that products substantially equivalent to the brands designated qualify for consideration; and
 - c. Any other specification requirements;
3. Terms and Conditions, including:
 - a. Whether the contract will include an option for extension; and
 - b. Any other contract terms and conditions.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-B302. Pre-offer Conferences

An agency chief procurement officer may conduct one or more pre-offer conferences. If a pre-offer conference is conducted, it shall be not less than seven days before the offer due date and time, unless the agency chief procurement officer makes a written determination that the specific needs of the procurement justify a shorter time. Statements made during a pre-offer conference are not amendments to the solicitation.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-B303. Solicitation Amendment

- A. An agency chief procurement officer shall issue a solicitation amendment to do any or all of the following:
 1. Make changes in the solicitation;
 2. Correct defects or ambiguities;
 3. Provide additional information or instructions; or
 4. Extend the offer due date and time if the agency chief procurement officer determines that an extension is in the best interest of the state.
- B. If a solicitation is changed by a solicitation amendment, the agency chief procurement officer shall notify suppliers to whom the agency chief procurement officer distributed the solicitation.
- C. It is the responsibility of the offeror to obtain any solicitation amendments. An offeror shall acknowledge receipt of an amendment in the manner specified in the solicitation or solicitation amendment on or before the offer due date and time.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-B304. Modification or Withdrawal of Offer Before Offer Due Date and Time

- A. An offeror may modify or withdraw its offer, in writing, before the offer due date and time.
- B. The agency chief procurement officer shall place the document submitted by the offeror in the procurement file as a record of the modification or withdrawal.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-B305. Cancellation of a Solicitation Before Offer Due Date and Time

- A. Based on the best interest of the state, an agency chief procurement officer may cancel a solicitation before the offer due date and time.
- B. The agency chief procurement officer shall notify suppliers to whom the agency chief procurement officer distributed the solicitation.
- C. The agency chief procurement officer shall not open offers after cancellation. The agency chief procurement officer may discard the offer after 30 days from notice of solicitation cancellation, unless the offeror requests the offer be returned.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-B306. Receipt, Opening, and Recording of Offers

- A. An agency chief procurement officer shall maintain a record of offers received for each solicitation and shall record the time and date when an offer is received. The agency chief procurement officer shall store each unopened offer in a secure place until the offer due date and time.

- B. A purchasing agency may open an offer to identify the offeror. If this occurs, the agency chief procurement officer shall record the reason for opening the offer, the date and time the offer was opened, and the solicitation number. The agency chief procurement officer shall secure the offer and retain it for public opening.
- C. The agency chief procurement officer shall open offers publicly, in the presence of one or more witnesses, after the offer due date and time. The agency chief procurement officer shall announce the name of the offeror; the amount of each offer; and any other relevant information as determined by the agency chief procurement officer. The agency chief procurement officer shall record the name of each offeror, and the amount of each offer. The reader and the witness shall sign the record of offers and place it in the procurement file. The agency chief procurement officer shall make the record of offers available for public viewing.
- D. Except for the information identified in subsection (C), the agency chief procurement officer shall ensure that information contained in the offer remains confidential until contract award and is shown only to those persons assisting in the evaluation process.
- C. The agency chief procurement officer shall retain offers received under the canceled solicitation in the procurement file. If the purchasing agency intends to issue another solicitation within six months after cancellation of the procurement, the agency chief procurement officer shall withhold the offers from public inspection. After award of a contract under the subsequent solicitation, the agency chief procurement officer shall make offers submitted in response to the canceled solicitation available for public inspection except for information determined to be confidential pursuant to R2-7-103.
- D. In the event of cancellation, the agency chief procurement officer shall promptly return any bid security provided by an offeror.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-B309. One Offer Received

If only one offer is received in response to a solicitation, the agency chief procurement officer shall review the offer and either:

1. Award the contract to the offeror and prepare a written determination that:
 - a. The price submitted is fair and reasonable under R2-7-702,
 - b. The offer is responsive, and
 - c. The offeror is responsible, or
2. Reject the offer and:
 - a. Resolicit for new offers,
 - b. Cancel the procurement, or
 - c. Use a different source selection method authorized under the Arizona Procurement Code.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1). Amended by final rulemaking at 18 A.A.R. 3118, effective January 7, 2013 (Supp. 12-4).

R2-7-B310. Offer Mistakes Discovered After Offer Opening and Before Award

- A. If an apparent mistake in an offer, relevant to the award determination, is discovered after opening and before award, an agency chief procurement officer shall contact the offeror for written confirmation of the offer. The agency chief procurement officer shall designate a time-frame within which the offeror shall either:
 1. Confirm that no mistake was made and assert that the offer stands as submitted; or
 2. Acknowledge that a mistake was made, and include all of the following in a written response:
 - a. Explanation of the mistake and any other relevant information;
 - b. A request for correction including the corrected offer or a request for withdrawal; and
 - c. The reasons why correction or withdrawal is consistent with fair competition and in the best interest of the state.
- B. An offeror who discovers a mistake in its offer may request correction or withdrawal in writing and shall include all of the following in the written request:
 1. Explanation of the mistake and any other relevant information;
 2. A request for correction including the corrected offer or a request for withdrawal; and
 3. The reasons why correction or withdrawal is consistent with fair competition and in the best interest of the state.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-B307. Late Offers, Modifications, Withdrawals

- A. If an offer, modification, or withdrawal is received after the due date and time, at the location designated in the solicitation, an agency chief procurement officer shall determine the offer, modification, or withdrawal as late.
- B. The agency chief procurement officer shall reject a late offer, modification, or withdrawal unless:
 1. The document is received before the contract award at the location designated in the solicitation; and
 2. The document would have been received by the offer due date and time, but for the action or inaction of personnel directly serving the purchasing agency.
- C. Upon receiving a late offer, modification, or withdrawal, the agency chief procurement officer shall:
 1. If the document is hand delivered, refuse to accept delivery; or
 2. If the document is not hand delivered, record the time and date of receipt and promptly send written notice of late receipt to the offeror. The agency chief procurement officer may discard the document within 30 days after the date on the notice unless the offeror requests the document be returned.
- D. The agency chief procurement officer shall document a refusal under subsection (C)(1) and place the document or a copy of the notice required in subsection (C)(2) in the procurement file.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-B308. Cancellation of Solicitation After Receipt of Offers and Before Award

- A. Based on the best interest of the state, an agency chief procurement officer may cancel a solicitation after offer due date and time. The agency chief procurement officer shall prepare a written justification for cancellation and place it in the procurement file.
- B. The agency chief procurement officer shall notify offerors of the cancellation in writing.

- C. An agency chief procurement officer may permit an offeror to correct a mistake if the mistake and the intended offer are evident in the uncorrected offer; for example, an error in the extension of unit prices. The agency chief procurement officer shall not permit a correction that is prejudicial to the state or fair competition.
- D. An agency chief procurement officer shall permit an offeror to furnish information called for in the solicitation but not supplied if the intended offer is evident and submittal of the information is not prejudicial to other offerors.
- E. An agency chief procurement officer shall make a written determination of whether correction or withdrawal is permitted, based on whether the action is consistent with fair competition and in the best interest of the state.
- F. If the offeror fails to act under subsection (A) the offeror is considered nonresponsive and the agency chief procurement officer shall place a written determination that the offeror is nonresponsive in the procurement file.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-B311. Extension of Offer Acceptance Period

- A. To extend the offer acceptance period, an agency chief procurement officer shall notify all offerors in writing of an extension and request written concurrence from each offeror.
- B. To be eligible for a contract award, an offeror shall submit a written concurrence to the extension. The agency chief procurement officer shall reject an offer as nonresponsive if written concurrence is not provided as requested.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-B312. Bid Evaluation

- A. An agency chief procurement officer shall evaluate offers to determine which offer provides the lowest cost to the state in accordance with any objectively measurable factors set forth in the solicitation. Examples of such factors include, but are not limited to, transportation cost, energy cost, ownership cost, and any other identifiable cost or life cycle cost formula. The factors need not be precise predictors of actual future costs, but to the extent possible the factors shall be reasonable estimates based upon information the agency chief procurement officer has available concerning future use.
 - 1. An agency chief procurement officer shall consider life cycle costs and application benefits when evaluating offers for the procurement of material or services identified in A.R.S. § 41-2553.
 - 2. An agency chief procurement officer shall consider total life cycle costs including residual value when evaluating offers for the procurement of materials or services identified in A.R.S. § 41-2554.
- B. An agency chief procurement officer shall conduct an evaluation to determine whether an offeror is responsive, based upon the requirements set forth in the solicitation. The agency chief procurement officer shall reject as nonresponsive any offer that does not meet the solicitation requirements.
- C. If there are two or more low, responsive offers from responsible offerors that are identical in price, the agency chief procurement officer shall make the award by drawing lots. If time permits, the agency chief procurement officer shall provide the offerors involved an opportunity to attend the drawing. The agency chief procurement officer shall ensure that the drawing is witnessed by at least one person other than the agency chief procurement officer.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-B313. Responsibility Determinations

- A. The agency chief procurement officer shall determine before an award whether an offeror is responsible or nonresponsible.
- B. The agency chief procurement officer shall consider the following factors before determining that an offeror is responsible or nonresponsible:
 - 1. The offeror's financial, business, personnel, or other resources, such as subcontractors;
 - 2. The offeror's record of performance and integrity;
 - 3. Whether the offeror has been debarred or suspended;
 - 4. Whether the offeror is legally qualified to contract with the state;
 - 5. Whether the offeror promptly supplied all requested information concerning its responsibility; and
 - 6. Whether the offeror meets the responsibility criteria specified in the solicitation.
- C. If the agency chief procurement officer determines an offeror is nonresponsible, the agency chief procurement officer shall promptly send a determination to the offeror stating the basis for the determination. The agency chief procurement officer shall file a copy of the determination in the procurement file.
- D. The agency chief procurement officer shall only disclose responsibility information furnished by an offeror in accordance with A.R.S. § 41-2540.
- E. For the offeror awarded a contract, the agency chief procurement officer's signature on the contract constitutes a determination that the offeror is responsible.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-B314. Contract Award

- A. An agency chief procurement officer shall award the contract to the lowest responsible and responsive offeror whose offer conforms in all material respects to the requirements and criteria set forth in the solicitation. Unless otherwise provided in the solicitation, an award may be made for an individual line item, any group of line items, or all line items.
- B. The agency chief procurement officer shall keep a record showing the basis for determining the successful offeror or offerors in the procurement file.
- C. The agency chief procurement officer shall notify all offerors of an award.
- D. After a contract is awarded, the agency chief procurement officer shall return any bid security provided by the offeror.
- E. Within 10 days after a contract is awarded, the agency chief procurement officer shall make the procurement file, including all offers, available for public inspection, redacting information that is confidential under R2-7-103.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-B315. Mistakes Discovered After Award

- A. If a mistake in the offer is discovered after the award, the offeror may request withdrawal or correction in writing and shall include all of the following in the written request:
 - 1. Explanation of the mistake and any other relevant information;
 - 2. A request for correction including the corrected offer or a request for withdrawal; and
 - 3. The reasons why correction or withdrawal is consistent with fair competition and in the best interest of the state.

- B. Based on the considerations of fair competition and the best interest of the state, the agency chief procurement officer may:
 1. Allow correction of the mistake, if the resulting dollar amount of the correction is less than the next lowest offer;
 2. Cancel all or part of the award; or
 3. Deny correction or withdrawal.
- C. After cancellation of all or part of an award, if the offer acceptance period has not expired, the agency chief procurement officer may award all or part of the contract to the next lowest responsible and responsive offeror, based on the considerations of fair competition and the best interest of the state.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-B316. Multistep Sealed Bidding

- A. An agency chief procurement officer shall obtain approval from the state procurement administrator before using multistep sealed bidding as a source selection method.
- B. To obtain approval for multistep sealed bidding, an agency chief procurement officer shall submit a written request to the state procurement administrator.
 1. The written request shall contain all of the following:
 - a. An explanation that specifications or purchase descriptions are not available or sufficiently complete to permit full competition without technical evaluations and negotiations to ensure mutual understanding between each offeror and the state;
 - b. An identification of definite criteria that exist for evaluation of technical offers;
 - c. An identification that more than one available and technically qualified source exists; and
 - d. Confirmation that a fixed-price contract will be used.
 2. The state procurement administrator shall:
 - a. Issue written approval, with any conditions or restrictions;
 - b. Request additional information from the agency chief procurement officer; or
 - c. Deny the request.
- C. Multi-step sealed bidding is initiated by the issuance of an invitation to submit technical offers. An agency chief procurement officer shall issue an invitation to submit technical offers that contains all of the following information:
 1. Notice that the procurement is conducted in two phases. In phase one unpriced technical offers are considered and selected. In phase two there is competitive bidding by offerors whose offers were selected in phase one;
 2. The best description of the material or service solicited;
 3. The requirements for each technical offer, such as drawings and descriptive literature;
 4. The criteria for evaluating each technical offer;
 5. The closing date and time for receipt of technical offers and the location where offers should be delivered or mailed; and
 6. A statement that negotiations may be held regarding the unpriced technical offer.
- D. An agency chief procurement officer may conduct a pre-offer conference. If a pre-offer conference is conducted, it shall be not less than seven days before the offer due date and time, unless the agency chief procurement officer makes a written determination that the specific needs of the procurement justify a shorter time period. Statements made during the pre-offer conference shall not be considered modifications to the solicitation.
- E. An agency chief procurement officer may amend an invitation to submit technical offers before or after submission of unpriced technical offers. The agency chief procurement officer shall notify all suppliers who received the solicitation of the amendment and specify a revised offer due date and time. These suppliers may submit new offers or revise existing offers. It is the responsibility of the offeror to obtain any solicitation amendments. An offeror shall acknowledge receipt of an amendment in the manner specified in the solicitation or solicitation amendment on or before the offer due date and time.
- F. Unpriced technical offers shall not be opened publicly but shall be opened in the presence of two or more procurement officials. Late technical offers are not considered except under the circumstances set forth in R2-7-B307(B). The agency chief procurement officer shall not disclose the contents of an unpriced technical offer to unauthorized persons.
- G. Each unpriced technical offer shall be evaluated in accordance with the criteria in the invitation to submit technical offers to determine whether the offer is acceptable, potentially acceptable, or unacceptable. If the offer is unacceptable, the agency chief procurement officer shall issue a written determination that the offer is unacceptable, state the basis for the determination, and place the determination in the procurement file. If the agency chief procurement officer determines that an offeror's unpriced technical offer is unacceptable, the agency chief procurement officer shall notify that offeror in writing of the determination and indicate in the notice that the offeror is not afforded an opportunity to amend a technical offer.
- H. An agency chief procurement officer may conduct negotiations with any offeror that submits an acceptable or potentially acceptable technical offer. During negotiations, the agency chief procurement officer shall not disclose any information obtained from an unpriced technical offer to any other offeror. After negotiations, the agency chief procurement officer shall establish a closing date for receipt of final technical offers and provide written notice of the closing date to offerors that submitted acceptable or potentially acceptable offers. The agency chief procurement officer shall maintain a record of all negotiations.
- I. After receipt of final technical offers, an agency chief procurement officer shall determine which technical offers are acceptable for consideration in phase two. The agency chief procurement officer shall notify in writing each offeror whose technical offer was determined unacceptable.
- J. At any time during phase one, an offeror may withdraw an offer.
- K. Upon completion of phase one, an agency chief procurement officer shall issue a solicitation and conduct phase two as prescribed under R2-7-B301 through R2-7-B315 as a competitive sealed bidding procurement, except that the solicitation shall be issued only to offerors that submitted acceptable technical offers in phase one.
- L. An agency chief procurement officer shall ensure that unpriced technical offers of unsuccessful offerors are available for public inspection except to the extent that the offer is confidential under R2-7-B306.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

PART C. COMPETITIVE SEALED PROPOSALS

R2-7-C301. Solicitation

- A. Before soliciting for offers under this Section, an agency chief procurement officer shall determine in writing that an invitation for bid is not practicable or advantageous to the state

before soliciting for offers under this Section. Competitive sealed bidding may not be practicable or advantageous if it is necessary to:

1. Use a contract other than a fixed-price type;
 2. Negotiate with offerors concerning the technical and price aspects of their offers and any other aspects of their offer or the solicitation;
 3. Permit offerors to revise their offers; or
 4. Compare the different price, quality, and contractual factors of the offers submitted.
- B.** The state procurement administrator may make a class determination that it is either not practicable or not advantageous to the state to procure specified types of materials or services by invitation for bid. The state procurement administrator may modify or revoke a class determination at any time.
- C.** An agency chief procurement officer shall issue a request for proposal at least 14 days before the offer due date and time, unless the agency chief procurement officer determines a shorter time is necessary for a particular procurement. If a shorter time is necessary, the agency chief procurement officer shall document the specific reasons in the procurement file.
- D.** The agency chief procurement officer shall:
1. Advertise in accordance with A.R.S. § 41-2534(C); and
 2. At a minimum, provide written notice to prospective suppliers that have registered with the state procurement office for the specific material, service, or construction solicited.
- E.** The agency chief procurement officer shall include the following in the solicitation:
1. Instructions to offerors, including:
 - a. Instructions and information to offerors concerning the offer submission requirements, offer due date and time, the location where offers will be received, and the offer acceptance period;
 - b. The deadline date for requesting a substitution or exception to the solicitation;
 - c. The manner by which the offeror is required to acknowledge amendments;
 - d. The minimum information required in the offer;
 - e. The specific requirements for designating trade secrets and other proprietary information as confidential;
 - f. Any specific responsibility or susceptibility criteria;
 - g. Whether the offeror is required to submit samples, descriptive literature, and technical data with the offer;
 - h. Evaluation factors and the relative order of importance;
 - i. A statement of where documents incorporated by reference are available for inspection and copying;
 - j. A statement that the agency may cancel the solicitation or reject an offer in whole or in part;
 - k. Certification by the offeror that submission of the offer did not include collusion or other anticompetitive practices;
 - l. Certification by the offeror of compliance with A.R.S. § 41-3532 when offering electronics or information technology products, services, or maintenance;
 - m. That the offeror is required to declare whether the offeror has been debarred, suspended, or otherwise lawfully prohibited from participating in any public procurement activity, including, but not limited to, being disapproved as a subcontractor of any public procurement unit or other governmental body;
 - n. Any offer security required;
 - o. The means required for submission of offer. The solicitation shall specifically indicate whether hand delivery, U.S. mail, electronic mail, facsimile, or other means are acceptable methods of submission;
 - p. Any cost or pricing data required;
 - q. The type of contract to be used;
 - r. A statement that negotiations may be conducted with offerors reasonably susceptible of being selected for award and that fall within the competitive range; and
 - s. Any other offer requirements specific to the solicitation.
 2. Specifications, including:
 - a. Any purchase description, specifications, delivery or performance schedule, and inspection and acceptance requirements;
 - b. If a brand name or equal specification is used, instructions that the use of a brand name is for the purpose of describing the standard of quality, performance, and characteristics desired and is not intended to limit or restrict competition. The solicitation shall state that products substantially equivalent to those brands designated shall qualify for consideration; and
 - c. Any other specification requirements specific to the solicitation.
 3. Terms and Conditions, including:
 - a. Whether the contract is to include an extension option; and
 - b. Any other contract terms and conditions.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-C302. Pre-offer Conferences

An agency chief procurement officer may conduct one or more pre-offer conferences. If a pre-offer conference is conducted, it shall be not less than seven days before the offer due date and time, unless the agency chief procurement officer makes a written determination that the specific needs of the procurement justify a shorter time. Statements made during a pre-offer conference are not amendments to the solicitation.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-C303. Solicitation Amendment

- A.** An agency chief procurement officer shall issue a solicitation amendment to do any or all of the following:
1. Make changes in the solicitation;
 2. Correct defects or ambiguities;
 3. Provide additional information or instructions; or
 4. Extend the offer due date and time if the agency chief procurement officer determines that an extension is in the best interest of the state.
- B.** If a solicitation is changed by a written solicitation amendment, the agency chief procurement officer shall notify suppliers to whom the agency chief procurement officer distributed the solicitation.
- C.** It is the responsibility of the offeror to obtain any solicitation amendments. An offeror shall acknowledge receipt of an amendment in a manner specified in the solicitation amendment on or before the offer due date and time.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-C304. Modification or Withdrawal of Offer Before Offer Due Date and Time

- A. An offeror may modify or withdraw their offer at any time, in writing, before the offer due date and time.
- B. The agency chief procurement officer shall place the document submitted in the procurement file as a record of the modification or withdrawal.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-C305. Cancellation of Solicitation Before Offer Due Date and Time

- A. Based on the best interest of the state, an agency chief procurement officer may cancel a solicitation before the offer due date and time.
- B. The agency chief procurement officer shall notify suppliers to whom the agency chief procurement officer distributed the solicitation.
- C. The agency chief procurement officer shall not open offers after cancellation. The agency chief procurement officer may discard the offer after 30 days from notice of solicitation cancellation unless the offeror requests the offer be returned.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-C306. Receipt, Opening, and Recording of Offers

- A. An agency chief procurement officer shall maintain a record of offers received for each solicitation and shall record the time and date when an offer is received. The agency chief procurement officer shall store each unopened offer in a secure place until the offer due date and time.
- B. A purchasing agency may open an offer to identify the offeror. If this occurs, the agency chief procurement officer shall record the reason for opening the offer, the date and time the offer was opened, and the solicitation number. The agency chief procurement officer shall secure the offer and retain it for public opening.
- C. The agency chief procurement officer shall open offers publicly, in the presence of one or more witnesses, after the offer due date and time. The agency chief procurement officer shall announce and record the name of each offeror and any other relevant information as determined by the agency chief procurement officer. The agency chief procurement officer shall make the record of offers available for public viewing.
- D. Except for the information identified in subsection (C), the agency chief procurement officer shall ensure that information contained in the offer remains confidential until contract award and is shown only to those persons assisting in the evaluation process.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-C307. Late Offers, Modifications, and Withdrawals Before Offer Due Date and Time

- A. If an offer, modification, or withdrawal is not received by the offer due date and time, at the location designated in the solicitation, an agency chief procurement officer shall determine the offer, modification, or withdrawal as late. This rule does not apply to revision or withdrawal of offers as described in R2-7-C314.
- B. The agency chief procurement officer shall reject a late offer, modification, or withdrawal unless:

1. The document is received before contract award at the location designated in the solicitation; and
 2. The document would have been received by the offer due date and time, but for the action or inaction of personnel directly serving the purchasing agency.
- C. Upon receiving a late offer, modification, or withdrawal, the agency chief procurement officer shall:
 1. If the document is hand delivered, refuse to accept the delivery; or
 2. If the document is not hand delivered, record the time and date of receipt and promptly send written notice of late receipt to the offeror. The agency chief procurement officer may discard the document within 30 days after the date on the notice unless the offeror requests the document be returned.
 - D. The agency chief procurement officer shall document a refusal under (C)(1) and place the document or a copy of the notice required in (C)(2) in the procurement file.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-C308. Cancellation of Solicitation After Offer Opening and Before Award

- A. Based on the best interest of the state, an agency chief procurement officer may cancel a solicitation after offer due date and time. The agency chief procurement officer shall prepare a written justification for cancellation and place it in the procurement file.
- B. The agency chief procurement officer shall notify offerors of the cancellation in writing.
- C. The agency chief procurement officer shall retain offers received under the canceled solicitation in the procurement file. If the purchasing agency intends to issue another solicitation within six months after cancellation of the procurement, the agency chief procurement officer may withhold the offers from public inspection. After award of a contract under the subsequent solicitation, the agency chief procurement officer shall make offers submitted in response to the cancelled solicitation open for public inspection except for information determined to be confidential pursuant to R2-7-103.
- D. In the event of cancellation, the agency chief procurement officer shall promptly return any offer security provided by an offeror.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-C309. Only One Offer Received

If only one offer is received in response to a solicitation, the agency chief procurement officer shall review the offer and either:

1. Award the contract to the offeror and prepare a written determination that:
 - a. The price submitted is fair and reasonable pursuant to R2-7-702; and
 - b. The offeror is responsive; and
 - c. The offeror is responsible; or
2. Reject the offer and:
 - a. Resolicit for new offers;
 - b. Cancel the procurement; or
 - c. Use a different source selection method authorized under the Arizona Procurement Code.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1). Amended by final rulemaking at 18 A.A.R. 3118, effective January 7, 2013

(Supp. 12-4).

R2-7-C310. Extension of Offer Acceptance Period

- A.** To extend the offer acceptance period, an agency chief procurement officer shall notify offerors in writing of an extension and request written concurrence from all offerors.
- B.** To be eligible for a contract award, an offeror shall submit written concurrence to the extension. The agency chief procurement officer shall not consider the offer from an offeror who fails to respond to the notice of extension.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-C311. Determination of Not Susceptible for Award

- A.** An agency chief procurement officer may determine at any time during the evaluation period and before award that an offer is not susceptible for award or not within the competitive range. The agency chief procurement officer shall place a written determination, based on one or more of the following, in the procurement file:
 1. The offer fails to substantially meet one or more of the mandatory requirements of the solicitation;
 2. The offer fails to comply with any susceptibility criteria identified in the solicitation; or
 3. The offer is not susceptible for award or is not within the competitive range in comparison to other offers based on the criteria set forth in the solicitation. When there is doubt as to whether an offer is susceptible for award or is in the competitive range, the offer should be included for further consideration.
- B.** The agency chief procurement officer shall promptly notify the offeror in writing of the final determination that the offer is not susceptible for award or not within the competitive range, unless the agency chief procurement officer determines notification to the offeror would compromise the state's ability to negotiate with other offerors.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1). Amended by final rulemaking at 18 A.A.R. 3118, effective January 7, 2013 (Supp. 12-4).

R2-7-C312. Responsibility Determinations

- A.** An agency chief procurement officer shall determine, at any time during the evaluation period and before award, that an offeror is responsible or nonresponsible.
- B.** The agency chief procurement officer may consider the following factors before determining that an offeror is responsible or nonresponsible:
 1. The offeror's financial, business, personnel, or other resources, including subcontractors;
 2. The offeror's record of performance and integrity;
 3. Whether the offeror has been debarred or suspended;
 4. Whether the offeror is legally qualified to contract with the state;
 5. Whether the offeror promptly supplied all requested information concerning its responsibility; and
 6. Whether the offeror meets any responsibility criteria specified in the solicitation.
- C.** The agency chief procurement officer shall promptly notify the offeror in writing of the final determination that the offer is nonresponsible unless the agency chief procurement officer determines notification to the offeror would compromise the state's ability to negotiate with other offerors. The agency chief procurement office shall file a copy of the determination in the procurement file.

- D.** The agency chief procurement officer shall only disclose responsibility information furnished by an offeror in accordance with A.R.S. § 41-2540(B).
- E.** For the offeror awarded a contract, the agency chief procurement officer's signature on the contract constitutes a determination that the offeror is responsible.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-C313. Clarification of Offers

- A.** The purpose for clarifications is to provide for a greater mutual understanding of the offer. Clarifications are not negotiations and material changes to the request for proposal or offer shall not be made by clarification.
- B.** The agency chief procurement officer may request clarifications from offerors at any time after receipt of offers. Clarifications may be requested orally or in writing. If clarifications are requested orally, the offeror shall confirm the request in writing. A request for clarifications shall not be considered a determination that the offeror is susceptible for award.
- C.** The agency chief procurement officer shall retain any clarifications in the procurement file.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-C314. Negotiations with Responsible Offerors and Revisions of Offers

- A.** An agency chief procurement officer shall establish procedures and schedules for conducting negotiations. The agency chief procurement officer shall ensure there is no disclosure of one offeror's price or any information derived from competing offers to another offeror.
- B.** Negotiations may be conducted orally or in writing. If oral negotiations are conducted, the chief procurement officer shall confirm the negotiations in writing and provide to the offeror.
- C.** If negotiations are conducted, negotiations shall be conducted with all offerors determined to be in the competitive range or reasonably susceptible for award. Offerors may revise offers based on negotiations provided that any revision is confirmed in writing.
- D.** An agency chief procurement officer may conduct negotiations with responsible offerors to improve offers in such areas as cost, price, specifications, performance, or terms, to achieve best value for the state based on the requirements and the evaluation factors set forth in the solicitation.
- E.** Responsible offerors determined to be susceptible for award and within the competitive range, with which negotiations have been held, may revise their offer in writing during negotiations.
- F.** An offeror may withdraw an offer at any time before the final proposal revision due date and time by submitting a written request to the agency chief procurement officer.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1). Amended by final rulemaking at 18 A.A.R. 3118, effective January 7, 2013 (Supp. 12-4).

R2-7-C315. Final Proposal Revisions

- A.** An agency chief procurement officer shall request written final proposal revisions from any offeror with whom negotiations have been conducted, unless the offeror has been determined not within the competitive range or not susceptible for award under R2-7-C311 or nonresponsible under R2-7-C312. The

agency chief procurement officer shall include in the written request:

1. The date, time, and place for submission of final proposal revisions; and
 2. A statement that if offerors do not submit a written notice of withdrawal or a written final proposal revision, their immediate previous written proposal revision will be accepted as their final proposal revision.
- B.** The agency chief procurement officer shall request written final proposal revisions only once, unless the state procurement administrator makes a written determination that it is advantageous to the state to conduct further negotiations or change the state's requirements.
- C.** If an apparent mistake, relevant to the award determination, is discovered after opening of final proposal revisions, the agency chief procurement officer shall contact the offeror for written confirmation. The agency chief procurement officer shall designate a time-frame within which the offeror shall either:
1. Confirm that no mistake was made and assert that the offer stands as submitted; or
 2. Acknowledge that a mistake was made, and include the following in a written response:
 - a. Explanation of the mistake and any other relevant information,
 - b. A request for correction including the corrected offer or a request for withdrawal, and
 - c. The reasons why correction or withdrawal is consistent with fair competition and in the best interest of the state.
- D.** An offeror who discovers a mistake in their final proposal revision may request withdrawal or correction in writing, and shall include the following in the written request:
1. Explanation of the mistake and any other relevant information,
 2. A request for correction including the corrected offer or a request for withdrawal, and
 3. The reasons why correction or withdrawal is consistent with fair competition and in the best interest of the state.
- E.** In response to a request made under subsections (C) or (D), the agency chief procurement officer shall make a written determination of whether correction or withdrawal will be allowed based on whether the action is consistent with fair competition and in the best interest of the state. If an offeror does not provide written confirmation of the final proposal revision, the agency chief procurement officer shall make a written determination that the most recent written proposal revision submitted is the final proposal revision.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1). Amended by final rulemaking at 18 A.A.R. 3118, effective January 7, 2013 (Supp. 12-4).

R2-7-C316. Evaluation of Offers

- A.** An agency chief procurement officer shall evaluate offers and final proposal revisions based on the evaluation criteria contained in the request for proposals. The agency chief procurement officer shall not modify evaluation criteria or their relative order of importance after offer due date and time.
- B.** An agency chief procurement officer may appoint an evaluation committee to assist in the evaluation of offers. If offers are evaluated by an evaluation committee, the evaluation committee shall prepare an evaluation report for the agency chief procurement officer. This evaluation report shall supersede all

previous draft evaluations or evaluation reports. The agency chief procurement officer may:

1. Accept or reject the findings of the evaluation committee,
 2. Request additional information from the evaluation committee, or
 3. Replace the evaluation committee.
- C.** The agency chief procurement officer shall prepare an award determination and place the determination, including any evaluation report or other supporting documentation, in the procurement file.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1). Amended by final rulemaking at 18 A.A.R. 3118, effective January 7, 2013 (Supp. 12-4).

R2-7-C317. Contract Award

- A.** An agency chief procurement officer shall award the contract to the responsible offeror whose offer is determined to be most advantageous to the state based on the evaluation factors set forth in the solicitation. The agency chief procurement officer shall make a written determination explaining the basis for the award and place it in the procurement file.
- B.** Before awarding any cost reimbursement contract, the agency chief procurement officer shall determine in writing that:
1. The offeror's accounting system will permit timely development of all necessary cost data in the form required by the specific contract type contemplated, and
 2. It is adequate to allocate costs pursuant to Article 7.
- C.** The agency chief procurement officer shall notify all offerors of an award.
- D.** After contract award, the agency chief procurement officer shall return any offer security provided by the offeror.
- E.** Within 10 days after contract award the agency chief procurement officer shall make the procurement file, including all offers, available for public inspection, redacting information that is confidential under R2-7-103.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-C318. Mistakes Discovered After Award

- A.** If a mistake in the offer is discovered after the award, the offeror may request correction or withdrawal in writing, and shall include all of the following in their written request:
1. Explanation of the mistake and any other relevant information;
 2. A request for correction including the corrected offer or a request for withdrawal; and
 3. The reasons why correction or withdrawal is consistent with fair competition and in the best interest of the state.
- B.** Based on the considerations of fair competition and the best interest of the state, the agency chief procurement officer may:
1. Allow correction of the mistake;
 2. Cancel all or part of the award; or
 3. Deny correction or withdrawal.
- C.** After cancellation of all or part of an award, if the offer acceptance period has not expired, the agency chief procurement officer may award all or part of the contract to the next responsible offeror whose offer is determined to be the next most advantageous to the state according to the evaluation factors contained in the solicitation.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

**PART D. PROCUREMENTS NOT EXCEEDING THE
AMOUNT PRESCRIBED IN A.R.S. § 41-2535**

R2-7-D301. Applicability

For purchases not exceeding the amount prescribed in A.R.S. § 41-2535, including construction, the agency chief procurement officer shall issue a request for quotation under R2-7-D303 unless any of the following apply:

1. The purchase can be made from a state or agency contract;
2. The purchase can be made from a set-aside organization as established in Article 10;
3. The purchase is not expected to exceed \$5,000.00;
4. The purchase is made as a sole-source procurement under A.R.S. § 41-2536;
5. The agency chief procurement officer makes a written determination that competition is not practicable under the circumstances. The purchase shall be made with as much competition as is practicable under the circumstances.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-D302. Solicitation – Request for Quotation

A. A request for quotation shall be issued for purchases estimated to exceed \$5,000 but less than that specified in A.R.S. § 41-2535. The agency chief procurement officer shall include the following in the solicitation:

1. Offer submission requirements, including offer due date and time, where offers will be received, and offer acceptance period;
2. Any purchase description, specifications, delivery or performance schedule, and inspection and acceptance requirements;
3. The minimum information that the offer shall contain;
4. Any evaluation factors;
5. Whether negotiations may be held;
6. Any contract options including renewal or extension;
7. The uniform terms and conditions by text or reference; and
8. Any other terms, conditions, or instructions specific to the procurement.

B. The request for quotation shall include a statement that only a small business, as defined in R2-7-101, shall be awarded a contract, unless any of the following apply:

1. The purchase has been unsuccessfully competed under R2-7-D303, including failure to obtain fair and reasonable prices; or
2. The agency chief procurement officer has made a written determination that restricting the procurement to small business is not practical under the circumstances.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-D303. Request for Quotation Issuance

The agency chief procurement officer shall issue the request for quotation by distributing the request for quotation to a minimum of three small businesses. The agency chief procurement officer shall rotate suppliers invited to submit quotations. The agency chief procurement officer may cancel the request for quotation at any time.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1). Amended by final rulemaking at 18 A.A.R. 3118, effective January 7, 2013

(12-4).

R2-7-D304. Contract Award

- A. If only one responsive offer is received, the agency chief procurement officer shall explain in writing whether award of the contract is advantageous to the state and place the determination in the procurement file.
- B. The agency chief procurement officer shall award a contract to the small business determined to be most advantageous to the state in accordance with any evaluation factors identified in the request for quotation. If award is pursuant to R2-7-D302(B)(1) or R2-7-D302(B)(2), the agency chief procurement officer shall award a contract to the offeror determined to be most advantageous to the state in accordance with any evaluation factors identified in the request for quotation.
- C. The agency chief procurement officer shall place the written basis for the award in the procurement file.
- D. The agency chief procurement officer shall make the procurement file available to the public on the date of contract award, except for those items considered confidential under R2-7-103.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-D305. Purchases of \$5,000 and Less

The agency chief procurement officer shall use reasonable judgment in awarding contracts of \$5,000 and less that are advantageous to the state. The agency chief procurement officer may but is not required to request quotations.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

**PART E. LIMITED COMPETITION FOR
PROCUREMENTS EXCEEDING THE AMOUNT
PRESCRIBED IN A.R.S. § 41-2535**

R2-7-E301. Sole Source Procurements

- A. For the purposes of this Section, the term “sole-source procurement” means a material or service procured without competition when:
 1. There is only a single source for the material or service, or
 2. No reasonable alternative source exists.
- B. The state procurement administrator may delegate this authority to the agency chief procurement officer in accordance with R2-7-202. If not delegated to the agency chief procurement officer, the agency chief procurement officer shall submit a written request for approval to procure from a sole source to the state procurement administrator before proceeding. The request shall include the following information:
 1. A description of the procurement need and the reason why there is only a single source available or no reasonable alternative exists,
 2. The name of the proposed supplier,
 3. The duration and estimated total dollar value of the proposed procurement,
 4. Documentation that the price submitted is fair and reasonable pursuant to R2-7-702, and
 5. A description of efforts made to seek other sources.
- C. The state procurement administrator shall send notice to registered vendors on the electronic system to invite comments on the sole-source request for three working days. Following this period, the state procurement administrator shall either:
 1. Issue written approval, with any conditions or restrictions;

2. Request additional information from the agency chief procurement officer; or
 3. Deny the request if input or information received shows that more than one source is available or a reasonable alternative source exists for the procurement need.
- D.** If the sole-source procurement is authorized or approved, the agency chief procurement officer shall negotiate a contract advantageous to the state.
- E.** The agency chief procurement officer shall keep a record of all sole-source procurements pursuant to A.R.S. § 41-2551.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1). Amended by final rulemaking at 18 A.A.R. 3118, effective January 7, 2013 (12-4).

R2-7-E302. Emergency Procurements

- A.** For the purposes of Section, the term “emergency” means any condition creating an immediate and serious need for materials, services, or construction in which the state’s best interests are not met through the use of other source-selection methods. The condition must seriously threaten the functioning of state government, the preservation or protection of property, or the health or safety of a person.
- B.** This Section applies to only emergency procurements, estimated to exceed the amount prescribed in A.R.S. § 41-2535. The agency chief procurement officer may procure a material or service without competition when there is an emergency by complying with this Section.
- C.** The state procurement administrator may delegate this authority to the agency chief procurement officer in accordance with R2-7-202. If not delegated to the agency chief procurement officer, the agency chief procurement officer shall submit the written request for, or notification of, the emergency procurement to the state procurement administrator. The request shall include the following information:
1. A description of the procurement need and the reason for the emergency;
 2. The name of the supplier;
 3. The duration and estimated total dollar value of the procurement; and
 4. Documentation that the price submitted is fair and reasonable pursuant to R2-7-702.
- D.** The agency chief procurement officer shall obtain approval from the state procurement administrator before proceeding with an emergency procurement. The state procurement administrator shall either:
1. Issue written approval, with any conditions or restrictions;
 2. Request additional information from the agency chief procurement officer; or
 3. Deny the request.
- E.** An employee acting within the authority of a using agency may proceed with an emergency procurement without approval from the state procurement administrator if the emergency necessitates immediate response and it is impracticable to contact the state procurement administrator. The agency chief procurement officer shall submit a written confirmation of the emergency procurement to the state procurement administrator within five working days of the emergency.
- F.** A using agency making an emergency procurement shall limit the procurement to such actions necessary to address the emergency.
- G.** A using agency making an emergency procurement shall employ maximum competition, given the circumstances, to protect the interests of the state.

- H.** The agency chief procurement officer shall keep a record of all emergency procurements pursuant to A.R.S. § 41-2551.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-E303. Competition Impracticable Procurements

- A.** For the purposes of this Section, “competition impracticable” means a procurement requirement exists which makes compliance with A.R.S. §§ 41-2533, 41-2534, 41-2538, or 41-2578 impracticable, unnecessary, or contrary to the public interest, but which is not an emergency under R2-7-E302. Procurements with a documented lack of available vendors in the marketplace and which require an open and continuous availability of offerors may be procured by this method.
- B.** An agency chief procurement officer seeking a competition impracticable procurement shall obtain the approval of the state procurement administrator before proceeding. The state procurement administrator may delegate this authority to the agency chief procurement officer in accordance with R2-7-202.
- C.** The agency chief procurement officer shall submit a written request for approval containing the following:
1. An explanation of the competition impracticable need and the unusual or unique situation that makes compliance with A.R.S. §§ 41-2533, 41-2534, 41-2538, or 41-2578 impracticable, unnecessary, or contrary to the public interest;
 2. A definition of the proposed procurement process to be utilized and an explanation of how this process will foster as much competition as is practicable;
 3. An explanation of why the proposed procurement process is advantageous to the state; and
 4. The scope, duration, and estimated total dollar value of the procurement need.
- D.** The state procurement administrator shall:
1. Issue written approval, with any conditions or restrictions;
 2. Request additional information from the agency chief procurement officer; or
 3. Deny the request.
- E.** Before modifying the scope, duration, or cost of an approved competition impracticable procurement, the agency chief procurement officer shall request approval for the modifications in writing from the state procurement administrator.
- F.** The agency chief procurement officer shall keep a record of all competition impracticable procurements as required by A.R.S. § 41-2551.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1). Amended by final rulemaking at 18 A.A.R. 3118, effective January 7, 2013 (12-4).

PART F. COMPETITIVE SELECTION PROCESS FOR SERVICES OF CLERGY, PHYSICIANS, DENTISTS, LEGAL COUNSEL, OR CERTIFIED PUBLIC ACCOUNTANTS

R2-7-F301. Statement of Qualifications

- A.** The procurement officer may request that persons desiring to provide the services specified in A.R.S. § 41-2513 submit statements of qualifications on a prescribed form which shall include, but not be limited to the following information:
1. Technical education and training;
 2. General or special experience, certifications, licenses, and memberships in professional associations, societies, or boards; and

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3. Any other relevant information requested by the purchasing agency.
- B. Persons who have submitted statement of qualifications may submit additional information or change information that was previously submitted at any time.
- C. The procurement officer may, in lieu of subsection (A), incorporate the statement of qualifications as part of the solicitation pursuant to R2-7-F302.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-F302. Solicitation

- A. For procurements not exceeding the amount prescribed in A.R.S. § 41-2535, except as authorized under A.R.S. § 41-2536, the procurement officer shall comply with Part D of this Article.
- B. For procurements exceeding the amount prescribed in A.R.S. § 41-2535, the procurement officer shall follow the procedures below, except as authorized under A.R.S. §§ 41-2536 or 41-2537:
 1. The procurement officer shall issue a request for proposal providing adequate notice based on the circumstances.
 2. The procurement officer shall provide notice to prospective suppliers registered at the state procurement office for the specific service and, if R2-7-F301 has been implemented, to persons who have submitted statements of qualifications for the particular services solicited, or both.
 3. The procurement officer shall include the following in the solicitation:
 - a. A specific offer due date and time, or that offers will be accepted on an open and continuous basis. If offers are accepted on an open and continuous basis, the designated, continuous day and time in which offers will be opened;
 - b. The location where offers will be received;
 - c. The offer acceptance period;
 - d. The manner by which the offeror is required to acknowledge amendments;
 - e. A description of the services needed;
 - f. The type of qualifications, experience, licensing, or other information required;
 - g. The minimum information in the offer;
 - h. Any evaluation criteria;
 - i. Any applicable contract terms and conditions;
 - j. A statement that negotiations may be conducted to determine the offeror's qualifications for further consideration;
 - k. Any cost or pricing data required;
 - l. The type of contract to be used;
 - m. A statement that the agency may cancel the solicitation or reject an offer in whole or in part;
 - n. Certification by the offeror that submission of the offer did not involve collusion or other anticompetitive practices; and
 - o. A statement of whether the services shall be retained for a stated or ongoing period of time and whether the contract is to include any option for renewal or extension.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-F303. Solicitation Amendment

- A. A procurement officer shall issue a solicitation amendment to do any or all of the following:

1. Make changes in the solicitation;
2. Correct defects or ambiguities;
3. Provide additional information or instructions; or
4. Extend the offer due date and time if the procurement officer determines that an extension is in the best interest of the state.
- B. If a solicitation is changed by a written solicitation amendment, the procurement officer shall notify suppliers to whom the procurement officer distributed the solicitation.
- C. It is the responsibility of the offeror to obtain any solicitation amendments. An offeror shall acknowledge receipt of an amendment in a manner specified in the solicitation amendment on or before the offer due date and time.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-F304. Cancellation of Solicitation

- A. Based on the best interest of the state, the procurement officer may cancel a solicitation at any time before award.
- B. Based on the best interest of the state, the procurement officer may cancel an open and continuous solicitation at any time during the active period of the solicitation. Contracts that have already been awarded in accordance with the solicitation shall not be affected by the cancellation.
- C. The procurement officer shall notify offerors of the cancellation in writing.
- D. The procurement officer shall return any offers received to the offerors.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-F305. Receipt, Opening, and Recording of Offers

- A. A procurement officer shall maintain a record of offers received for each solicitation and shall record the time and date when an offer is received. The procurement officer shall store each unopened offer in a secure place until the offer due date and time.
- B. A purchasing agency may open an offer to identify the offeror. If this occurs, the procurement officer shall record the reason for opening the offer, the date and time the offer was opened, and the solicitation number. The procurement officer shall secure the offer and retain it for public opening.
- C. The procurement officer shall open offers publicly, in the presence of one or more witnesses, after the offer due date and time. The procurement officer shall announce and record the name of each offeror and any other relevant information as determined by the procurement officer. The reader and the witness shall sign the record of offers and place it in the procurement file. The procurement officer shall make the record of offers available for public viewing.
- D. Except for the information identified in R2-7-C306(C), the procurement officer shall ensure that information contained in the offer remains confidential until contract award and is shown only to those persons assisting in the evaluation process.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-F306. Timely and Late Modifications or Withdrawals of Offer

- A. An authorized representative of an offeror may withdraw an offer in writing if the written request for withdrawal is received by the procurement officer before the designated

offer due date and time or the designated, continuous offer due day and time.

- B.** An offeror may withdraw or modify an offer at any time before the due date and time or designated, continuous day and time for offer opening and before contract award by submitting a written request to the procurement officer.
- C.** If a modification or a withdrawal is not received by the designated offer due date and time or the designated, continuous day and time for offer opening, the procurement officer shall determine the modification or withdrawal as late. The procurement officer shall reject a late modification or withdrawal unless:
 - 1. The document is received before the contract award; and
 - 2. The document would have been received by the designated offer due date and time or the designated, continuous day and time for offer opening but for the action or inaction of state personnel directly serving the purchasing agency.
- D.** Upon receiving a late modification or withdrawal, the procurement officer shall:
 - 1. If the document is hand delivered, refuse to accept delivery; or
 - 2. If the document is not hand delivered, record the time and date of receipt, and promptly send written notice of late receipt to the offeror. The agency chief procurement officer may discard the document within 30 days after the date on the notice unless the offeror requests the document be returned.
- E.** The procurement officer shall document a refusal under (D)(1) and place this document or a copy of the notice required in (D)(2) in the procurement file.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-F307. Late Offers

- A.** If a specific offer due date and time has been identified in the solicitation, the procurement officer shall reject any offer received after the specified offer due date and time.
 - 1. The procurement officer shall accept a late offer if the document is received before contract award or it would have been received by the offer due date and time but for the action or inaction of state personnel directly serving the purchasing agency.
 - 2. Upon receiving a late offer, the procurement officer shall:
 - a. If the document is hand delivered, refuse to accept the delivery; or
 - b. If the document is not hand delivered, record the time and date of receipt and promptly send written notice of late receipt to the offeror. The agency chief procurement officer may discard the document within 30 days after the date on the notice unless the offeror requests the document be returned.
 - 3. The procurement officer shall document a late offer in the procurement file; with as much information as available.
- B.** If the solicitation has a designated, continuous day and time for offer opening and an offer is received after the day and time for offer opening, the procurement officer shall accept and log in the offer for the next scheduled day and time for offer opening.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1). Amended by final rulemaking at 18 A.A.R. 3118, effective January 7, 2013 (12-4).

R2-7-F308. Negotiations with Offerors

- A.** The procurement officer may conduct negotiations with any or none of the offerors.
- B.** The procurement officer may conduct negotiations to improve offers in such areas as cost, price, specifications, performance, or terms, and to achieve best value for the state.
- C.** The procurement officer shall document the results of negotiations in writing. Final proposal revisions are not required, but may be used at the discretion of the procurement officer.
- D.** The procurement officer shall ensure that negotiations do not disclose any information derived from other offers.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-F309. Contract Award

- A.** The procurement officer shall award the contract to the offeror best qualified based on the evaluation factors set forth in the request for proposal and after making a written determination that the price is fair and reasonable. The procurement officer shall not award a contract based solely on price.
- B.** The procurement officer shall make a written determination explaining the basis for the award and place it in the procurement file.
- C.** The procurement officer shall award contracts pursuant to A.R.S. § 41-2513(B) through (D) where applicable.
- D.** Within 10 days after contract award the procurement officer shall make the procurement file, including all offers, available for public inspection, redacting information that is confidential under R2-7-103.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-F310. Mistakes Discovered After Award

- A.** If a mistake in the offer is discovered after the award, the offeror may request correction or withdrawal in writing, and shall include all of the following in the written request:
 - 1. Explanation of the mistake and any other relevant information;
 - 2. A request for correction including the corrected offer or a request for withdrawal; and
 - 3. The reasons why correction or withdrawal is consistent with fair competition and in the best interest of the state.
- B.** Based on the considerations of fair competition and the best interest of the state, the procurement officer may:
 - 1. Allow correction of the mistake;
 - 2. Cancel all or part of the award; or
 - 3. Deny correction or withdrawal.
- C.** After cancellation of all or part of an award, if the offer acceptance period has not expired, the procurement officer may award all or part of the contract to the next responsible offeror whose offer is determined to be the next most advantageous to the state according to the evaluation factors contained in the solicitation.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

PART G. OTHER SOURCE SELECTION

R2-7-G301. Request for Information

An agency chief procurement officer may issue a request for information to obtain price, delivery, technical information or capabilities for planning purposes.

- 1. Responses to a request for information are not offers and cannot be accepted to form a binding contract.

2. Information contained in a response to a request for information shall be considered confidential until the procurement process is concluded or two years, whichever occurs first unless authorized by the state procurement administrator.
3. There is no required format to be used for requests for information.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1). Amended by final rulemaking at 18 A.A.R. 3118, effective January 7, 2013 (12-4).

R2-7-G302. Demonstration Projects

- A. An agency chief procurement officer shall submit a written request to the state procurement administrator to award a contract for a demonstration project. The written request shall contain the following:
 1. Name of the agency or agencies;
 2. Name of the contractor;
 3. Description of the project, including unique and innovative features of the project;
 4. Statement and explanation that the project is in best interest of the state;
 5. Duration of the project; and
 6. Proposed contract terms and conditions.
- B. The agency chief procurement officer shall obtain approval from the state procurement administrator before proceeding with a demonstration project. The state procurement administrator shall either:
 1. Issue written approval, with any conditions or restrictions;
 2. Request additional information from the agency chief procurement officer; or
 3. Deny the request.
- C. Demonstration projects shall be provided by the contractor at no cost, and the state shall not be obligated to purchase or lease the services or materials from the contractor.
- D. The agency chief procurement officer may submit a written request to the state procurement administrator to purchase or lease from the demonstration contractor. The written request shall be submitted within 12 months after the demonstration project begins or within 12 months after the demonstration project ends and contain the following:
 1. Name of the agency or agencies;
 2. Name of the contractor;
 3. Description of the project, including unique and innovative features of the project;
 4. Statement and explanation that lease or purchase is in best interest of the state;
 5. Cost to the state;
 6. Duration of the proposed contract; and
 7. Proposed contract terms and conditions.
- E. The agency chief procurement officer shall obtain approval from the state procurement administrator before proceeding with purchasing or leasing from the demonstration contractor. The state procurement administrator shall:
 1. Issue written approval, with any conditions or restrictions;
 2. Request additional information from the agency chief procurement officer; or
 3. Deny the request.
- F. The term of the contract resulting from a demonstration project shall not exceed two years.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508,

effective April 8, 2006 (Supp. 06-1).

R2-7-G303. Unsolicited Proposals

- A. An unsolicited proposal shall be a proposal that is submitted at the initiative of the offeror, and not in response to a solicitation.
- B. An unsolicited proposal shall be submitted in writing and in sufficient detail for the agency chief procurement officer to understand the proposal.
- C. An unsolicited proposal shall not be an advance offer to a known state requirement.
- D. An agency chief procurement officer shall submit a written request to the state procurement administrator to award a contract resulting from an unsolicited proposal. The written request shall contain the following:
 1. Name of the agency or agencies;
 2. Name of the contractor;
 3. Description of the project, including unique and innovative features of the project;
 4. Statement and explanation that project is in best interest of the state;
 5. Duration of the project; and
 6. Proposed contract terms and conditions.
- E. The agency chief procurement officer shall obtain approval from the state procurement administrator before proceeding with an unsolicited proposal. The state procurement administrator shall:
 1. Issue written approval, with any conditions or restrictions;
 2. Request additional information from the agency chief procurement officer; or
 3. Deny the request.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-G304. General Services Administration Contracts

- A. An agency chief procurement officer may purchase products or services using General Services Administration (GSA) schedules or contracts under the following conditions:
 1. Use of the GSA contract or schedule is cost effective and in the best interest of the state;
 2. Price is equal to or less than the contractor's current GSA price;
 3. Price is fair and reasonable;
 4. Contractor is willing to offer GSA pricing and terms to the state;
 5. Comparable products or services are not available under a state or agency contract;
 6. Comparable products or services are not restricted under a set-aside contract; and
 7. Contractor accepts required state contract terms and conditions.
- B. An agency chief procurement officer shall make a written determination that use of the GSA contract or schedule is in the best interest of the state. The determination shall contain the following:
 1. Name of the contractor;
 2. GSA contract or schedule number;
 3. Procurement description;
 4. Analysis of price, quality, and other relevant factors; and
 5. Statement that the price is fair and reasonable.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-G305. Public-Private Partnership Contracts

- A.** As referenced in this Article, a public-private partnership contract is a government contract and not a partnership. The government shall not jointly own or share property with the contractor and the government shall not be responsible for the contractor's liabilities.
- B.** An agency chief procurement officer shall submit a written request to the state procurement administrator to enter into a public-private partnership contract. The written request shall contain the following:
 - 1. Name of the agency or agencies;
 - 2. Name of the contractor;
 - 3. Description of the public-private partnership, including obligations of the agency and the contractor;
 - 4. Statement and explanation that the project is in best interest of the state;
 - 5. Proposed contract price and assessment of the proposed value;
 - 6. Description of the proposed performance measurement criteria and methods;
 - 7. Duration of the project; and
 - 8. Proposed contract terms and conditions.
- C.** The agency chief procurement officer shall obtain approval from the state procurement administrator before proceeding with a public-private partnership. The state procurement administrator shall either:
 - 1. Issue written approval, with any conditions or restrictions;
 - 2. Request additional information from the agency chief procurement officer; or
 - 3. Deny the request.
- D.** If the request is approved, the contract shall be awarded in accordance with A.R.S. §§ 41-2533, 41-2534, 41-2535, 41-2536, or 41-2537.
- E.** The using agency is responsible for obtaining all necessary approvals, including approvals from the Government Information Technology Agency and Joint Legislative Budget Committee, before entering into a public-private partnership contract.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

ARTICLE 4. SPECIFICATIONS**R2-7-401. Preparation of Specifications**

- A.** State governmental units may prepare and utilize specifications only under the authority delegated by the state procurement administrator under R2-7-202.
- B.** An agency chief procurement officer delegated the authority to prepare and utilize specifications shall comply with the requirements of A.R.S. § 41-2561 through A.R.S. § 41-2568 and ensure specifications used support maximum practical competition.
- C.** The agency chief procurement officer may contract for the preparation of specifications with persons other than state personnel.
- D.** Notwithstanding the provisions of this Section, the state procurement administrator retains the authority to prepare, issue, revise, and monitor all specifications and plans.
- E.** If a mandatory specification has been designated by the state procurement administrator for a particular material, service, or construction item, it shall be used unless the state procurement administrator makes a written determination that its use is not advantageous to the state and that another specification may be used.

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Definitions placed in alphabetical order (Supp. 93-2). Section repealed; new Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-402. Utilization of Specifications

The agency chief procurement officer may use any type of specification that describes the procurement requirement and promotes competition, except that the agency chief procurement officer shall not use proprietary or restrictive specifications without the prior written approval of the state procurement administrator.

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Amended by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-403. Determination for Use of Brand Name Type Specifications

- A.** The state procurement administrator may authorize the use of a brand name only specification if the state procurement administrator makes a written determination that only the identified brand name item will satisfy the state's needs.
- B.** The agency chief procurement officer shall, to the extent practicable, identify sources from which the designated brand name item can be obtained and shall solicit such sources to achieve the maximum practical competition.
- C.** The agency chief procurement officer may use a brand name or equal specification when the agency chief procurement officer determines this type of specification is in the best interest of the state.

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Amended effective April 2, 1993 (Supp. 93-2). Amended by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-404. Conflict of Interest

- A.** No person preparing or assisting in the preparation of specifications, plans or scopes of work shall receive any direct benefit from the utilization of those specifications, plans or scopes of work.
- B.** The state procurement administrator may waive the restriction set forth in subsection (A) of this Section if the state procurement administrator determines in writing that the rule's application would not be in the state's best interest. The determination shall state the specific reasons that the restriction in subsection (A) of this Section has been waived.

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Amended effective April 2, 1993 (Supp. 93-2). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1). New Section made by final rulemaking at 18 A.A.R. 3118, effective January 7, 2013 (Supp. 12-4).

R2-7-405. Repealed**Historical Note**

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Amended effective April 2, 1993 (Supp. 93-2). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-406. Reserved**R2-7-407. Repealed****Historical Note**

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Amended effective April 2, 1993 (Supp. 93-2). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-408. Repealed**Historical Note**

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Amended effective April 2, 1993 (Supp. 93-2). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-409. Repealed**Historical Note**

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Amended effective April 2, 1993 (Supp. 93-2). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-410. Repealed**Historical Note**

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Amended effective April 2, 1993 (Supp. 93-2). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-411. Repealed**Historical Note**

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Amended effective April 2, 1993 (Supp. 93-2). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

ARTICLE 5. PROCUREMENT OF CONSTRUCTION AND SPECIFIED PROFESSIONAL SERVICES

R2-7-501. Procurement of Specified Professional and Construction Services

- A.** The agency chief procurement officer shall procure specified professional services as defined in A.R.S. §§ 41-2578, 41-2579, and 41-2581 in the following manner:
1. Through existing state contracts if available;
 2. In accordance with A.R.S. § 41-2535 and Part D of Article 3 of this Chapter or A.R.S. § 41-2533 procurements not to exceed the amount prescribed in A.R.S. § 41-2535;
 3. May procure services in accordance with A.R.S. §§ 41-2536, 41-2537, or 41-2581.
- B.** Unless an alternate project delivery method is used as permitted under R2-7-503, the agency chief procurement officer shall procure construction in the following manner:
1. Through existing state contracts if available;
 2. In accordance with A.R.S. § 41-2535 and Part D of Article 3 of this Chapter or A.R.S. § 41-2533 for single award procurements not to exceed the amount prescribed in A.R.S. §§ 41-2535 or 41-2579 for multiple award procurements;
 3. In accordance with A.R.S. § 41-2533 for procurements estimated to exceed the amount prescribed in A.R.S. § 41-2535; or
 4. May procure construction in accordance with A.R.S. §§ 41-2536 or 41-2581.
- C.** The agency chief procurement officer shall procure construction through an alternate project delivery method in the following manner:
1. Through existing state contracts if available;
 2. In accordance with A.R.S. § 41-2535 and Part D of Article 3 of this Chapter or A.R.S. § 41-2578 for procurements not estimated to exceed the amount prescribed in A.R.S. § 41-2535;
 3. May procure construction in accordance with A.R.S. §§ 41-2536, 41-2537, or 41-2581.

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Section repealed; new Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1). New Section made by final rulemaking at 18 A.A.R. 3118, effective January 7, 2013 (Supp. 12-4). Amended by final rulemaking at 18 A.A.R. 3118, effective January 7, 2013 (Supp. 12-4).

R2-7-502. Compliance with the Department

A purchasing agency shall comply with the procurement and contract administration requirements of the Department as required by A.R.S. § 41-790 et seq.

Historical Note

Adopted effective April 2, 1993 (Supp. 93-2). Amended by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-503. Procurement of Construction Using Alternate Project Delivery Method

The agency chief procurement officer may use an alternate project delivery method if the agency chief procurement officer determines in writing that it is in the best interest of the state pursuant to A.R.S. §§ 41-2578 and 41-2579, based on the following factors:

1. Cost and cost control method,
2. Value engineering,
3. Market conditions,
4. Schedule,
5. Required specialized expertise,

6. Technical complexity of the project, or
7. Project management.

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Amended effective April 2, 1993 (Supp. 93-2). Section repealed; new Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1). Amended by final rulemaking at 18 A.A.R. 3118, effective January 7, 2013 (Supp. 12-4).

R2-7-504. Notice

- A. The agency chief procurement officer shall provide a copy of a solicitation for specified professional services or construction services to any person who requests a copy of the solicitation.
- B. For procurements not estimated to exceed the amount prescribed in A.R.S. § 41-2535, the agency chief procurement officer shall provide notice of the procurement in accordance with Part D of Article 3 of this Chapter, unless otherwise authorized pursuant to A.R.S. §§ 41-2536 or 41-2537.
- C. For procurements estimated to exceed the amount prescribed in A.R.S. § 41-2535:
 1. The agency chief procurement officer shall make the solicitation available to prospective offerors registered at the State Procurement Office for the specific material, service, or construction being solicited; and
 2. The agency chief procurement officer shall advertise at least once in a general circulation or industry trade publication. If practicable, the date of the advertisement shall be at least 14 days before the offer due date.

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Amended effective April 2, 1993 (Supp. 93-2). Section repealed; new Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1). Amended by final rulemaking at 18 A.A.R. 3118, effective January 7, 2013 (Supp. 12-4).

R2-7-505. Selection Committee

- A. The agency chief procurement officer shall appoint a selection committee when required under A.R.S. §§ 41-2578, 41-2579, or 41-2581.
- B. For the procurement of specified professional services not estimated to exceed the amount prescribed in A.R.S. § 41-2581, the selection committee shall meet the requirements of A.R.S. § 41-2578(C)(1) and shall consist of three to five members who are appropriately qualified including the agency chief procurement officer as chair.
- C. For the procurement of specified professional services estimated to exceed the amount prescribed in A.R.S. §§ 41-2578, 41-2579, or 41-2581.

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Section repealed; new Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1). Amended by final rulemaking at 18 A.A.R. 3118, effective January 7, 2013 (Supp. 12-4).

R2-7-506. Bid Security

- A. The agency chief procurement officer shall include the bid security requirements of A.R.S. § 41-2573 in the solicitation.
- B. If an offeror fails to submit the bid security required by A.R.S. § 41-2573 with the offer, the agency chief procurement officer shall reject the offer.
- C. The offeror shall submit bid security in one of the following forms:
 1. An annual or one-time surety bond executed solely by a surety company authorized to transact surety business in this state, issued by the Director of the Department of Insurance under A.R.S. Title 20, Chapter 2, Article 1, and in a format prescribed by A.R.S. § 41-2573 and this Section; or
 2. A certified or cashier check.
- D. The state procurement administrator or, in the case of construction on state property, the Assistant Director of General Services, may issue a written determination to accept the bid security if the bid security fails to comply in a nonsubstantial manner when:
 1. Only one offer is received and there is not sufficient time to re-solicit;
 2. The amount of the bid security submitted, although less than the amount required by the solicitation, is equal to or greater than the difference between the apparent low offer and the next higher acceptable offer; or
 3. The bid security is inadequate as a result of correcting or modifying an offer in accordance with R2-7-B310, if the offeror increases the amount of the security to required limits within two days after notification.
- E. The state procurement administrator or, in the case of construction on state property, the Assistant Director of General Services, shall determine if the bid security may be released without penalty under § 41-2573(E).

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Amended effective April 2, 1993 (Supp. 93-2). Amended by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-507. Offer Mistakes Discovered After Offer Opening and Before Award

- A. If an apparent mistake, relevant to the award determination is discovered after offer opening and before award, the agency chief procurement officer shall contact the offeror for written confirmation of the offer. The agency chief procurement officer shall designate a time-frame within which the offeror shall either:
 1. Confirm that no mistake was made and assert that the offer stands as submitted; or
 2. Acknowledge that a mistake was made, and include all of the following in a written response:
 - a. Explanation of the mistake and any other relevant information;
 - b. A request for correction including the corrected offer or a request for withdrawal; and
 - c. The reasons why correction or withdrawal is consistent with fair competition and in the best interest of the state.
- B. An offeror who discovers a mistake in its offer may request correction or withdrawal in writing, and shall include all of the following in the written request:
 1. Explanation of the mistake and any other relevant information;

2. A request for correction including the corrected offer or a request for withdrawal; and
 3. The reasons why correction or withdrawal is consistent with fair competition and in the best interest of the state.
- C.** An agency chief procurement officer may permit an offeror to correct a mistake if the mistake and the intended offer are evident in the uncorrected offer; for example, an error in the extension of unit prices. The agency chief procurement officer shall not permit a correction that is prejudicial to the state or fair competition.
- D.** An agency chief procurement officer shall permit an offeror to furnish information called for in the solicitation but not supplied if the intended offer is evident and submittal of the information is not prejudicial to other offerors.
- E.** An agency chief procurement officer shall make a written determination of whether correction or withdrawal is permitted, based on whether the action is consistent with fair competition and in the best interest of the state.
- F.** If the offeror fails to act under subsection (A), the offeror is considered nonresponsive and the agency chief procurement officer shall place a written determination that the offeror is nonresponsive in the procurement file.

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Amended effective January 13, 1987 (Supp. 87-1). Amended effective April 2, 1993 (Supp. 93-2). Section repealed; new Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-508. Performance and Payment Bonds

- A.** The agency chief procurement officer shall ensure that performance and payment bonds are executed solely by a surety company or companies holding a certificate of authority to transact surety business in this state issued by the Department of Insurance under A.R.S. Title 20, Chapter 2, Article 1 and in a format prescribed by A.R.S. § 41-2574.
- B.** The contractor shall submit to the state the performance bond and the payment bond upon request of the agency chief procurement officer. If a contractor fails to deliver the required performance bond or payment bond by the designated date, the contractor's offer shall be rejected, its bid security shall be enforced, and award of the contract shall be made as prescribed in this Chapter.

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Repealed effective April 2, 1993 (Supp. 93-2). New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-509. Conditions for Use of Substitute Security in Lieu of Retention

A contractor may submit substitute security to replace contract payment retention if:

1. The contractor requests the use of substitute security before the first progress payment;
2. The contractor submits an invoice with each progress payment in an amount of no less than 10% of the progress payment, or the contractor submits an invoice once at the beginning of the project in an amount no less than 5% of the total contract amount;

3. The interest earned on the security shall accrue to the benefit of the contractor but shall be retained by the contractor until the agency chief procurement officer has approved completion and acceptance of all work to be performed under the contract; and
4. The contractor ensures that the date of maturity of the security is after the estimated contract completion date, but no later than one year after the estimated contract completion date.

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Amended effective April 2, 1993 (Supp. 93-2). Section repealed; new Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-510. The Form of Substitute Security in Lieu of Retention

If the conditions identified under R2-7-506 are met, the agency chief procurement officer shall accept a substitute security from a contractor in the form of one of the following:

1. An assignment of a time certificate of deposit by a financial institution licensed by this state;
2. Share certificates of a financial institution or credit union authorized to transact business in this state; or
3. Security issued or guaranteed as to principal and interest by:
 - a. The United States;
 - b. The state; or
 - c. Counties, municipalities, and school districts within this state.

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Section repealed; new Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-511. Individual Job Order Contracting

- A.** The state procurement administrator may award or authorize an agency chief procurement officer to award job order contracts for job orders estimated to cost \$1,000,000 or less.
- B.** An agency chief procurement officer may use job order contracting for individual job orders estimated to cost \$250,000 or less, provided that:
1. The agency chief procurement officer obtains a cost estimate for the job order, before obtaining a cost proposal from the job order contractor; and
 2. The agency chief procurement officer makes a written determination that award of the job order is in the best interest of the state before awarding a job order.
- C.** When authorized by the state procurement administrator, an agency chief procurement officer may use job order contracting for individual job orders estimated to cost more than \$250,000 or less than or equal to \$1,000,000, provided that:
1. The agency chief procurement officer obtains a cost estimate for the job order from a person as defined in A.R.S. Title 32, Chapter 1, Article 1 before requesting a cost proposal from the job order contractor; and
 2. The agency chief procurement officer makes a written determination that award of the job order is in the best interest of the state before awarding a job order.

- D. The agency chief procurement officer may request cost proposals from multiple job order contractors or negotiate with a single job order contractor.
- E. The agency chief procurement officer may authorize contract change orders or amendments that result in the individual job order cost exceeding \$1,000,000 only with authorization from the state procurement administrator.
- F. Upon completion of the job order, the agency chief procurement officer shall document in the contract file a summary of the estimated or final costs and the reasons the award is in the best interests of the state.
- G. Conduct the procurement, as necessary in accordance with R2-7-B302, R2-7-B311, R2-7-B313, and R2-7-B315, unless a modified process is approved by the state procurement administrator.

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Amended effective April 2, 1993 (Supp. 93-2). Section repealed; new Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1). Amended by final rulemaking at 18 A.A.R. 3118, effective January 7, 2013 (Supp. 12-4).

R2-7-512. Repealed**Historical Note**

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-513. Repealed**Historical Note**

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-514. Repealed**Historical Note**

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-515. Repealed**Historical Note**

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Amended effective April 2, 1993 (Supp. 93-2). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

ARTICLE 6. CONTRACT CLAUSES**R2-7-601. Contract Clauses**

The agency chief procurement officer shall include in solicitations and contracts all contract clauses necessary to ensure the state's interests are addressed.

Historical Note

Adopted effective April 2, 1993 (Supp. 93-2). Section repealed; new Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-602. Assignment of Rights and Duties

A contractor shall not assign or transfer the rights or duties of a state contract without the written consent of the agency chief procurement officer.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-603. Change of Name

If a contractor requests to change the name in which it holds a state contract, the agency chief procurement officer may, upon receipt of a document indicating name change, enter into a written amendment with the contractor to effect the name change. The amendment shall provide that no other terms and conditions of the contract are changed.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-604. Contract Change Orders and Amendments

- A. The agency chief procurement officer may extend or authorize options in a contract provided the price of the extension or option was evaluated under the contractor's original offer.
- B. Any contract change order or amendment not covered under subsection (A) that exceeds \$100,000 may be executed only if the state procurement administrator or, in the case of construction on state property, the Assistant Director of General Services, determines in writing that the change order or amendment is advantageous to the state and the price is determined fair and reasonable pursuant to R2-7-702.
- C. The agency chief procurement officer may, in situations in which time or economic consideration preclude re-solicitation, negotiate a reduction to the contract, including scope, price, and contract requirements under A.R.S. § 41-2537.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-605. Multi-term Contracts

- A. With a written determination from state procurement administrator that an extension of time would be advantageous to the state, the agency chief procurement officer may enter into a contract for materials or services for a period exceeding the time identified in A.R.S. § 41-2546(A).
- B. The agency chief procurement officer shall submit a request to the state procurement administrator in writing indicating:
 1. The time period requested for the contract;
 2. Documentation that the estimated requirements are reasonable and continuing;
 3. Documentation that such a contract will serve the best interests of the state by encouraging effective competition or otherwise promoting economies in state procurement.
- C. The agency chief procurement officer shall include in all multi-term contracts a clause specifying that the contract shall be cancelled if monies are not appropriated or otherwise made available to support the continuation of performance in a subsequent fiscal year. If the contract is cancelled under this Sec-

tion, the contractor may only be reimbursed for the reasonable value of any nonrecurring costs incurred but not amortized in the price of the materials or services delivered under the contract or which are otherwise not recoverable.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-606. Terms and Conditions

- A. The state procurement administrator may publish uniform terms and conditions for use in solicitations and contracts issued by a state governmental unit.
- B. The state procurement administrator may authorize an agency chief procurement officer to make changes to uniform terms and conditions.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-607. Mandatory Statewide Contracts

State governmental units shall use existing Arizona state contracts to satisfy their needs for those materials and services covered under such contracts, unless authorized by the state procurement administrator.

Historical Note

New Section made by final rulemaking, 18 A.A.R. 3118, effective January 7, 2013 (Supp. 12-4).

R2-7-608. Multiple Source Contracts

Multiple award contracts shall be limited to the least number of suppliers necessary to meet the requirements of the state or the cooperative procurement members, unless authorized by the state procurement administrator.

Historical Note

New Section made by final rulemaking, 18 A.A.R. 3118, effective January 7, 2013 (Supp. 12-4).

ARTICLE 7. COST PRINCIPLES

R2-7-701. Cost Principles

The cost principles set forth in the Code of Federal Regulations, 48 CFR 31, (September 2001) shall be used to determine the allowability of incurred costs for the purpose of reimbursing costs under contract provisions that provide for the reimbursement of costs. This document is incorporated by reference and on file with the Department. This incorporation by reference contains no future editions or amendments.

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Amended effective April 2, 1993 (Supp. 93-2). Amended by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-702. Determination of Fair and Reasonable Price

- A. For contracts or contract modifications that exceed \$100,000, the agency chief procurement officer shall determine in writing that the price is fair and reasonable only when one of the following requirements is met:
 1. The contract or modification is based on adequate price competition;
 2. Price is supported by an established catalog or market prices;
 3. Price is set by law or rule; or
 4. Price is supported by relevant, historical price data.

- B. The agency chief procurement officer shall request the submission of cost or pricing data from the offeror or contractor when:
 1. The agency chief procurement officer cannot determine the price is fair and reasonable based on the criteria in subsection (A); or
 2. The agency chief procurement officer determines in writing that it is in the best interest of the state regardless of the amount of the contract or contract modification.

- C. The agency chief procurement officer shall submit a request to the state procurement administrator to waive the requirement for submission of cost or pricing data to the state procurement administrator if the proposed contract or contract modification exceeds \$100,000. The request shall be in writing and state the reasons for the waiver.

- D. The state procurement administrator shall either:
 1. Issue written approval of the request for waiver;
 2. Request additional information from the agency chief procurement officer upon which to base a decision; or
 3. Deny the request.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-703. Submission and Certification of Cost or Pricing Data

- A. The offeror or contractor shall submit certified cost or pricing data in the manner, and within the time-frames, prescribed by the agency chief procurement officer.
- B. The offeror or contractor shall keep all cost or pricing data submitted current until the negotiations are concluded.
- C. The offeror or contractor shall certify cost or pricing data by including a signed statement with the submission that all data is accurate, complete, and current to the best of the offeror's or contractor's knowledge and belief as of a date mutually determined with the agency chief procurement officer.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-704. Refusal to Submit Cost or Pricing Data

- A. If an offeror fails to submit cost or pricing data in the required form and within the time-frames required, the agency chief procurement officer may reject the offer.
- B. If a contractor fails to submit data to support a contract modification in the form required and within the time-frames required, the agency chief procurement officer may:
 1. Reject the contract modification; or
 2. Set the amount of the contract modification subject to the contractor's rights under Article 9 of the Arizona Procurement Code.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-705. Defective Cost or Pricing Data

- A. The agency chief procurement officer may reduce the contract price if, upon written determination, the cost or pricing data is defective.
- B. The agency chief procurement officer shall reduce the contract price in the amount of the defect plus related overhead and profit or fee, if the defective data was used in awarding the contract or contract modification.
- C. The offeror or contractor may appeal any dispute regarding the existence of defective cost or pricing data or the amount of an adjustment due to defective cost or pricing data as a contract

claim under Article 9 of this Chapter. The price, as adjusted by the agency chief procurement officer, shall remain in effect until any claim is settled or resolved under Article 9 of this Chapter.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

ARTICLE 8. TRANSFERRED

Article 8, consisting of Sections R2-7-801 through R2-7-810, transferred to Title 2, Chapter 15, Article 3, Sections R2-15-301 through R2-15-210, Department of Administration, General Services Division.

R2-7-801. Transferred

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Transferred to R2-15-801 (Supp. 91-3).

R2-7-802. Transferred

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Transferred to R2-15-802 (Supp. 91-3).

R2-7-803. Transferred

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Transferred to R2-15-803 (Supp. 91-3).

R2-7-804. Transferred

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Transferred to R2-15-804 (Supp. 91-3).

R2-7-805. Transferred

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Transferred to R2-15-805 (Supp. 91-3).

R2-7-806. Transferred

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Transferred to R2-15-806 (Supp. 91-3).

R2-7-807. Transferred

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp.

84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Transferred to R2-15-807 (Supp. 91-3).

R2-7-808. Transferred

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Transferred to R2-15-808 (Supp. 91-3).

R2-7-809. Transferred

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Transferred to R2-15-809 (Supp. 91-3).

R2-7-810. Transferred

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Transferred to R2-15-810 (Supp. 91-3).

ARTICLE 9. LEGAL AND CONTRACTUAL REMEDIES

R2-7-901. Repealed

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Amended effective April 2, 1993 (Supp. 93-2). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-902. Repealed

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-903. Repealed

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-904. Repealed

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Amended effective April 2, 1993 (Supp. 93-2). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-933. Repealed**Historical Note**

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-934. Repealed**Historical Note**

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Amended effective April 2, 1993 (Supp. 93-2). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-935. Repealed**Historical Note**

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-936. Repealed**Historical Note**

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-937. Repealed**Historical Note**

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Section repealed by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

PART A. PROTEST OF SOLICITATIONS AND CONTRACT AWARDS**R2-7-A901. Protest of Solicitations and Contract Awards**

- A. Any interested party may protest a solicitation, a determination of not susceptible for award, or the award of a contract.
- B. The interested party shall file the protest in writing with the agency chief procurement officer, with a copy to the state procurement administrator, and shall include the following information:
 1. The name, address and telephone number of the interested party;
 2. The signature of the interested party or the interested party's representative;
 3. Identification of the purchasing agency and the solicitation or contract number;
 4. A detailed statement of the legal and factual grounds of the protest including copies of relevant documents; and
 5. The form of relief requested.
- C. If the protest is based upon alleged improprieties in a solicitation that are apparent before the offer due date and time, the

interested party shall file the protest before the offer due date and time.

- D. In cases other than those covered in subsection (C), the interested party shall file the protest within 10 days after the agency chief procurement officer makes the procurement file available for public inspection.
- E. The interested party may submit a written request to the agency chief procurement officer for an extension of the time limit for protest filing set forth in subsection (D). The written request shall be submitted before the expiration of the time limit set forth in subsection (D) and shall set forth good cause as to the specific action or inaction of the purchasing agency that resulted in the interested party being unable to submit the protest within the 10 days. The agency chief procurement officer shall approve or deny the request in writing, state the reasons for the determination, and, if an extension is granted set forth a new date for submission of the filing.
- F. If the interested party shows good cause, the agency chief procurement officer may consider a protest that is not timely filed.
- G. The agency chief procurement officer shall immediately give notice of a protest to all offerors.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-A902. Stay of Procurements During the Protest

- A. If a protest is filed before the solicitation due date, before the award of a contract, or before performance of a contract has begun, the agency chief procurement officer shall make a written determination to either:
 1. Proceed with the award or contract performance, or
 2. Stay all or part of the procurement if there is a reasonable probability the protest will be upheld or that a stay is in the best interest of the state.
- B. The agency chief procurement officer shall provide the interested party, state procurement administrator, and other interested parties with a copy of the written determination.
- C. The agency chief procurement officer may stay all or part of the procurement if it is determined that there is a reasonable probability the protest will be upheld or that a stay is in the best interest of the state. Determination of the stay decision shall be issued no later than the time of issuance of a procurement officer's decision in accordance with R2-7-A903.
- D. Should the stay request be denied by the agency chief procurement officer the protestant may request a procurement stay from the state procurement administrator. Such requests for a procurement stay shall be submitted within 10 days of notification of the stay denial by the agency chief procurement officer.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1). Amended by final rulemaking at 18 A.A.R. 3118, effective January 7, 2013 (Supp. 12-4).

R2-7-A903. Resolution of Solicitation and Contract Award Protests

- A. The agency chief procurement officer has the authority to resolve a protest.
- B. The agency chief procurement officer shall issue a written decision within 14 days after a protest has been filed under R2-7-A901. The decision of the agency chief procurement officer shall contain the basis for the decision and a statement that the decision may be appealed to the Director within 30 days from receipt of the decision.

- C. The agency chief procurement officer shall furnish the decision to the interested party, by certified mail, return receipt requested, or by any other method that provides evidence of receipt, with a copy to the state procurement administrator and the director.
- D. The agency chief procurement officer may submit a written request to the director for an extension of the time limit for decisions under subsection (B). The director shall approve or deny the request in writing, state the reasons for the determination, and, if an extension is granted, set forth a new date for submission of the decision, not to exceed an additional 30 days. The director shall notify the agency chief procurement officer, the interested party, and the state procurement administrator in writing that the time for the issuance of a decision has been extended and the date by which a decision shall be issued.
- E. If the agency chief procurement officer fails to issue a decision within the time limits set forth in this Article, the interested party may proceed as if the agency chief procurement officer had issued an adverse decision.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-A904. Remedies by the Agency Chief Procurement Officer

- A. If the agency chief procurement officer sustains a protest in whole or part and determines that a solicitation, a determination of not susceptible for award, or contract award does not comply with the procurement statutes and regulations, the agency chief procurement officer shall implement an appropriate remedy.
- B. In determining an appropriate remedy, the agency chief procurement officer shall consider all the circumstances surrounding the procurement or proposed procurement including:
 1. The seriousness of the procurement deficiency;
 2. The degree of prejudice to other interested parties or to the integrity of the procurement system;
 3. The good faith of the parties;
 4. The extent of performance;
 5. The costs to the state;
 6. The urgency of the procurement;
 7. The impact on the agency's mission; and
 8. Other relevant issues.
- C. An agency chief procurement officer may implement any of the following appropriate remedies:
 1. Decline to exercise an option to renew under the contract;
 2. Terminate the contract;
 3. Amend the solicitation;
 4. Issue a new solicitation;
 5. Award a contract consistent with procurement statutes and regulations; or
 6. Render such other relief as determined necessary to ensure compliance with procurement statutes and regulations.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-A905. Appeals to the Director

- A. An interested party may appeal the decision entered or deemed to be entered by the agency chief procurement officer to the director within 30 days after the date the decision is received or deemed received under R2-7-A903. The interested party shall file a copy of the appeal with the director, the agency

chief procurement officer, and the state procurement administrator.

- B. The interested party shall file the appeal in writing and shall include the following information:
 1. The information prescribed in R2-7-A901(B) including the identification of confidential information under R2-7-103;
 2. A copy of the decision of the agency chief procurement officer; and
 3. The precise factual or legal error in the decision of the agency chief procurement officer from which an appeal is taken.
- C. The director may consider any appeal that is not filed timely if:
 1. The interested party shows good cause; or
 2. The director finds there is good cause.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-A906. Notice of Appeal to the Director

- A. The agency chief procurement officer shall promptly give notice of the appeal to all offerors.
- B. The director shall, upon request, furnish copies of the appeal to all offerors subject to the provisions of R2-7-103.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-A907. Stay of Procurement During Appeal to Director

- A. If a stay is issued under R2-7-A902, the filing of an appeal shall automatically continue the stay, unless the Director makes a written determination that the award of the contract or a notice to proceed with contract performance is necessary to protect the substantial interests of the state.
- B. Following a review of the agency chief procurement officer's or the state procurement officer's decision and the interested party's appeal, the director may stay the procurement if the director determines that there is a reasonable probability the protest will be upheld or that a stay is in the best interests of the state.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-A908. Agency Report

- A. The agency chief procurement officer shall file a complete report on the appeal with the director and the state procurement administrator within 21 days after the date the appeal is filed, at the same time furnishing a copy of the report to the interested party. The agency chief procurement officer shall also provide a copy of the report to any interested parties who request a copy, at their cost. The report shall contain copies of:
 1. The appeal;
 2. The offer submitted by the interested party;
 3. The offer of the firm that is being considered for award;
 4. The solicitation, including the specifications or portions relevant to the appeal;
 5. The abstract of offers or relevant portions;
 6. Any other documents that are relevant to the protest; and
 7. A statement by the agency chief procurement officer setting forth findings, actions, recommendations and any additional evidence or information necessary to determine the validity of the appeal.
- B. The agency chief procurement officer may submit a written request to the director for an extension of the time period for filing the report as prescribed in subsection (A), identifying

the reason for extension. The director shall approve or deny the request in writing, state the reasons for the determination, and, if an extension is granted, set forth a new date for the submission of the report. The director shall notify the agency chief procurement officer, the state procurement administrator, and the interested party in writing that the time for the submission of the report is extended, providing the date on which the report must be submitted.

- C. The interested party shall file comments on the agency report with the director within 10 days after receipt of the report. The interested party shall provide copies of the comments to the agency chief procurement officer, the state procurement administrator, and other interested parties.
- D. The interested party may submit a written request to the director for an extension of the period for submission of comments, identifying the reasons for the extension. The director shall approve or deny the request in writing, state the reasons for the determination, and, if an extension is granted, set forth a new date for the submission of filing comments. The director shall notify the agency chief procurement officer and the state procurement administrator of any extension.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1). Amended by final rulemaking at 18 A.A.R. 3118, effective January 7, 2013 (Supp. 12-4).

R2-7-A909. Remedies by the Director

If the director sustains the appeal in whole or part and determines that a solicitation, a not susceptible for award determination, or an award does not comply with procurement statutes and regulations, the director shall implement remedies as provided in R2-7-A904.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-A910. Dismissal Before Hearing

- A. The director shall dismiss, upon written determination, an appeal in whole or in part before scheduling a hearing if:
 - 1. The appeal does not state a valid basis for protest;
 - 2. The appeal is untimely as prescribed under R2-7-A905; or
 - 3. The appeal attempts to raise issues not raised in the protest.
- B. The Director shall notify the interested party, the agency chief procurement officer, and the state procurement administrator in writing of a determination to dismiss an appeal before hearing.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-A911. Hearing

The Director shall resolve appeals of solicitation or contract award decisions as contested cases under A.R.S. § 41-1092.07.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

PART B. CONTRACT CLAIMS

R2-7-B901. Controversies Involving Contract Claims Against the State

- A. A claimant shall file a contract claim with the agency chief procurement officer, with a copy to the state procurement administrator, within 180 days after the claim arises. The claim shall include the following:
 1. The name, address, and telephone number of the claimant;
 2. The signature of the claimant or claimant's representative;
 3. Identification of the purchasing agency and the solicitation or contract number;
 4. A detailed statement of the legal and factual grounds of the claim including copies of the relevant documents; and
 5. The form and dollar amount of the relief requested.
- B. The agency chief procurement officer shall have the authority to settle and resolve contract claims, except that the agency chief procurement officer shall receive prior written approval of the state procurement administrator for the settlement or resolution of a claim in excess of the amount prescribed in A.R.S. § 41-2535.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-B902. Agency Chief Procurement Officer's Decision

- A. If a claim cannot be resolved under R2-7-B901, the agency chief procurement officer shall, upon a written request by the claimant for a final decision, issue a written decision no more than 60 days after the request is filed. Before issuing a final decision, the agency chief procurement officer shall review the facts pertinent to the claim and secure any necessary assistance from legal, fiscal, and other advisors.
- B. The agency chief procurement officer shall furnish the decision to the claimant, by certified mail, return receipt requested, or by any other method that provides evidence of receipt, with a copy to the state procurement administrator. The decision shall include:
 1. A description of the claim;
 2. A reference to the pertinent contract provision;
 3. A statement of the factual areas of agreement or disagreement;
 4. A statement of the agency chief procurement officer's decision, with supporting rationale;
 5. A paragraph which substantially states: "This is the final decision of the agency chief procurement officer. This decision may be appealed to the director of the Department of Administration. If you appeal, you must file a written notice of appeal containing the information required in R2-7-B904(B) with the director within 30 days from the date you receive this decision."

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-B903. Issuance of a Timely Decision

If the agency chief procurement officer fails to issue a decision within 60 days after the request is filed, the claimant may proceed as if the agency chief procurement officer had issued an adverse decision.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-B904. Appeals and Reports to the Director

- A. The claimant may appeal the final decision of the agency chief procurement officer to the director within 30 days from the date the decision is received. The claimant shall file a copy of the appeal with the director, the agency chief procurement officer, and the state procurement administrator.
- B. The claimant shall file the appeal in writing and shall include the following:

1. A copy of the decision of the agency chief procurement officer;
 2. A statement of the factual areas of agreement or disagreement; and
 3. The precise factual or legal error in the decision of the agency chief procurement officer from which an appeal is taken.
- C. The agency chief procurement officer shall file a complete report on the appeal with the director and the state procurement administrator within 14 days from the date the appeal is filed, providing a copy to the claimant at that time by certified mail, return receipt requested, or by any other method that provides evidence of receipt. The report shall include a copy of the claim, a copy of the agency chief procurement officer's decision, if applicable, and any other documents that are relevant to the claim.
- D. The director shall resolve appeals on claim decisions as contested cases under A.R.S. § 41-1092.07.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-B905. Controversies Involving State Claims Against the Contractor

If the agency chief procurement officer is unable to resolve, by mutual agreement, a claim asserted by the state against a contractor, the agency chief procurement officer shall promptly refer the matter in writing to the director for resolution under A.R.S. § 41-1092.07. The agency chief procurement officer shall furnish a copy of the claim to the state procurement administrator.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

PART C. DEBARMENTS AND SUSPENSIONS**R2-7-C901. Authority to Debar or Suspend**

The director has the sole authority to debar or suspend a person from participating in state procurements under A.R.S. § 41-2613.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-C902. Initiation of Debarment

Upon receipt of information concerning a possible cause for debarment, the director shall investigate the possible cause. If the director has a reasonable basis to believe that a cause for debarment exists, the director may propose debarment under R2-7-C904.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-C903. Period of Debarment

- A. The director shall not establish the period of time for a debarment that exceeds three years from the date of the debarment determination.
- B. If debarment is based solely upon debarment by another governmental agency, the director may establish that the period of debarment is to run concurrently with the period established by the other debarring agency.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-C904. Notice of Debarment and Hearing

- A. If debarment is proposed, the director shall notify the person and affected affiliates in writing within seven days by certified

mail, return receipt requested, or any other method that provides evidence of receipt. The notice shall state that the person and affected affiliates have the right to a hearing to contest the proposed debarment.

- B. The person proposed for debarment and any affected affiliates shall file a written request for a hearing within 10 days of receipt of the director's notice of proposed debarment.
- C. The hearing shall be conducted as a contested case under A.R.S. §§ 41-1092.07 and 41-2613.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-C905. Imputed Knowledge

- A. The director may attribute improper conduct to an affiliate for purposes of debarment where the impropriety occurred in connection with the affiliate's duties for or on behalf of, or with the knowledge, approval, or acquiescence of, the contractor.
- B. The director may attribute improper conduct of a person or its affiliate having a contract with a contractor to the contractor for purposes of debarment where the impropriety occurred in connection with the person's duties for or on behalf of, or with the knowledge, approval, or acquiescence of, the contractor.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-C906. Reinstatement

- A. The director may at any time after a final decision on a debarment reinstate a debarred person or rescind the debarment upon a determination that the cause upon which the debarment is based no longer exists.
- B. Any debarred person may request reinstatement by submitting a petition to the director supported by documentary evidence showing that the cause for debarment no longer exists or has been substantially mitigated.
- C. The director may require a hearing on the request for reinstatement.
- D. The director shall make a written decision on reinstatement within 30 days after the request is filed and specify the factors on which it is based.
- E. Reinstatement decisions by the director are not subject to administrative review.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-C907. Limited Participation

The director may allow a debarred person to participate in state contracts on a limited basis during the debarment period upon a written determination that participation is advantageous to the state. The determination shall specify the factors on which it is based and define the extent of the limits imposed.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-C908. Suspension

- A. If the director determines that reasonable grounds for debarment exist, the director may suspend a person from receiving any award under R2-7-C910.
- B. For purposes of suspension, a person's conduct may be attributed to an affiliate or another person under R2-7-C905.
- C. The director shall not suspend a person pending debarment unless compelling reasons require suspension to protect state interests.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-C909. Period and Scope of Suspension

Unless otherwise agreed to by the parties, the director shall not implement a period of suspension of more than 35 days without satisfying the notice requirements of R2-7-C910.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-C910. Notice, Hearing, Determination, and Appeal

- A. The director shall notify the person suspended by certified mail, return receipt requested, or by any other method that provides evidence of receipt.
- B. The notice of suspension shall state:
 1. The basis for suspension;
 2. The period, including dates, of the suspension;
 3. That offers received from the person will not be considered; and
 4. That the person is entitled to a hearing on the suspension if the person files a written request for a hearing with the director within 30 days after receipt of the notice.
- C. Within 30 days receipt of the notice of suspension, the suspended party may file a written request for hearing with the director. The appeal shall include the following information:
 1. A copy of the decision of the director; and
 2. The precise factual or legal error in the decision from which the appeal is taken.
- D. The suspension shall be resolved as an appealable agency action under A.R.S. §§ 41-1092.03 and 41-2613.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-C911. Master List

- A. The director shall maintain a master list of debarments, suspensions, and voluntary exclusions under this Article.
- B. The master list shall show at a minimum, the following information:
 1. The names and vendor numbers of those persons whom the state has debarred or suspended under this Article;
 2. The statutory authority for the action;
 3. The period of debarment or suspension, including the expiration date;
 4. The name of the debarring or suspending agency, if the state's debarment or suspension is based on debarment or suspension by another governmental agency; and
 5. A separate section listing persons voluntarily excluded from participation in state contracts.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

PART D. HEARING PROCEDURES**R2-7-D901. Hearings**

If a hearing is required or permitted under this Chapter, the director shall refer the matter to the Office of Administrative Hearings for findings of fact, conclusions of law, and a recommended decision. The director may also direct the parties to engage in settlement negotiations or alternative dispute resolution procedures before referring the matter for a hearing.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-D902. Rehearing of Director's Decision

- A. Any person, including an agency chief procurement officer, who is aggrieved by the director's decision may file a written request for rehearing of the decision under A.R.S. § 41-1092.09.
- B. The director, within the time for filing a request for rehearing under this rule, may upon the director's own initiative, order a rehearing for any reason for which a rehearing may have been granted on request of a party.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

ARTICLE 10. INTERGOVERNMENTAL PROCUREMENT**R2-7-1001. Approval to Enter into a Cooperative Purchasing Agreement**

- A. Agency chief procurement officers may use Arizona state contracts without a cooperative purchasing agreement.
- B. Agency chief procurement officers shall submit a written request to the state procurement administrator before participating in a cooperative purchasing agreement with another public procurement unit or group of public procurement units. The written request for approval shall specify the manner which the administering public procurement unit complies with A.R.S. § 41-2634.
- C. The state procurement administrator shall either:
 1. Issue written approval, with any conditions or restrictions;
 2. Request additional information from the state government unit; or
 3. Deny the request.

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Section repealed; new Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-1002. Cooperative Purchasing Agreement Administered by an Agency Chief Procurement Officer

- A. An agency chief procurement officer shall ensure that any cooperative purchasing agreement administered for use by other eligible procurement units under A.R.S. § 41-2632 provides that:
 1. Payment for materials or services and inspection and acceptance of materials or services are the responsibility of the using eligible procurement unit;
 2. Failure of an eligible procurement unit to secure performance from the contractor in accordance with the terms and conditions of its purchase order does not necessarily require the state to exercise rights or remedies;
 3. The exercise of any rights or remedies by the eligible procurement unit shall be the exclusive obligation of that unit. The state, as the contract administrator and without subjecting itself to any liability, may join in the resolution of any controversy;
 4. The eligible procurement unit shall not use an Arizona state contract as a method for obtaining additional concessions or reduced prices for similar material or services; and
 5. An agency chief procurement officer may terminate without notice any cooperative purchasing agreement if the eligible procurement unit fails to comply with the terms of the contract.

- B. The state procurement administrator may authorize a state governmental unit to establish an Arizona state contract which may be used by designated eligible procurement units.

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Section repealed; new Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-1003. Establishment of a Committee as Required by A.R.S. § 41-2636

- A. The director shall appoint a committee as required by A.R.S. § 41-2636.
- B. The committee shall be comprised of at least seven members, including the committee chair, representing:
1. Arizona Correctional Industries ("ACI");
 2. Arizona Industries for the Blind ("AIB");
 3. Certified Non-Profit Agencies for Disabled Individuals (CNADI) as defined in A.R.S. § 41-2636(G);
 4. Other public procurement units.
- C. The state procurement administrator or the state procurement administrator's designee shall chair the committee.
- D. The committee chair may appoint sub-committees to assist in the evaluation of materials and services under consideration by the committee as a set-aside.
- E. The committee shall meet at least once each fiscal year quarter to report compliance with A.R.S. § 41-2636(E).

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Amended effective April 2, 1993 (Supp. 93-2). Section repealed; new Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-1004. Certification as Non-Profit Agency for Disabled Individuals

- A. A non-profit organization may request written approval from the committee for certified status as a non-profit agency for disabled individuals for the purpose of being eligible for set-aside contracts by submitting information that satisfies the criteria identified in A.R.S. § 41-2636(G).
- B. The committee shall review the information submitted and respond to the requestor in writing by:
1. Approving the request;
 2. Denying the request; or
 3. Requesting more information.

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Amended effective April 2, 1993 (Supp. 93-2). Section repealed; new Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-1005. Application for Approval as Required by A.R.S. § 41-2636 to Become a Certified Non-Profit Agency for Disabled Individuals

- A. A non-profit organization requesting certification by the committee as a non-profit agency for disabled individuals shall submit the following written information to the State Procurement Office, attention of the committee chair:

1. Name of organization, address, contact name, and contact information;
2. Description of the non-profit activity center;
3. Evidence of the organization's non-profit status;
4. A statement that the business is operated in accordance with A.R.S. § 41-2636(G);
5. A statement of Occupational Safety and Health Administration compliance; and
6. The signature and title of the responsible party within the applicant's organization.

- B. The committee shall review the submitted application at the next scheduled committee meeting and may do any of the following:

1. Approve the organization as a certified non-profit agency for disabled individuals;
2. Table the application and request additional information; or
3. Decline the application.

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Amended effective April 2, 1993 (Supp. 93-2). Section repealed; new Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-1006. Approval of Specific Materials or Services for Set-aside Use

- A. ACI, AIB, and CNADI shall submit the information required by A.R.S. § 41-2636(B) to the committee to request approval of the material or service for mandatory set-aside use. The applicant shall also include the following information:
1. A description of the specific material or service;
 2. The pricing offered;
 3. Documentation that the pricing offered is fair market pricing; and
 4. Information regarding availability.
- B. The committee shall evaluate each offered material or service to determine:
1. The existence and extent of a need within state governmental units for the material or service;
 2. The ability to produce and deliver the material or service to meet the reasonable requirements of the state governmental units; and
 3. Whether the offered price for the material or service is reasonable.
- C. The committee may:
1. Approve the requested material or service for use as a mandatory set-aside contract;
 2. Establish a sub-committee to study and make a recommendation on the request;
 3. Request additional information;
 4. Deny the request; or
 5. Designate the material or service as available for optional use by a state governmental unit or local public procurement unit under A.R.S. § 41-2636(D).

Historical Note

Former Section R2-7-1006 adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Section repealed, new Section R2-7-1006 renumbered from R2-7-1007 and amended effective April 2, 1993 (Supp. 93-2). Section repealed; new Section made by final rulemaking at 12 A.A.R. 508, effective April 8,

2006 (Supp. 06-1).

R2-7-1007. Contract Awards Directed by the Committee

- A.** The State Procurement Office or the agency chief procurement officer designated by the state procurement administrator shall enter into a contract as directed by the committee. Such contracts shall not exceed five years, including any renewal options.
- B.** Contracts may be renewed as follows:
 - 1. For mandatory state contracts, if the State Procurement Office makes an initial determination that the criteria set forth in R2-7-1006(B) are no longer being met, it shall refer the matter to the committee for a final determination.
 - 2. The committee may:
 - a. Approve the contract renewal;
 - b. Establish a sub-committee to study and make a recommendation on contract renewal;
 - c. Request additional information;
 - d. Deny the contract renewal; or
 - e. Take other action as may be appropriate.
- C.** The State Procurement Office or agency chief procurement officer designated by the state procurement administrator shall take action as directed by the committee.

Historical Note

Former Section R2-7-1007 adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Section renumbered to R2-7-1006, new Section R2-7-1007 adopted effective April 2, 1993 (Supp. 93-2). Section repealed; new Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-1008. Contract Awards Initiated by an Agency Chief Procurement Officer or Local Public Procurement Unit

- A.** Competition is not required under A.R.S. § 41-2636(D) to enter into a contract for a material or service that is offered from a set-aside agency, but may be used at the discretion of the agency chief procurement officer or local public procurement unit. If competition is used, an agency chief procurement officer may either:
 - 1. Seek competition only from applicable set-aside agencies; or
 - 2. Seek competition under A.R.S. §§ 41-2533, 41-2534, or 2535.
- B.** Contracts awarded under this Section, shall not exceed five years, including any renewal options.

Historical Note

Adopted as an emergency effective January 1, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Emergency expired. Permanent rule adopted effective April 3, 1985 (Supp. 85-2). Former Section R2-7-1008 renumbered to R2-7-1009, new Section R2-7-1008 adopted effective April 2, 1993 (Supp. 93-2). Section repealed; new Section made by final rulemaking at 12

A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-1009. Set-aside Application Dispute Process

- A.** Any interested party may dispute any committee decision.
- B.** An interested party shall submit the dispute of a committee decision to the committee chair in writing and shall include:
 - 1. Name, address, and telephone number of the person submitting the dispute;
 - 2. Signature of the person or the person's representative;
 - 3. Identification of the set-aside application disputed;
 - 4. A detailed statement of the legal and factual grounds for the dispute including copies of relevant documents; and
 - 5. The form of relief requested.
- C.** A dispute of a set-aside application shall be filed with the committee chair through the State Procurement Office within 14 days after the person who submits the dispute knows or should have known the basis of the dispute.
- D.** The committee chair shall promptly give written notice of the dispute to the set-aside applicant and the committee.
- E.** The committee chair shall resolve the dispute. The committee chair shall issue a written decision within 14 days after the date the dispute has been filed. If the committee chair fails to issue a decision within 14 days, the person who submits the dispute may proceed as if the dispute has been denied.
- F.** An appeal of the decision of the committee chair shall be made to the director under R2-7-A905.

Historical Note

Emergency rule adopted effective July 17, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-3). Emergency expired. Emergency rule re-adopted without change effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency expired, text rescinded. Former Section R2-7-1009 renumbered to R2-7-1010, new Section R2-7-1009 renumbered from R2-7-1008 and amended effective April 2, 1993 (Supp. 93-2). Section repealed; new Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1).

R2-7-1010. Renumbered**Historical Note**

Former Section R2-7-1009 renumbered to R2-7-1010 effective April 2, 1993 (Supp. 93-2).

ARTICLE 11. RESERVED**ARTICLE 12. RESERVED****ARTICLE 13. REPEALED****R2-7-1301. Repealed****Historical Note**

New Section made by final rulemaking at 12 A.A.R. 508, effective April 8, 2006 (Supp. 06-1). Repealed by final rulemaking at 18 A.A.R. 3118, effective January 7, 2013 (Supp. 12-4).

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State Retirement System Board

TITLE 2. ADMINISTRATION

CHAPTER 8. STATE RETIREMENT SYSTEM BOARD

Authority: A.R.S. § 38-701 et seq.

**ARTICLE 1. RETIREMENT SYSTEM; DEFINED
BENEFIT PLAN**

Section	
R2-8-101.	Repealed
R2-8-102.	Repealed
R2-8-103.	Repealed
R2-8-104.	Definitions
R2-8-105.	Repealed
R2-8-106.	Reserved
R2-8-107.	Reserved
R2-8-108.	Reserved
R2-8-109.	Reserved
R2-8-110.	Reserved
R2-8-111.	Reserved
R2-8-112.	Reserved
R2-8-113.	Emergency Expired
R2-8-114.	Emergency Expired
R2-8-115.	Return of Contributions Upon Termination of Membership by Separation from All ASRS Employment by Other Than Retirement or Death; Payment of Survivor Benefits Upon the Death of a Member
R2-8-116.	Expired
R2-8-117.	Repealed
R2-8-118.	Application of Interest Rates
R2-8-119.	Expired
R2-8-120.	Repealed
R2-8-121.	Repealed
R2-8-122.	Remittance of contributions
R2-8-123.	Expired
Table 1.	Expired
Table 2.	Expired
Table 3.	Repealed
Table 3A.	Expired
Table 3B.	Expired
Table 4.	Expired
Table 4A.	Repealed
Table 4B.	Repealed
Table 4C.	Repealed
Table 5.	Expired
Table 6.	Expired
Table 7.	Expired
R2-8-124.	Repealed
R2-8-125.	Repealed
R2-8-126.	Calculating Benefits
Table 1.	Repealed
Table 2.	Repealed
Table 3.	Repealed
Table 4.	Repealed
Table 5.	Repealed
Table 6.	Repealed
Table 7.	Repealed
Table 8.	Repealed
Table 9.	Repealed
Table 10.	Repealed
Table 11.	Repealed
Exhibit A.	Repealed
Exhibit B.	Repealed
Table 1.	Repealed
Table 2.	Repealed

Table 3.	Repealed
Exhibit C.	Repealed
Exhibit D.	Repealed
Table 1.	Repealed
Table 2.	Repealed
Table 3.	Repealed
Table 4.	Repealed
Table 5.	Repealed
Table 6.	Repealed
Exhibit E.	Repealed
Table 1.	Repealed
Table 2.	Repealed
Table 3.	Repealed
Table 4.	Repealed
Table 5.	Repealed
Table 6.	Repealed
Exhibit F.	Repealed
Table 1.	Repealed
Table 2.	Repealed
Table 3.	Repealed
Table 4.	Repealed
Table 5.	Repealed
Table 6.	Repealed
Exhibit G.	Repealed
Exhibit H.	Repealed
Exhibit I.	Repealed
Exhibit J.	Repealed
Exhibit K.	Repealed
Exhibit L.	Repealed
Table 1.	Repealed
Table 2.	Repealed
Table 3.	Repealed
Table 4.	Repealed
Table 5.	Repealed
Table 6.	Repealed
Table 7.	Repealed
Exhibit M.	Repealed
Table 1.	Repealed
Table 2.	Repealed
Table 3.	Repealed
Table 4.	Repealed
Table 5.	Repealed
Table 6.	Repealed

**ARTICLE 2. STATE RETIREMENT DEFINED
CONTRIBUTION PROGRAM**

Article 2, consisting of R2-8-201 through R2-8-207, made by final rulemaking at 10 A.A.R. 1962, effective May 4, 2004 (Supp. 04-2).

Section	
R2-8-201.	Definitions
R2-8-202.	Expired
R2-8-203.	Expired
R2-8-204.	Expired
R2-8-205.	Expired
R2-8-206.	Expired
R2-8-207.	Return of Contributions

ARTICLE 3. RESERVED

ARTICLE 4. PRACTICE AND PROCEDURE BEFORE THE BOARD

Article 4, consisting of R2-8-401 through R2-8-405, made by final rulemaking at 11 A.A.R. 444, effective January 4, 2005 (Supp. 05-1).

Section

- R2-8-401. Definitions
- R2-8-402. General Procedures
- R2-8-403. Request for a Hearing of an Appealable Agency Action
- R2-8-404. Board Decisions on Hearings before the Office of Administrative Hearings
- R2-8-405. Rehearing; Review of a Final Decision

ARTICLE 5. PURCHASING SERVICE CREDIT

Article 5, consisting of R2-8-501 through R2-8-521, made by final rulemaking at 11 A.A.R. 2640, effective June 30, 2005 (Supp. 05-2).

- R2-8-501. Definitions
- R2-8-502. Request to Purchase Service Credit and Notification of Cost
- R2-8-503. Requirements Applicable to All Service Credit Purchases
- R2-8-504. Service Credit Calculation for Purchasing Service Credit
- R2-8-505. Restrictions on Purchasing Overlapping Service Credit; Transfers
- R2-8-506. Cost Calculation for Purchasing Service Credit
- R2-8-507. Required Documentation and Calculations for Forfeited Service Credit
- R2-8-508. Required Documentation and Calculations for Leave of Absence Service Credit
- R2-8-509. Required Documentation and Calculations for Military Service Credit
- R2-8-510. Required Documentation and Calculations for Presidential Call-up Service Credit
- R2-8-511. Required Documentation and Calculations for Other Public Service Credit
- R2-8-512. Purchasing Service Credit by Check, Cashier's Check, or Money Order
- R2-8-513. Purchasing Service Credit by Irrevocable Payroll Deduction Authorization
- R2-8-513.01. Irrevocable Payroll Deduction Authorization and Transfer of Employment to a Different ASRS Employer
- R2-8-513.02. Termination Date
- R2-8-514. Purchasing Service Credit by Direct Rollover
- R2-8-515. Purchasing Service Credit by Trustee-to-Trustee Transfer
- R2-8-516. Purchasing Service Credit by Indirect IRA Rollover
- R2-8-517. Purchasing Service Credit by Distributed Rollover Contribution
- R2-8-518. Repealed
- R2-8-519. Purchasing Service Credit by Termination Pay Distribution
- R2-8-520. Termination of Employment and Request Return of Retirement Contributions or Death of Member While Purchasing Service Credit by an Irrevocable Payroll Deduction Authorization
- R2-8-521. Adjustment of Errors

ARTICLE 6. PUBLIC PARTICIPATION IN RULEMAKING

Article 6, consisting of R2-8-601 through R2-8-607, made by final rulemaking at 12 A.A.R. 964, effective March 7, 2006 (Supp. 06-1).

Section

- R2-8-601. Definitions
- R2-8-602. Reviewing Agency Rulemaking Record and Directory of Substantive Policy Statements
- R2-8-603. Petition for Rulemaking
- R2-8-604. Review of a Rule, Agency Practice, or Substantive Policy Statement
- R2-8-605. Objection to Rule Based Upon Economic, Small Business, and Consumer Impact
- R2-8-606. Oral Proceedings
- R2-8-607. Petition for Delayed Effective Date

ARTICLE 7. CONTRIBUTIONS NOT WITHHELD

Article 7, consisting of R2-8-701 through R2-8-709, made by final rulemaking at 12 A.A.R. 4793, effective December 5, 2006 (Supp. 06-4).

Section

- R2-8-701. Definitions
- R2-8-702. General Information
- R2-8-703. ASRS Employer's Discovery of Error
- R2-8-704. Member's Discovery of Error
- R2-8-705. ASRS' Discovery of Error
- R2-8-706. Determination of Contributions Not Withheld
- R2-8-707. Submission of Payment
- R2-8-708. Dispute of an ASRS Determination Regarding Contributions Not Withheld
- R2-8-709. Nonpayment of Contributions

ARTICLE 1. RETIREMENT SYSTEM; DEFINED BENEFIT PLAN**R2-8-101. Repealed****Historical Note**

Former Rule, Social Security Regulation 1; Former Section R2-8-01 renumbered as Section R2-8-101 without change effective May 21, 1982 (Supp. 82-3). Amended subsections (A) and (C) effective April 12, 1984 (Supp. 84-2). Section repealed by final rulemaking at 10 A.A.R. 669, effective February 3, 2004 (Supp. 04-1).

R2-8-102. Repealed**Historical Note**

Former Rule, Social Security Regulation 2; Amended effective April 15, 1980 (Supp. 80-2). Former Section R2-8-02 renumbered as Section R2-8-102 without change effective May 21, 1982 (Supp. 82-3). Amended as an emergency by adding subsection (E) effective January 1, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Emergency expired. Permanent rule, subsections (A), (B), and (D), amended effective April 12, 1984 (Supp. 84-2). Correction, subsection (B), as amended effective April 12, 1984 (Supp. 84-3). Section repealed by final rulemaking at 10 A.A.R. 669, effective February 3, 2004 (Supp. 04-1).

R2-8-103. Repealed**Historical Note**

Former Rule, Social Security Regulation 3; Amended effective April 15, 1980 (Supp. 80-2). Former Section R2-8-03 renumbered as Section R2-8-103 without change

effective May 21, 1982 (Supp. 82-3). Amended as an emergency by adding subsection (E) effective January 1, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Emergency expired. Permanent rule, subsections (A) thru (C), amended effective April 12, 1984 (Supp. 84-2). Section repealed by final rulemaking at 10 A.A.R. 669, effective February 3, 2004 (Supp. 04-1).

R2-8-104. Definitions

- A.** Proprietary functions: Services performed in a single proprietary function for a political subdivision are those services normally carried on by private enterprises. These include, but are not limited to, municipal water departments, municipal transportation departments, municipal housing and airport authorities. For other political subdivisions such as school districts, these functions include cafeteria workers and bookstore employees. School district bus drivers engaged in transporting students without charge are not engaged in a proprietary function. Hospitals operated for the care of the indigent sick by political subdivisions constitute a governmental function, and the employees in such a hospital, therefore, are not performing services in proprietary functions.
- B.** Who are employees:
 - 1. Every individual is an employee if the political subdivision for which he performs services has the right to control and direct him not only as to what shall be done but how it shall be done. It is not necessary that the political subdivision actually control or direct the manner in which the services are performed; it is sufficient if the subdivision has the right to do so. The right to discharge strongly implies the right to control.
 - 2. Officers of a political subdivision are its employees. So are any individuals performing services under contract in the exercise of a governmental function. Individuals such as physicians, dentists, and lawyers, engaged in an independent profession in which they offer their services to the public, are employees if their services include the exercise of a governmental function. If not, they may or may not be employees depending upon the degree to which they are subject to control by the political subdivision.
 - 3. Whether the individual is an employee depends upon the actual facts of his relationship with the political subdivision. A juror is not an employee since he is not a public officer and is not subject to control as to how he votes on a verdict. A physician who contracts with a county Board of Supervisors to furnish medical services to the indigent sick is an employee when the duty of caring for indigent sick is by law placed in the Board.
- C.** Mandatory exclusion: Prior to the 1967 Social Security Amendments, the state had the option of excluding emergency services. Beginning January 1, 1968, services performed by an individual as an employee serving on a temporary basis in case of fire, storm, snow, earthquake, flood, or other similar emergency are mandatorily excluded. This mandatory exclusion is applicable to services for groups already covered as well as to services for groups which may be covered in the future.
- D.** Elective positions: Elective positions as used in agreements excluding such positions from coverage means those positions filled by a vote of a legislative body, a board or committee, or by the qualified electorate at large for the subdivision or instrumentality covered by the agreement, which would constitute an election under the law of Arizona.
- E.** Class or classes of part-time positions: Services performed in a position which does not require more than 150 hours of service in a calendar quarter are services in a part-time position. If a position is established during a calendar quarter and if such position would require more than 150 hours of service if it had been in existence for the entire quarter, such position would not be a part-time position and services in such a position would not be excluded under the state's definition. The time requirements of the position itself, and not the number of hours worked by an individual, is the determinative factor. For example, an individual may be employed and compensated for only a few hours in only one day of a calendar quarter and such individual may be subject to coverage if the position is one which requires more than 150 hours of service.
- F.** Class or classes of positions the compensation for which is on a fee basis:
 - 1. Compensation is considered to be on a salary basis when the payments are made at regular and fixed intervals based on services for definite and regular periods of time; and on a fee basis when made for particular services rendered at irregular and uncertain periods. Persons performing personal services of a governmental nature for a political subdivision are employees regardless of whether compensation is on a salary or fee basis. The services of such a person may be excluded, however, if compensated on a fee rather than a salary basis and the agreement between the Arizona State Retirement System Board and the subdivision excludes positions on a fee basis.
 - 2. Individuals performing governmental services in the practice of their profession, such as doctors or lawyers, may be on either a fee or salary basis depending on the nature of their contract of employment with the political subdivision. For example, a city attorney working full time for a regular monthly salary is not on a fee basis. An attorney employed by the city for special services to be rendered at irregular and uncertain periods for a fixed amount (even though weekly, monthly or other partial advances may be made) is compensated on a fee basis. When, as with some justices of the peace or tax collectors, the compensation is derived in part from fees and part from salary, the position is to be considered as on a fee basis if fees constitute the primary source of compensation. The fees may be received from either the public or the political subdivision. If the fee-basis exclusion is taken and if the position is a fee-basis position, all fees and salary received for services in such a position are not to be reported. If the exclusion is not exercised, all fees received, whether from the political subdivision or other sources, are to be reported.
 - 3. Beginning January 1, 1968, services performed by state and local employees in positions compensated solely by fees, which are not covered under an agreement, are compulsorily covered as self-employment. However, an individual occupying such a fee-basis position in 1968 could elect not to have his fees covered as self-employment income, if he filed a certificate of election of exemption with the Internal Revenue Service on or before the due date of his 1968 federal income tax return.
 - 4. An entity may modify its agreement to extend coverage to services performed after 1967 in any class or classes of positions compensated solely by fees not covered under an agreement prior to 1968. However, the entity must specifically include such services where this coverage is desired. Such coverage shall be effective with respect to services in such fee-basis positions performed beginning with the first day of the year after the year in which the agreement is approved.
 - 5. An entity may at any time after 1967 modify its agreement to exclude services performed in any class or classes of positions compensated solely by fees. Such an

exclusion from coverage is effective the first day of the year following the year in which the agreement is approved. If any class or classes of positions are so excluded, the entity cannot at a later date modify its agreement to again cover the services.

G. Exclusion by class or classes of positions:

1. Basic classifications may be made within either elective, part-time, or fee-basis positions according to a class or classes of positions having common characteristics or attributes, and exclusions limited to such classes. A class of positions includes all of the positions in the coverage group which have these common characteristics. Services in one or more classes or combinations of classes may be excluded. Positions may be excluded in one class and covered in another. For example, in a coverage group there may be excluded services in all elective positions or the exclusion could be limited to services in all elective positions except elective judicial positions and except part-time elective positions.
2. Positions in a single organizational unit of the coverage group do not constitute a class of positions. Therefore, while all of the part-time maintenance workers of a county could be excluded under the part-time option, the exclusion could not be limited to all or any class or part-time maintenance workers in the Office of the County Clerk, which is an organizational unit of the county.

H. Agricultural labor which would be excluded if performed for a private employer:

1. Under the federal Social Security Act, when the agricultural exclusion has been taken, tests as to services which are excluded should be applied to all reports covering reporting quarters beginning on or after January 1, 1957. Cash remuneration paid to an employee for agricultural services should be reported only if:
 - a. Such remuneration paid the employee during a calendar year (even though part of it was for services performed in a previous calendar year) amounts to \$150 or more; or
 - b. The employee performs agricultural services for the employer on some part of a day on at least 20 days during a calendar year for cash remuneration computed on a time basis, as by the hour, day, or week; in which event the amount of cash remuneration is immaterial in determining if the services are covered.
2. Services performed by individuals lawfully admitted from any foreign country on a temporary basis to perform agricultural labor are excluded.

I. Student service exclusion: Only those student services which would be mandatorily excluded if performed for a private employer fall within this exclusion. Where this exclusion is taken, the following services are not covered:

1. Services performed by a student regularly enrolled and attending classes in the employ of his school, college, or university. This means the employing entity and not necessarily the individual institution. The exclusion applies only during periods of regular school attendance. Thus, the exclusion does not apply to work done during summer vacation unless the student is attending a summer session. This is true even though the student was enrolled and regularly attending classes in the school during the previous year and expects to return to school the following year. Services performed on holidays and weekends falling within the academic year when classes are not scheduled, on the other hand, are excluded.

2. Services performed as a student nurse in the employ of a hospital or nurses' training school by an individual who is enrolled and regularly attending classes in a nurses' training school chartered or approved pursuant to state law. It is not necessary that the nurses' training school in which the student nurse is enrolled and attending classes be located within the approving state as long as the school meets the educational standards established by state law for the approval of schools within the state.

J. Services performed by election officials or election workers if remuneration paid in a calendar quarter is less than \$50:

1. Prior to the 1967 amendments to the Social Security Act, there was no provision for a specific exclusion of the services of election officials or election workers. The exclusion of such services was possible, however, by exclusion of a class of services for which an exclusion was permitted, i.e., exclusion of election officials and election workers as a class of part-time or fee-basis positions.
2. This optional exclusion of services performed by election officials or election workers is dependent on the amount paid in a calendar quarter for such services, e.g., if the remuneration paid in the third calendar quarter of a year amounts to \$50 or more, the services are covered and must be reported regardless of the fact that the remuneration paid in any other calendar quarter for election officials' or election workers' services amount to \$49.99 or less and is not reportable.
3. These services may continue to be excluded as a class of part-time or fee-basis positions without regard to the amount paid for such services. These services would, of course, be excluded already if a part-time or fee-basis position exclusion in broad enough terms was previously exercised. The purpose of the optional exclusion of services performed by election officials or election workers if remuneration in a calendar quarter is less than \$50 is to permit the exclusion to be taken where one was not previously taken. The effective date of exclusion for these services may not be earlier than the last day of the calendar quarter in which the modification to state's Social Security agreement is mailed to the Secretary of Health and Human Services.
4. On or after January 1, 1978, a political entity can modify its agreement to specifically exclude the services of election officials or election workers if the remuneration paid in a calendar year is less than \$100. A change to \$100 in a year from \$50 in a calendar quarter requires the execution of a new modification. For modification executed after December 31, 1977, the \$100 in a year test must be used.

K. "Wages" -- (A.R.S. § 38-701(8)) means all remuneration paid to employees whose services are covered under an agreement in a calendar year not in excess of the maximum reportable wages on which social security contributions are due.

1. Wages include the cash value of remuneration paid to employees other than money, for example, the value of room and board. The valuation of room and board furnished an employee by a political entity shall be computed at the same valuation as computed by the Industrial Commission for payment of workmen's compensation premiums.
2. If, as a part of the employment, it is understood that the employee is entitled to meals and the employer is to furnish them, the value of such meals is wages and should be reported. If there is no understanding (either orally or in writing) that meals will be furnished the employee, but they are in fact provided, the value of the meals would be wages if it is substantial. The value of meals may be con-

sidered as not substantial if it is less than five percent of the cash pay.

3. The employer's report of wages paid for each calendar quarter to the Arizona State Retirement System Board shall include for each employee both the cash wages and the value of room and board as a lump sum for the quarter for which the report is made.
4. The employee tax shall be deducted from the wages paid in accordance with the method of including the value of remuneration paid in any medium other than cash in each pay period or in a single pay period in the calendar quarter.
5. The value of meals and lodging furnished by, or on behalf of an employer to an employee, the employee's spouse, or any of the employee's dependents is not wages for Social Security purposes if:
 - a. The meals or lodging are furnished on the business premises of the employer, and
 - b. The meals or lodging are furnished for the convenience of the employer, and
 - c. The employee is required to accept such lodging as a condition of employment.

Historical Note

Former Rule, Social Security Regulation 4; Former Section R2-8-04 renumbered as Section R2-8-104 without change effective May 21, 1982 (Supp. 82-3). Amended subsections (G), (J), and (K) effective April 12, 1984 (Supp. 84-2). Typographical error corrected in subsection (5)(c) "required" corrected to "required" (Supp. 97-1).

R2-8-105. Repealed

Historical Note

Former Rule, Social Security Regulation 5; Amended effective April 15, 1980 (Supp. 80-2). Former Section R2-8-05 renumbered as Section R2-8-105 without change effective May 21, 1982 (Supp. 82-3). Amended as an emergency by adding subsection (E) effective January 1, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Emergency expired. Permanent rule amended effective April 12, 1984 (Supp. 84-2). Section repealed by final rulemaking at 10 A.A.R. 669, effective February 3, 2004 (Supp. 04-1).

R2-8-106. Reserved

R2-8-107. Reserved

R2-8-108. Reserved

R2-8-109. Reserved

R2-8-110. Reserved

R2-8-111. Reserved

R2-8-112. Reserved

R2-8-113. Emergency Expired

Historical Note

New Section made by emergency rulemaking at 11 A.A.R. 579, effective January 4, 2005 (05-1). Emergency rule expired (Supp. 05-2).

R2-8-114. Emergency Expired

Historical Note

New Section made by emergency rulemaking at 11 A.A.R. 579, effective January 4, 2005 (05-1). Emergency rule expired (Supp. 05-2).

R2-8-115. Return of Contributions Upon Termination of Membership by Separation from All ASRS Employment by Other Than Retirement or Death; Payment of Survivor Benefits Upon the Death of a Member

- A.** The following definitions apply to this Section unless otherwise specified:
1. "ASRS" means the same as in A.R.S. § 38-711.
 2. "ASRS employer" has the same meaning as "employer" in A.R.S. § 38-711.
 3. "Authorized employer representative" means an individual specified by the ASRS employer to provide the ASRS with information about a member who previously worked for the ASRS employer.
 4. "Beneficiary" means the individual specified by a member to receive the balance of the member's account or, if applicable, selected benefits upon the death of the member.
 5. "Contribution" means:
 - a. Amounts required by A.R.S. Title 38, Chapter 5, Article 2 to be paid to ASRS by a member or an employer on behalf of a member other than amounts attributed to the long-term disability program;
 - b. Any voluntary amounts paid by a System member to ASRS to be placed in the System member's account; and
 - c. Any amount credited to a non-retired System member's employer account or to a retired System member's non-guaranteed benefit as determined by Section 24(B) of Arizona Session Laws 1995, Chapter 32, Section 24, as amended by Arizona Session Laws 1999, Chapter 66, Section 1.
 6. "Court" means a superior, appellate, or the Supreme court of this state, a corresponding court of another state of the United States, or a federal court of the United States.
 7. "Designated beneficiary" has the same meaning as in A.R.S. § 38-762(H).
 8. "Domestic relations order" has the same meaning as in A.R.S. § 38-773(G).
 9. "Eligible retirement plan" has the same meaning as in A.R.S. § 38-770(C)(3).
 10. "Employer number" means a unique identifier the ASRS assigns to a member employer.
 11. "Employer plan" means the types of eligible retirement plans specified in A.R.S. § 38-770(C)(3)(c), (d), (e), and (f).
 12. "Fiscal year" means July 1 of one year to June 30 of the next year.
 13. "Individual retirement account" means the types of eligible retirement plans specified in A.R.S. § 38-770(C)(3)(a) and (b).
 14. "Lump-sum payment" means a member receives the total amount in the member's ASRS account to which the member is entitled by law.
 15. "Member" has the same meaning as in A.R.S. § 38-711.
 16. "Personal representative" means a person who is authorized by law to represent the estate of a deceased individual.
 17. "Process date" means the calendar day the ASRS generates contribution withdrawal documents to be sent to a member.
 18. "Service year" has the same meaning as in A.R.S. § 38-711.
 19. "System" means the same as "defined contribution plan" as defined in A.R.S. § 38-769, and which is administered by the ASRS.

20. "Terminate employment" means to end the employment relationship between a member and an ASRS employer with the intent that the member not return to employment with that ASRS employer.
 21. "Trustee" means an individual who holds monetary assets in an eligible retirement plan under the Internal Revenue Code for the benefit of the member.
 22. "United States" means the same as in A.R.S. § 1-215.
 23. "Warrant" means a voucher authorizing payment of funds due to a member.
- B.** A member who terminates from all ASRS employment by other than retirement or death and desires a return of the member's contributions, including amounts received for the purchase of service, any employer contributions authorized under A.R.S. § 38-740, and interest on the contributions, shall request from the ASRS, in writing or verbally, the documents necessary to apply for the withdrawal of the member's contributions.
- C.** Upon receipt of the request, the ASRS shall provide the member with:
1. An Application for Withdrawal of Contributions and Termination of Membership form,
 2. An Ending Payroll Verification – Withdrawal of Contribution and Termination of Membership form, and
 3. The process date.
- D.** The member shall complete and return to the ASRS the Application for Withdrawal of Contributions and Termination of Membership form that includes the following information:
1. The member's full name;
 2. The member's Social Security number;
 3. The member's current mailing address;
 4. The member's daytime telephone number, if applicable;
 5. The member's birth date;
 6. The date of termination;
 7. Dated signature of the member certifying that the member:
 - a. Is no longer employed by any ASRS employer;
 - b. Is neither under contract nor has any verbal or written agreement for future employment with an ASRS employer;
 - c. Is not currently in a leave of absence status with an ASRS employer;
 - d. Understands that each of the member's former ASRS employers' payroll departments will complete a payroll verification form if payroll transactions occurred with the ASRS employer within the six months before the process date;
 - e. Has read and understands the Special Tax Notice Regarding Plan Payments the member received with the application;
 - f. Understands that the member is forfeiting all future retirement rights and privileges of membership with the ASRS;
 - g. Understands that long-term disability benefits will be canceled if the member elects to withdraw contributions while receiving or electing to receive long-term disability benefits;
 - h. Understands that if the member elects to roll over all or any portion of the member's distribution to another employer plan, it is the member's responsibility to verify that the receiving employer plan will accept the rollover and, if applicable, agree to separately account for the pre-tax and post-tax amounts rolled over and the related subsequent earnings on the amounts;
 - i. Understands that if the member elects to roll over all or any portion of the member's distribution to an individual retirement account, it is the member's responsibility to separately account for pre-tax and post-tax amounts; and
 - j. Understands that if the member elects a rollover to another employer plan or individual retirement account, any portion of the distribution not designated for rollover will be paid directly to the member and any taxable amounts will be subject to 20% federal income tax withholding and 5% state tax withholding;
8. Specify that:
- a. The entire amount of the distribution be paid directly to the member,
 - b. The entire amount of the distribution be transferred to an eligible retirement plan, or
 - c. An identified amount of the distribution be transferred to an eligible retirement plan and the remaining amount be paid directly to the member; and
9. If the member selects all or a portion of the withdrawal be paid to an eligible retirement plan, specify:
- a. The type of eligible retirement plan;
 - b. The eligible retirement plan account number, if applicable; and
 - c. The name and mailing address of the eligible retirement plan.
- E.** If a payroll transaction for the member occurred with any ASRS employer within six months before the process date the member shall complete and return to the ASRS an Ending Payroll Verification – Withdrawal of Contributions and Termination of Membership form for each ASRS employer that includes the following information:
1. Filled out by the member:
 - a. The member's full name, and
 - b. The member's Social Security number; and
 2. Filled out by each ASRS employer:
 - a. The member's termination date,
 - b. The member's final pay period ending date;
 - c. The final amount of contributions, including any adjustments or corrections, but not including any long-term disability contributions,
 - d. The ASRS employer's name and telephone number;
 - e. The employer number;
 - f. The name and title of the authorized employer representative;
 - g. Certification by the authorized employer representative that:
 - i. The member terminated employment and is neither under contract nor bound by any verbal or written agreement for employment with the employer;
 - ii. There is no agreement to re-employ the member; and
 - iii. The authorized employer representative has the legal power to bind the employer in transactions with the ASRS; and
 - h. The signature of the authorized employer representative and date of signature.
- F.** If the member requests a return of contributions and a warrant is distributed during the fiscal year that the member began membership in the ASRS, no interest is paid to the account of the member.
- G.** If the member requests a return of contributions after the first fiscal year of membership, ASRS shall credit interest at the rate specified in Column 3 of the table in R2-8-118(B) to the

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account of the member as of June 30 of each year, on the basis of the balance in the account of the member as of the previous June 30. The ASRS shall credit interest for a partial fiscal year of membership in the ASRS on the previous June 30 balance based on the number of days of membership up to and including the day the ASRS issues the warrant divided by the total number days in the fiscal year. Contributions made after the previous June 30 are returned without interest.

- H. Upon submitting to the ASRS the completed and accurate Application for Withdrawal of Contributions and Termination of Membership form and, if applicable, any Ending Payroll Verification – Withdrawal of Contributions and Termination of Membership forms, a member is entitled to payment of the amount due to the member as specified in subsection (F) or (G) unless a present or former spouse submits to the ASRS a domestic relations order that specifies entitlement to all or part of the return of contributions under A.R.S. § 38-773 before the ASRS returns the contributions as specified by the member.
- I. Upon death of a member, the ASRS shall provide survivor benefits based on the deceased member's last dated, written designation of beneficiary that is on file with the ASRS before the date of the member's death.
- J. If there is no designation of beneficiary or if the designated beneficiary predeceases the member, the survivor benefit is paid as specified in A.R.S. § 38-762(F). The designated beneficiary or other person specified in A.R.S. § 38-762(F) shall:
 - 1. Provide a certified copy of a death certificate or a certified copy of a court order that establishes the member's death;
 - 2. Provide a certified copy of the court order of appointment as administrator, if applicable; and
 - 3. Except if the deceased member was retired and elected the joint and survivor option, complete and have notarized an application for survivor benefits, provided by the ASRS, that includes:
 - a. The deceased member's full name,
 - b. The deceased member's Social Security number,
 - c. The following, as it pertains to the designated beneficiary or other person specified in A.R.S. § 38-762(F):
 - i. Full name;
 - ii. Mailing address;

- iii. Contact telephone number;
- iv. Date of birth, if applicable; and
- v. Social Security number or Tax ID number, if applicable.

Historical Note

Former Rule, Social Security Regulation 1; Amended effective Dec. 20, 1979 (Supp. 79-6). Former Section R2-8-15 renumbered as Section R2-8-115 without change effective May 21, 1982 (Supp. 82-3). Amended by final rulemaking at 11 A.A.R. 1416, effective April 5, 2005 (Supp. 05-2). Amended by final rulemaking at 12 A.A.R. 644, effective February 7, 2006 (Supp. 06-1).

R2-8-116. Expired

Historical Note

Former Rule, Retirement System Regulation 2; Former Section R2-8-16 renumbered as Section R2-8-116 without change effective May 21, 1982 (Supp. 82-3). Section expired under A.R.S. § 41-1056(E) at 16 A.A.R. 1765, effective July 14, 2010 (Supp. 10-3).

R2-8-117. Repealed

Historical Note

Former Rule, Retirement System Regulation 3; Former Section R2-8-17 renumbered as Section R2-8-117 without change effective May 21, 1982 (Supp. 82-3). Section repealed by final rulemaking at 11 A.A.R. 2640, effective June 30, 2005 (Supp. 05-2).

R2-8-118. Application of Interest Rates

- A. The following definitions apply to this Section unless otherwise specified:
 - 1. "ASRS" means the same as in A.R.S. § 38-711.
 - 2. "Member" has the same meaning as in A.R.S. § 38-711.
 - 3. "Plan" means the same as "defined benefit plan" in A.R.S. § 38-769, and administered by the ASRS.
 - 4. "System" means the same as "defined contribution plan" as defined in A.R.S. § 38-769, and that is administered by the ASRS.
- B. Application of interest from inception of the ASRS through the present is as follows:

Effective Date of Interest Rate Change	Assumed Actuarial Interest and Investment Yield Rate	Interest Rate Used to Determine Return of Contributions Upon Termination of Membership by Separation from Service by Other Than Retirement or Death		Interest Rate Used to Determine Survivor Benefits
7-1-1953	2.50%	2.50%		2.50%
7-1-1959	3.00%	3.00%		3.00%
7-1-1966	3.75%	3.75%		3.75%
7-1-1969	4.25%	4.25%		4.25%
7-1-1971	4.75%	4.75%		4.75%
7-1-1975	5.50%	5.50%		5.50%
7-1-1976	6.00%	5.50%		6.00%
7-1-1981	7.00%	5.50%		7.00%
7-1-1982	7.00%	7.00%		7.00%
7-1-1984	8.00%	8.00%		8.00%
7-1-2005	8.00%	4.00% for Plan Members	8.00% for System Members	8.00%

- C. At the beginning of each fiscal year interest is credited to the retirement account of each member on the June 30 that marks the end of the fiscal year based on the balance in the member's

account as of the previous June 30. The balance on which interest is credited includes:

- 1. Employer and employee contributions;

2. Voluntary additional contributions made by System members, if applicable;
3. Amounts credited by transfer under A.R.S. § 38-922;
4. Amounts credited to a non-retired system member's employer account or to a retired System member's non-guaranteed benefit as determined by Article 2 of this Chapter; and
5. Interest credited in previous years.

Historical Note

Former Rule, Retirement System Regulation 4; Amended effective July 1, 1975 (Supp. 75-1). Amended effective June 23, 1976 (Supp. 76-3). Former Section R2-8-18 renumbered and amended as Section R2-8-118 effective May 21, 1982 (Supp. 82-3). Amended by final rulemaking at 11 A.A.R. 1416, effective April 5, 2005 (Supp. 05-2).

R2-8-119. Expired**Historical Note**

Former Rule, Retirement System Regulation 5; Amended effective July 1, 1975 (Supp. 75-1). Amended effective June 23, 1976 (Supp. 76-3). Former Section R2-8-19 renumbered and amended as Section R2-8-119 effective May 21, 1982 (Supp. 82-3). Section R2-8-119 and Appendix A and B expired under A.R.S. § 41-1056(E) at 16 A.A.R. 1765, effective July 14, 2010 (Supp. 10-3).

R2-8-120. Repealed**Historical Note**

Former Rule, Social Security Regulation 6; Amended effective June 19, 1975 (Supp. 75-1). Amended effective July 13, 1979 (Supp. 79-4). Former Section R2-8-20 renumbered and amended as Section R2-8-120 effective May 21, 1982 (Supp. 82-3). Repealed effective July 24, 1985 (Supp. 85-4).

R2-8-121. Repealed**Historical Note**

Former Rule, Retirement System Regulation 7; Amended effective April 15, 1980 (Supp. 80-2). Former Section R2-8-21 renumbered as Section R2-8-121 without change effective May 21, 1982 (Supp. 82-3). Amended subsection (A) effective May 30, 1985 (Supp. 85-3). Section repealed by final rulemaking at 11 A.A.R. 444, effective January 4, 2005 (05-1).

R2-8-122. Remittance of contributions

- A.** Remittance of employee member contributions: Each state department and employer member of the Arizona State Retirement System, including, without limitation, any county, municipality or political subdivision, shall certify on each payroll the amount to be contributed by each one of their employee members of the Arizona State Retirement System and shall remit the amount of employee member contributions to the Arizona State Retirement System, together with such detailed report as may be required by the System to identify the individual owner of each such member contribution, not later than 14 calendar days after the last day of each payroll period. Payments of employee member contributions not received in the offices of the Arizona State Retirement System by the 14th calendar day after the last day of the applicable payroll period shall become delinquent after that date and shall be increased, by interest at the rate of eight percent per annum from and after the date of delinquency until payment is received by the Arizona State Retirement System.

- B.** Remittance of employer contributions: Each state department and employer member of the Arizona State Retirement System, including, without limitation, any county, municipality or political subdivision, shall remit the amount of employer contributions to the Arizona State Retirement System not later than 14 calendar days after the last day of each payroll period. Payments of employer contributions not received in the offices of the Arizona State Retirement System by the 14th calendar day after the last day of the applicable payroll period shall become delinquent after that date and shall be increased, by interest at the rate of eight percent per annum from and after the date of delinquency until payment is received by the Arizona State Retirement System.

Historical Note

Former Rule, Retirement System Regulation 8; Amended effective Dec. 8, 1978 (Supp. 78-6). Former Section R2-8-22 renumbered as Section R2-8-122 without change effective May 21, 1982 (Supp. 82-3).

R2-8-123. Expired**Historical Note**

Adopted effective July 1, 1975 (Supp. 75-1). Amended effective June 23, 1976 (Supp. 76-3). Amended effective December 20, 1977 (Supp. 77-6). Former Section R2-8-23 renumbered and amended as Section R2-8-123 effective May 21, 1982 (Supp. 82-3). Emergency amendments effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Emergency amendments adopted again effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Permanent amendments adopted effective December 22, 1993 (Supp. 93-4). Emergency amendments adopted effective January 30, 1997, pursuant to A.R.S. § 41-1026 for a maximum of 180 days (Supp. 97-1). Emergency expired. Permanent amendments adopted effective September 12, 1997 (Supp. 97-3). Amended by emergency rulemaking under A.R.S. § 41-1026 at 9 A.A.R. 1006, effective February 24, 2003 for a period of 180 days (Supp. 03-1). Emergency rulemaking renewed at 9 A.A.R. 3963, effective August 21, 2003 for a period of 180 days (Supp. 03-3). Amended by final rulemaking at 9 A.A.R. 4614, effective December 6, 2003 (Supp. 03-4). Amended by emergency rulemaking under A.R.S. § 41-1026 at 10 A.A.R. 2496, effective August 2, 2004 for 180 days (Supp. 04-2). Amended by final rulemaking at 10 A.A.R. 4012, effective November 13, 2004 (Supp. 04-3). Section expired under A.R.S. § 41-1056(E) at 16 A.A.R. 1765, effective July 14, 2010 (Supp. 10-3).

Table 1. Expired**Historical Note**

Emergency adoption effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Emergency rule adopted again effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Permanent rule adopted effective December 22, 1993 (Supp. 93-4). Emergency amendments to Table 1 adopted effective January 30, 1997, pursuant to A.R.S. § 41-1026 for a maximum of 180 days (Supp. 97-1). Emergency expired. Permanent amendments adopted effective September 12, 1997 (Supp. 97-3). Amended by emergency rulemaking under A.R.S. § 41-1026 at 10 A.A.R. 2496, effective August 2, 2004 for 180 days (Supp. 04-2). Amended by final rulemaking at 10 A.A.R. 4012, effective November 13,

2004 (Supp. 04-3). Table expired under A.R.S. § 41-1056(E) at 16 A.A.R. 1765, effective July 14, 2010 (Supp. 10-3).

Table 2. Expired

Historical Note

Emergency adoption effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Emergency rule adopted again effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Permanent rule adopted effective December 22, 1993 (Supp. 93-4). Emergency amendments to Table 2 adopted effective January 30, 1997, pursuant to A.R.S. § 41-1026 for a maximum of 180 days (Supp. 97-1). Emergency expired. Permanent amendments adopted effective September 12, 1997 (Supp. 97-3). Amended by emergency rulemaking under A.R.S. § 41-1026 at 10 A.A.R. 2496, effective August 2, 2004 for 180 days (Supp. 04-2). Amended by final rulemaking at 10 A.A.R. 4012, effective November 13, 2004 (Supp. 04-3). Table expired under A.R.S. § 41-1056(E) at 16 A.A.R. 1765, effective July 14, 2010 (Supp. 10-3).

Table 3. Repealed

Historical Note

Emergency adoption effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Emergency rule adopted again effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Permanent rule adopted effective December 22, 1993 (Supp. 93-4). Emergency amendments to Table 3 adopted effective January 30, 1997, pursuant to A.R.S. § 41-1026 for a maximum of 180 days (Supp. 97-1). Emergency expired. Permanent amendments adopted effective September 12, 1997 (Supp. 97-3). Table 3 repealed; new Table 3 renumbered from Table 4 by final rulemaking at 9 A.A.R. 4614, effective December 6, 2003 (Supp. 03-4). Table repealed by emergency rulemaking under A.R.S. § 41-1026 at 10 A.A.R. 2496, effective August 2, 2004 for 180 days (Supp. 04-2). Table repealed by final rulemaking at 10 A.A.R. 4012, effective November 13, 2004 (Supp. 04-3).

Table 3A. Expired

Historical Note

New Table made by emergency rulemaking under A.R.S. § 41-1026 at 10 A.A.R. 2496, effective August 2, 2004 for 180 days (Supp. 04-2). New Table made by final rulemaking at 10 A.A.R. 4012, effective November 13, 2004 (Supp. 04-3). Table expired under A.R.S. § 41-1056(E) at 16 A.A.R. 1765, effective July 14, 2010 (Supp. 10-3).

Table 3B. Expired

Historical Note

New Table made by emergency rulemaking under A.R.S. § 41-1026 at 10 A.A.R. 2496, effective August 2, 2004 for 180 days (Supp. 04-2). New Table made by final rulemaking at 10 A.A.R. 4012, effective November 13, 2004 (Supp. 04-3). Table expired under A.R.S. § 41-1056(E) at 16 A.A.R. 1765, effective July 14, 2010 (Supp. 10-3).

Table 4. Expired

Historical Note

Emergency adoption effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Emergency rule adopted again effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Permanent rule adopted effective December 22, 1993 (Supp. 93-4). Table 4 renumbered as Table 3 by final rulemaking at 9 A.A.R. 4614, effective December 6, 2003 (Supp. 03-4). New Table made by emergency rulemaking under A.R.S. § 41-1026 at 10 A.A.R. 2496, effective August 2, 2004 for 180 days (Supp. 04-2). New Table made by final rulemaking at 10 A.A.R. 4012, effective November 13, 2004 (Supp. 04-3). Table expired under A.R.S. § 41-1056(E) at 16 A.A.R. 1765, effective July 14, 2010 (Supp. 10-3).

Table 4A. Repealed

Historical Note

New Table made by final rulemaking at 9 A.A.R. 4614, effective December 6, 2003 (Supp. 03-4). Table repealed by emergency rulemaking under A.R.S. § 41-1026 at 10 A.A.R. 2496, effective August 2, 2004 for 180 days (Supp. 04-2). Table repealed by final rulemaking at 10 A.A.R. 4012, effective November 13, 2004 (Supp. 04-3).

Table 4B. Repealed

Historical Note

New Table made by final rulemaking at 9 A.A.R. 4614, effective December 6, 2003 (Supp. 03-4). Table repealed by emergency rulemaking under A.R.S. § 41-1026 at 10 A.A.R. 2496, effective August 2, 2004 for 180 days (Supp. 04-2). Table repealed by final rulemaking at 10 A.A.R. 4012, effective November 13, 2004 (Supp. 04-3).

Table 4C. Repealed

Historical Note

New Table made by final rulemaking at 9 A.A.R. 4614, effective December 6, 2003 (Supp. 03-4). Table repealed by emergency rulemaking under A.R.S. § 41-1026 at 10 A.A.R. 2496, effective August 2, 2004 for 180 days (Supp. 04-2). Table repealed by final rulemaking at 10 A.A.R. 4012, effective November 13, 2004 (Supp. 04-3).

Table 5. Expired

Historical Note

Emergency adoption effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Emergency rule adopted again effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Permanent rule adopted effective December 22, 1993 (Supp. 93-4). Table 5 repealed, new Table 5 adopted by emergency action effective January 30, 1997, pursuant to A.R.S. § 41-1026 for a maximum of 180 days (Supp. 97-1). Emergency expired. Table 5 repealed, new Table 5 adopted by regular rulemaking action effective September 12, 1997 (Supp. 97-3). Table 5 repealed; new Table 5 renumbered from Table 6 and amended by final rulemaking at 9 A.A.R. 4614, effective December 6, 2003 (Supp. 03-4). Table repealed; new Table made by emergency rulemaking under A.R.S. § 41-1026 at 10 A.A.R. 2496, effective August 2, 2004 for 180 days (Supp. 04-2). Former Table 5 renumbered to Table 6; new Table 5 made by final rulemaking at 10 A.A.R. 4012, effective November 13, 2004 (Supp. 04-3). Table

expired under A.R.S. § 41-1056(E) at 16 A.A.R. 1765, effective July 14, 2010 (Supp. 10-3).

Table 6. Expired

Historical Note

Emergency adoption effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Emergency rule adopted again effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Permanent rule adopted effective December 22, 1993 (Supp. 93-4). Table repealed, new Table adopted effective September 12, 1997 (Supp. 97-3). Former Table 6 renumbered to Table 5; new Table 6 renumbered from Table 7 and amended by final rulemaking at 9 A.A.R. 4614, effective December 6, 2003 (Supp. 03-4). Table repealed; new Table made by emergency rulemaking under A.R.S. § 41-1026 at 10 A.A.R. 2496, effective August 2, 2004 for 180 days (Supp. 04-2). Former Table 6 renumbered to Table 7; new Table 6 renumbered from Table 5 and amended by final rulemaking at 10 A.A.R. 4012, effective November 13, 2004 (Supp. 04-3). Table expired under A.R.S. § 41-1056(E) at 16 A.A.R. 1765, effective July 14, 2010 (Supp. 10-3).

Table 7. Expired

Historical Note

Emergency adoption effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Emergency rule adopted again effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Permanent rule adopted effective December 22, 1993 (Supp. 93-4). Table repealed, new Table adopted effective September 12, 1997 (Supp. 97-3). Renumbered to Table 6 by final rulemaking at 9 A.A.R. 4614, effective December 6, 2003 (Supp. 03-4). New Table made by emergency rulemaking under A.R.S. § 41-1026 at 10 A.A.R. 2496, effective August 2, 2004 for 180 days (Supp. 04-2). Table 7 renumbered from Table 6 and amended by final rulemaking at 10 A.A.R. 4012, effective November 13, 2004 (Supp. 04-3). Table expired under A.R.S. § 41-1056(E) at 16 A.A.R. 1765, effective July 14, 2010 (Supp. 10-3).

R2-8-124. Repealed

Historical Note

Adopted as an emergency effective August 25, 1975 (Supp. 75-1). Former Section R2-8-24 renumbered as Section R2-8-124 without change effective May 21, 1982 (Supp. 82-3). Section repealed by final rulemaking at 10 A.A.R. 669, effective February 3, 2004 (Supp. 04-1).

R2-8-125. Repealed

Historical Note

Adopted as an emergency effective July 30, 1975 (Supp. 75-1). Former Section R2-8-25 renumbered as Section R2-8-125 without change effective May 21, 1982 (Supp. 82-3). Section repealed by final rulemaking at 10 A.A.R. 669, effective February 3, 2004 (Supp. 04-1).

R2-8-126. Calculating Benefits

- A. The following definitions apply to this Section unless otherwise specified:
1. "Contingent annuitant" has the same meaning as in A.R.S. § 38-711.
 2. "Life annuity" has the same meaning as in A.R.S. § 38-711.

3. "Member" has the same meaning as in A.R.S. § 38-711.
 4. "Plan" means a "defined benefit plan" under A.R.S. § 38-769 that is administered by the ASRS.
 5. "Prior service" has the same meaning as in A.R.S. § 38-772.
 6. "System" means a "defined contribution plan" as defined under A.R.S. § 38-769 that is administered by the ASRS.
- B. An individual who is 104 years of age or older at the time of retirement and who elects a life annuity is not eligible to select the option of income for five years certain and for life thereafter.
- C. An individual who is 93 years of age or older at the time of retirement and who elects a life annuity is not eligible to select the option of income for ten years certain and for life thereafter.
- D. An individual who is 85 years of age or older at the time of retirement and who elects a life annuity is not eligible to select the option of income for 15 years certain and for life thereafter.
- E. If the life annuity of any Plan member is less than \$20 per month, the ASRS shall not pay the annuity. Instead, the ASRS shall make a lump sum payment in the amount determined by using the appropriate actuarial assumptions in R2-8-123.
- F. The ASRS shall calculate a member's or beneficiary's benefits, based on the attained age of the member or beneficiary, determined in years and full months, as of the effective date of the benefit payment.
- G. The ASRS shall add any prior service benefit that is payable to a member to the life annuity of the member before the ASRS applies any optional payment plan calculation provided for in A.R.S. § 38-760.
- H. A member who is ten or more years older than the member's non-spousal contingent annuitant is not eligible to participate in a 100% joint-and-survivor option. A member who is 24 or more years older than the member's non-spousal contingent annuitant is not eligible to participate in a 66 2/3% joint-and-survivor option.

Historical Note

Adopted effective September 12, 1977 (Supp. 77-5). Amended effective July 13, 1979 (Supp. 79-4). Former Section R2-8-26 renumbered and amended as Section R2-8-126 effective May 21, 1982 (Supp. 82-3). Amended subsections (A) through (D) effective October 18, 1984 (Supp. 84-5). Amended subsections (A) through (D) effective July 24, 1985 (Supp. 85-4). Amended by emergency effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Emergency amendments adopted again effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Permanent rule adopted effective December 22, 1993 (Supp. 93-4). Amended by emergency rulemaking at 7 A.A.R. 1621, effective March 21, 2001 (Supp. 01-1). Amended by emergency rulemaking under A.R.S. § 41-1026 at 10 A.A.R. 2496, effective August 2, 2004 for 180 days (Supp. 04-2). Amended by final rulemaking at 10 A.A.R. 4012, effective November 13, 2004 (Supp. 04-3).

Table 1. Repealed

Historical Note

Adopted effective September 12, 1977 (Supp. 77-5). Table 1 repealed, new Table 1 adopted effective July 24, 1985 (Supp. 85-4). Repealed by emergency effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Repealed again by emergency effective September 29, 1993, pursuant to A.R.S. § 41-

1026, valid for only 90 days (Supp. 93-3). Repealed effective December 22, 1993 (Supp. 93-4).

Table 2. Repealed

Historical Note

Adopted effective September 12, 1977 (Supp. 77-5). Table 2 repealed, new Table 2 adopted effective July 24, 1985 (Supp. 85-4). Repealed by emergency effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Repealed again by emergency effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Repealed effective December 22, 1993 (Supp. 93-4).

Table 3. Repealed

Historical Note

Adopted effective September 12, 1977 (Supp. 77-5). Table 3 repealed, new Table 3 adopted effective July 24, 1985 (Supp. 85-4). Repealed by emergency effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Repealed again by emergency effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Repealed effective December 22, 1993 (Supp. 93-4).

Table 4. Repealed

Historical Note

Adopted effective September 12, 1977 (Supp. 77-5). Table 4 repealed, new Table 4 adopted effective July 24, 1985 (Supp. 85-4). Repealed by emergency effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Repealed again by emergency effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Repealed effective December 22, 1993 (Supp. 93-4).

Table 5. Repealed

Historical Note

Adopted effective September 12, 1977 (Supp. 77-5). Table 5 repealed, new Table 5 adopted effective July 24, 1985 (Supp. 85-4). Repealed by emergency effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Repealed again by emergency effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Repealed effective December 22, 1993 (Supp. 93-4).

Table 6. Repealed

Historical Note

Adopted effective September 12, 1977 (Supp. 77-5). Table 6 repealed, new Table 6 adopted effective July 24, 1985 (Supp. 85-4). Repealed by emergency effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Repealed again by emergency effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Repealed effective December 22, 1993 (Supp. 93-4).

Table 7. Repealed

Historical Note

Adopted effective September 12, 1977 (Supp. 77-5). Table 7 repealed, new Table 7 adopted effective July 24, 1985 (Supp. 85-4). Repealed by emergency effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Repealed again by emergency effective September 29, 1993, pursuant to A.R.S. § 41-

1026, valid for only 90 days (Supp. 93-3). Repealed effective December 22, 1993 (Supp. 93-4).

Table 8. Repealed

Historical Note

Adopted effective September 12, 1977 (Supp. 77-5). Table 8 repealed, new Table 8 adopted effective July 24, 1985 (Supp. 85-4). Repealed by emergency effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Repealed again by emergency effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Repealed effective December 22, 1993 (Supp. 93-4).

Table 9. Repealed

Historical Note

Adopted effective September 12, 1977 (Supp. 77-5). Table 9 repealed, new Table 9 adopted effective July 24, 1985 (Supp. 85-4). Repealed by emergency effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Repealed again by emergency effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Repealed effective December 22, 1993 (Supp. 93-4).

Table 10. Repealed

Historical Note

Adopted effective October 18, 1984 (Supp. 84-5). Table 10 repealed, new Table 10 adopted effective July 24, 1985 (Supp. 85-4). Repealed by emergency effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Repealed again by emergency effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Repealed effective December 22, 1993 (Supp. 93-4).

Table 11. Repealed

Historical Note

Adopted effective October 18, 1984 (Supp. 84-5). Table 11 repealed, new Table 11 adopted effective July 24, 1985 (Supp. 85-4). Repealed by emergency effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Repealed again by emergency effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Repealed effective December 22, 1993 (Supp. 93-4).

Exhibit A. Repealed

Historical Note

Adopted by emergency effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Emergency rule adopted again effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Permanent rule adopted effective December 22, 1993 (Supp. 93-4). Repealed by emergency rulemaking under A.R.S. § 41-1026 at 10 A.A.R. 2496, effective August 2, 2004 for 180 days (Supp. 04-2). Repealed by final rulemaking at 10 A.A.R. 4012, effective November 13, 2004 (Supp. 04-3).

Exhibit B, Table 1. Repealed

Historical Note

Adopted by emergency effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Emergency rule adopted again effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90

A.A.R. 2496, effective August 2, 2004 for 180 days (Supp. 04-2). Repealed by final rulemaking at 10 A.A.R. 4012, effective November 13, 2004 (Supp. 04-3).

Exhibit F, Table 1. Repealed

Historical Note

Adopted by emergency effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Emergency rule adopted again effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Permanent rule adopted effective December 22, 1993 (Supp. 93-4). Repealed by emergency rulemaking under A.R.S. § 41-1026 at 10 A.A.R. 2496, effective August 2, 2004 for 180 days (Supp. 04-2). Repealed by final rulemaking at 10 A.A.R. 4012, effective November 13, 2004 (Supp. 04-3).

Exhibit F, Table 2. Repealed

Historical Note

Adopted by emergency effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Emergency rule adopted again effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Permanent rule adopted effective December 22, 1993 (Supp. 93-4). Repealed by emergency rulemaking under A.R.S. § 41-1026 at 10 A.A.R. 2496, effective August 2, 2004 for 180 days (Supp. 04-2). Repealed by final rulemaking at 10 A.A.R. 4012, effective November 13, 2004 (Supp. 04-3).

Exhibit F, Table 3. Repealed

Historical Note

Adopted by emergency effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Emergency rule adopted again effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Permanent rule adopted effective December 22, 1993 (Supp. 93-4). Repealed by emergency rulemaking under A.R.S. § 41-1026 at 10 A.A.R. 2496, effective August 2, 2004 for 180 days (Supp. 04-2). Repealed by final rulemaking at 10 A.A.R. 4012, effective November 13, 2004 (Supp. 04-3).

Exhibit F, Table 4. Repealed

Historical Note

Adopted by emergency effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Emergency rule adopted again effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Permanent rule adopted effective December 22, 1993 (Supp. 93-4). Repealed by emergency rulemaking under A.R.S. § 41-1026 at 10 A.A.R. 2496, effective August 2, 2004 for 180 days (Supp. 04-2). Repealed by final rulemaking at 10 A.A.R. 4012, effective November 13, 2004 (Supp. 04-3).

Exhibit F, Table 5. Repealed

Historical Note

Adopted by emergency effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Emergency rule adopted again effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Permanent rule adopted effective December 22, 1993 (Supp. 93-4). Repealed by emergency rulemaking under A.R.S. § 41-1026 at 10 A.A.R. 2496, effective August 2, 2004 for 180 days

(Supp. 04-2). Repealed by final rulemaking at 10 A.A.R. 4012, effective November 13, 2004 (Supp. 04-3).

Exhibit M, Table 2. Repealed

Historical Note

Adopted by emergency effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Emergency rule adopted again effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Permanent rule adopted effective December 22, 1993 (Supp. 93-4). Repealed by emergency rulemaking under A.R.S. § 41-1026 at 10 A.A.R. 2496, effective August 2, 2004 for 180 days (Supp. 04-2). Repealed by final rulemaking at 10 A.A.R. 4012, effective November 13, 2004 (Supp. 04-3).

Exhibit M, Table 3. Repealed

Historical Note

Adopted by emergency effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Emergency rule adopted again effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Permanent rule adopted effective December 22, 1993 (Supp. 93-4). Repealed by emergency rulemaking under A.R.S. § 41-1026 at 10 A.A.R. 2496, effective August 2, 2004 for 180 days (Supp. 04-2). Repealed by final rulemaking at 10 A.A.R. 4012, effective November 13, 2004 (Supp. 04-3).

Exhibit M, Table 4. Repealed

Historical Note

Adopted by emergency effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Emergency rule adopted again effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Permanent rule adopted effective December 22, 1993 (Supp. 93-4). Repealed by emergency rulemaking under A.R.S. § 41-1026 at 10 A.A.R. 2496, effective August 2, 2004 for 180 days (Supp. 04-2). Repealed by final rulemaking at 10 A.A.R. 4012, effective November 13, 2004 (Supp. 04-3).

Exhibit M, Table 5. Repealed

Historical Note

Adopted by emergency effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Emergency rule adopted again effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Permanent rule adopted effective December 22, 1993 (Supp. 93-4). Repealed by emergency rulemaking under A.R.S. § 41-1026 at 10 A.A.R. 2496, effective August 2, 2004 for 180 days (Supp. 04-2). Repealed by final rulemaking at 10 A.A.R. 4012, effective November 13, 2004 (Supp. 04-3).

Historical Note

Adopted by emergency effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Emergency rule adopted again effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Permanent rule adopted effective December 22, 1993 (Supp. 93-4). Repealed by emergency rulemaking under A.R.S. § 41-1026 at 10 A.A.R. 2496, effective August 2, 2004 for 180 days

(Supp. 04-2). Repealed by final rulemaking at 10 A.A.R. 4012, effective November 13, 2004 (Supp. 04-3).

ARTICLE 2. STATE RETIREMENT DEFINED CONTRIBUTION PROGRAM

Article 2, consisting of R2-8-201 through R2-8-207, made by final rulemaking at 10 A.A.R. 1962, effective May 4, 2004 (Supp. 04-2).

R2-8-201. Definitions

The following definitions apply to this Article unless otherwise specified:

1. "13th check" means the aggregated amount of the annual annuities awarded to a retired System member as the member's pro rata share of the excess surplus allocated by the Board for an increase in retirement benefits and distributed once a year to a retired System member or, upon election by the retired System member, to the retired System member's surviving beneficiary.
2. "14th check" means the aggregated amount of the annual annuities awarded to a retired System member as the retired System member's pro rata share of the excess surplus due to changes in the interest rate assumption and life expectancy table assumption, allocated by the Board for an increase in retirement benefits distributed once a year to the retired System member or, upon election by the retired System member, to the retired System member's beneficiary.
3. "Actuary" means an individual who is a Fellow of the Society of Actuaries, and is hired and directed by the Board to make actuarial calculations, determinations, valuations, experience studies, recommendations, and other actions directed by the Board.
4. "ASRS" means the same as in A.R.S. § 38-711.
5. "Beneficiary longevity reserve account" means the account established under Laws of 1953 and continued in Section 24 (B) of the Implementing Statute that is used to maintain benefits payable to retired System members and System members' beneficiaries.
6. "Board" means the same as in A.R.S. § 38-711.
7. "Employer" means the same as in A.R.S. § 38-711.
8. "Employer account" means that portion of a non-retired member's System retirement account that contains employer contributions, supplemental credits, and accumulated interest on employer contributions and supplemental credits.
9. "Employer contributions" means the same as in A.R.S. § 38-711.
10. "Excess surplus" means the funds in the beneficiary longevity reserve account that exceed the funded status range and that are subject to allocation by the Board as provided in R2-8-203(A)(3).
11. "Fiscal year" means the same as in A.R.S. § 38-711.
12. "Funded status" means the ratio, expressed as a percentage, of the actuarial value of assets for System members to the total liabilities of the System for future benefits.
13. "Guaranteed account balance" means all System member and employer contributions in a System member's retirement account, not including supplemental adjustments, plus the interest credited annually on those contributions.
14. "Guaranteed benefit" means the portion of a retired system member's or the retired System member's beneficiary's monthly benefit derived from the guaranteed account balance and calculated at the time of retirement.
15. "Implementing Statute" means Arizona Session Laws 1995, Chapter 32, Section 24, as amended by Arizona Session Laws 1999, Chapter 66, Section 1.
16. "Interest" means the assumed actuarial investment earnings rate approved by the Board.
17. "Market value" means an estimated monetary worth of an asset, based on the current demand for the asset and the amount of that type of asset that is available for sale.
18. "Member" means the same as in A.R.S. § 38-711.
19. "Member contributions" means the same as in A.R.S. § 38-711.
20. "Monthly benefit" means the annuitized payment of a retired System member's guaranteed and non-guaranteed account balances.
21. "Non-guaranteed account balance" means the sum of all supplemental adjustments and interest credited on those adjustments.
22. "Non-guaranteed benefit" means:
 - a. The portion of the monthly benefit derived from all supplemental adjustments and interest credited on those adjustments,
 - b. The 13th check, and
 - c. The 14th check
23. "Plan" means the same as "defined benefit plan" in A.R.S. § 38-769, and administered by the ASRS.
24. "Retirement account" means the same as in A.R.S. § 38-771.
25. "Supplemental adjustment" means the amount credited or debited to a non-retired system member's employer account or to a retired System member's non-guaranteed benefit as determined by Section 24 (B) of the Implementing Statute.
26. "System" means the same as "defined contribution plan" as defined in A.R.S. § 38-769, and which is administered by the ASRS.
27. "Total liabilities" means the amount needed to pay all System benefits.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1962, effective May 4, 2004 (Supp. 04-2).

R2-8-202. Expired

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1962, effective May 4, 2004 (Supp. 04-2). Amended by emergency rulemaking at 10 A.A.R. 4259, effective September 30, 2004 (Supp. 04-3). Amended by final rulemaking at 10 A.A.R. 4346, effective October 5, 2004 (Supp. 04-3). Section amended and Table 1 repealed by final rulemaking at 13 A.A.R. 4581, effective February 2, 2008 (Supp. 07-4). Section expired under A.R.S. § 41-1056(E) at 16 A.A.R. 1765, effective July 14, 2010 (Supp. 10-3).

R2-8-203. Expired

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1962, effective May 4, 2004 (Supp. 04-2). Section expired under A.R.S. § 41-1056(E) at 16 A.A.R. 1765, effective July 14, 2010 (Supp. 10-3).

R2-8-204. Expired

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1962, effective May 4, 2004 (Supp. 04-2). Section expired under A.R.S. § 41-1056(E) at 16 A.A.R. 1765, effective July 14, 2010 (Supp. 10-3).

R2-8-205. Expired

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1962, effective May 4, 2004 (Supp. 04-2). Section expired under A.R.S. § 41-1056(E) at 16 A.A.R. 1765, effective July 14, 2010 (Supp. 10-3).

R2-8-206. Expired

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1962, effective May 4, 2004 (Supp. 04-2). Section expired under A.R.S. § 41-1056(E) at 16 A.A.R. 1765, effective July 14, 2010 (Supp. 10-3).

R2-8-207. Return of Contributions

- A.** A System member who elects to receive a return of contributions under A.R.S. § 38-740 is paid as follows:
 - 1. The ASRS shall pay the guaranteed portion of the account balance no sooner than 30 days after the member separates from service, unless earlier payment is otherwise authorized by law;
 - 2. The ASRS shall pay the non-guaranteed portion of the account balance upon completion of the actuarial valuation for the fiscal year end immediately before the date the member separates from service; and
 - 3. The ASRS shall pay the entire account balance no later than 90 days after the member separates from service.
- B.** A non-retired member's beneficiary who qualifies for and elects a lump-sum payout under A.R.S. § 38-762, is paid as follows:
 - 1. The ASRS shall pay the guaranteed portion of the account balance upon verification of the member's death and determination of the deceased member's guaranteed portion of the account balance,
 - 2. The ASRS shall pay the non-guaranteed portion of the account balance upon completion of the actuarial valuation for the fiscal year end immediately before the date of the member's death, and
 - 3. The ASRS shall pay the entire account balance no later than 90 days after the beneficiary requests the lump-sum payout.
- C.** If the ASRS pays a partial lump sum to a System member at retirement, the proportion of the guaranteed to non-guaranteed funds the ASRS pays to the System member is equal to the proportion of guaranteed to non-guaranteed funds in the System member's entire account.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1962, effective May 4, 2004 (Supp. 04-2).

ARTICLE 3. RESERVED

ARTICLE 4. PRACTICE AND PROCEDURE BEFORE THE BOARD

R2-8-401. Definitions

The following definitions apply to this Article unless otherwise specified:

- 1. "Appealable agency action" has the same meaning as in A.R.S. § 41-1092.
- 2. "Board" has the same meaning as in A.R.S. § 38-711.
- 3. "Director" means the Director appointed by the Board as provided in A.R.S. § 38-715.
- 4. "Party" has the same meaning as in A.R.S. § 41-1001.
- 5. "Person" has the same meaning as in A.R.S. § 41-1001.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 444, effective January 4, 2005 (Supp. 05-1).

R2-8-402. General Procedures

In computing any time period, parties shall exclude the day from which the designated time period begins to run. Parties shall include the last day of the period unless it falls on a Saturday, Sunday, or legal holiday. When the time period is 10 days or less, parties shall exclude Saturdays, Sundays, and legal holidays.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 444, effective January 4, 2005 (Supp. 05-1).

R2-8-403. Request for a Hearing of an Appealable Agency Action

- A.** A person who is not satisfied with a decision by the Director that is an appealable agency action may file a Request for a Hearing, in writing, with the Director. The request shall include the following:
 - 1. The name and mailing address of the member, employer, or other person filing the request;
 - 2. The name and mailing address of the attorney for the person filing the request, if applicable;
 - 3. A concise statement of the reasons for the appeal.
- B.** The person requesting a hearing shall file the Request for a Hearing with the ASRS Office of the Director within 30 days after receiving a decision of the Director and a Notice of an Appealable Agency Action. The date the request is filed is established by the Director's date stamp on the face of the first page of the request.
- C.** Upon receipt of the Request for a Hearing, the ASRS shall notify the Office of Administrative Hearings as required in A.R.S. § 41-1092.03.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 444, effective January 4, 2005 (Supp. 05-1).

R2-8-404. Board Decisions on Hearings before the Office of Administrative Hearings

A recommended decision from the Office of Administrative Hearings that is sent to ASRS at least 30 days before the Board's next regular monthly meeting, shall be reviewed by the Board at that monthly meeting. At the monthly meeting, the Board shall render a decision to accept, reject, or modify the findings of fact, conclusions of law and recommendations in whole or in part. If the Board modifies or rejects a recommended decision, the Board shall state the reasons for the modification or rejection. The Board shall deliver the Board's final decision to the Office of Administrative Hearings within five days after the monthly meeting at which the Board made the final decision.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 444, effective January 4, 2005 (Supp. 05-1).

R2-8-405. Rehearing; Review of a Final Decision

- A.** Except as provided in subsection (H), any party in an appealable agency action aggrieved by a final decision may file with the Board a written motion for rehearing or review of the final decision specifying the particular grounds not later than 30 days after service of the decision.
- B.** A party may amend a motion for rehearing or review at any time before the Board rules on the motion. A party may file a response within 15 days after the motion or amended motion is filed. The Board may require the filing of written briefs upon the issues raised in the motion and may provide for oral argument.

- C. The Board may grant a rehearing or review of a decision for any of the following causes materially affecting the moving party's rights:
1. Irregularity in the administrative proceedings of the agency or the hearing officer, or any order or abuse of discretion that deprives the moving party of a fair hearing;
 2. Misconduct of the Board, the hearing officer, or the prevailing party;
 3. Accident or surprise that could not have been prevented by ordinary prudence;
 4. Newly discovered material evidence that could not with reasonable diligence have been discovered and produced at the original hearing;
 5. Excessive or insufficient penalties;
 6. Error in the admission or rejection of evidence or other errors of law occurring at the administrative hearing; or
 7. That the decision is not justified by the evidence or is contrary to law.
- D. The Board may affirm or modify the decision or grant a rehearing or review to all or any of the parties on all or part of the issues for any of the reasons in subsection (C). An order granting a rehearing or review shall specify with particularity the grounds for the order.
- E. Not later than 10 days after the decision, the Board may, after giving each party notice and an opportunity to be heard, order a rehearing or review of its decision for any reason for which it might have granted a rehearing or review on motion of a party. After giving the parties or their counsel notice and an opportunity to be heard on the matter, the Board may grant a motion for rehearing or review for a reason not stated in the motion. In either case, the order granting a rehearing or review shall specify the grounds on which it is granted.
- F. When a motion for rehearing or review is based upon an affidavit, the affidavit shall be filed with the motion. An opposing party may, within 15 days after filing, file an opposing affidavit. The Board may extend the period for filing an opposing affidavit for not more than 20 days for good cause shown or by written stipulation of the parties. The Board may permit a reply affidavit.
- G. The Board shall rule on the motion within 15 days after the response to the motion is filed or if a response is not filed, within five days of the expiration of the response period.
- H. If the Board makes a specific finding that the immediate effectiveness of a particular decision is necessary for the preservation of the public peace, health, and safety and that a rehearing or review of the decision is impracticable, unnecessary, or contrary to the public interest, the decision may be issued as a final decision without an opportunity for a rehearing or review. If a decision is issued as a final decision without an opportunity for rehearing or review, an application for judicial review of the decision may be made within the time limits permitted for applications for judicial review of the Board's final decisions.
- Historical Note**
New Section made by final rulemaking at 11 A.A.R. 444, effective January 4, 2005 (Supp. 05-1).
- ARTICLE 5. PURCHASING SERVICE CREDIT**
- R2-8-501. Definitions**
The following definitions apply to this Article unless otherwise specified:
1. "Active duty" has the same meaning as in 32 U.S.C. 101.
 2. "Active duty termination date" means the day a member:
 - a. Separates from active military duty;
 - b. Is released from active duty-related hospitalization or one year after initiation of active duty-related hospitalization, whichever date is earlier; or
 - c. Dies as a result of active military duty.
 3. "Active member" means the same as in A.R.S. § 38-711.
 4. "Active reserve duty" means participating in required meetings and annual training in a Reserve or National Guard branch of the United States uniformed service.
 5. "Actuarial present value" means an amount in today's dollars of a member's future retirement benefit calculated using the actuarial assumptions in R2-8-123 and the:
 - a. Member's current years of credited service to the nearest month;
 - b. Member's age to the nearest day;
 - c. Amount of service credit the member wishes to purchase to the nearest month, except for the calculation in R2-8-506(A)(2); and
 - d. Member's current annual compensation.
 6. "ASRS" means the same as in A.R.S. § 38-711.
 7. "ASRS employer" means the same as "employer" in A.R.S. § 38-711.
 8. "Authorized employer representative" means an individual who has been delegated the authority to act on behalf of an ASRS employer to provide the ASRS with information.
 9. "Authorized representative" means an individual who has been delegated the authority to act on behalf of a custodian, trustee, plan administrator, or, if applicable, a member.
 10. "Compensation" means the same as in A.R.S. § 38-769.
 11. "Credited service" means the same as in A.R.S. § 38-711.
 12. "Current annual compensation" means the greater of:
 - a. *Annualized compensation of the full pay period immediately before the date of a request to ASRS to purchase credited service pursuant to section 38-743 or 38-745.*
 - b. *Annualized compensation of the partial year if the member has less than twelve months total credited service on the date of a request to purchase credited service pursuant to section 38-743 or 38-745.*
 - c. *The sum of the twelve months of compensation immediately before the date of a request to ASRS to purchase credited service pursuant to section 38-743 or 38-745.*
 - d. *The sum of the thirty-six months of compensation immediately before the date of a request to ASRS to purchase credited service pursuant to section 38-743 or 38-745 divided by three.*
 - e. *If the member has retired one or more times from ASRS, the average monthly compensation that was used for calculating the member's last pension benefit times twelve. A.R.S. § 38-711(10).*
 13. "Current years of credited service" means the amount of credited service a member has earned or purchased, and the amount of service credit for which an Irrevocable Payroll Deduction Authorization is in effect for which the member has not yet completed payment, but does not include any current requests to purchase service credit for which the member has not yet paid.
 14. "Custodian" means a financial institution that holds financial assets for guaranteed safekeeping.
 15. "Day" means a calendar day, and excludes the:
 - a. Day of the act or event from which a designated period of time begins to run; and
 - b. Last day of the period if a Saturday, Sunday, or official state holiday.

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16. "Direct rollover" means distribution of eligible funds made payable to the ASRS as a contribution for the benefit of an eligible member from a retirement plan listed in A.R.S. § 38-747(H)(2) or (H)(3).
17. "Eligible funds" means payments listed in A.R.S. § 38-747(H)(2) and (3).
18. "Eligible member" means an active member of the Plan or a Plan member who is receiving benefits under the Long Term Disability Program established by A.R.S. Title 38, Chapter 5, Article 2.1.
19. "Error" means a typographical mistake, incorrect information, or other inaccuracy, whether intentional or unintentional.
20. "Forms of payment" means check, cashier's check, money order, Irrevocable Payroll Deduction Authorization, direct rollover, trustee-to-trustee transfer, IRA rollover and termination pay distribution.
21. "Forfeited service" means credited service for which the ASRS has returned retirement contributions to the member under A.R.S. § 38-740.
22. "Immediate family member" means:
 - a. A member's spouse or life partner;
 - b. A member's natural, step, or adopted sibling;
 - c. A member's natural, step, or adopted child;
 - d. A member's natural, step, or adoptive parent; or
 - e. An individual for whom the member has legal guardianship.
23. "Indirect IRA rollover" means funds already distributed to the eligible member from a retirement plan listed in A.R.S. § 38-747(H)(3) that are then paid by the eligible member to the ASRS as a contribution for the benefit of the eligible member.
24. "IRA" means an Individual Retirement Account or Annuity under IRC § 408.
25. "IRC" means the Internal Revenue Code.
26. "Irrevocable payroll deduction authorization" means an irrevocable contract between an eligible member, an ASRS employer, and the ASRS that requires the ASRS employer to withhold payments from a member's pay for a specified amount and for a specified number of payments, as provided in A.R.S. § 38-747.
27. "Leave of absence" means the same as in A.R.S. § 38-711.
28. "Life partner" means an individual who lives with a member as a spouse, but without being legally married.
29. "Member" means the same as in A.R.S. § 38-711.
30. "Military service" means active duty or active reserve duty with any branch of the United States uniformed services.
31. "Military service record" means a United States uniformed services document that provides proof of active duty or active reserve duty time, including a military form DD-214 or other military form that provides the following information:
 - a. The member's full name;
 - b. The member's Social Security number;
 - c. Type of discharge the member received;
 - d. Active duty dates, if applicable; and
 - e. Active reserve duty dates, if applicable.
32. "Other public service" means previous employment listed in A.R.S. § 38-743(A).
33. "PDA pay-off letter" means written correspondence from the ASRS to a member that specifies the amount necessary to be paid by the member to complete an Irrevocable Payroll Deduction Authorization and receive the credited service specified in the Irrevocable Payroll Deduction Authorization.
34. "Person" means the same as in A.R.S. § 1-215.
35. "Plan" means the same as "defined benefit plan" in A.R.S. § 38-769, and administered by the ASRS.
36. "Plan Administrator" means the person authorized to represent a specific eligible plan as addressed in IRC § 414(g).
37. "Political subdivision" means the same as in A.R.S. § 38-711.
38. "Political subdivision entity" means the same as in A.R.S. § 38-711.
39. "Presidential Call-up" means a directive from the President of the United States, Cabinet Secretary, or Secretary of any United States uniformed service, initiating active duty for personnel of active military, or active or inactive National Guard and Reserve branches of the United States uniformed services.
40. "Public employer" means the United States government, a state of the United States, a political subdivision of a state of the United States, or a political subdivision entity.
41. "Rollover" means a contribution to the ASRS by an eligible member of an eligible rollover distribution from one or more of the retirement plans listed in A.R.S. § 38-747(H)(2) and (3).
42. "Service credit" means forfeited service under A.R.S. § 38-742, leave of absence under A.R.S. § 38-744, military service and Presidential Call-up service under A.R.S. § 38-745, and other public service under A.R.S. § 38-743 that an eligible member may purchase.
43. "SP invoice" means a written correspondence from the ASRS informing an eligible member of the amount of money required to purchase a specified amount of service credit.
44. "Terminate employment" means to end the employment relationship between a member and an ASRS employer with the intent that the member not return to employment with that ASRS employer.
45. "Termination pay distribution" means an ASRS employer's payment to the ASRS of an eligible member's termination pay to purchase service credit as specified in § 38-747(B)(2).
46. "Three full calendar months" means the first day of the first full month through the last day of the third full month.
47. "Transfer employment" means to terminate employment with one ASRS employer with which a member has an Irrevocable Payroll Deduction Authorization:
 - a. After accepting an offer to work for a new ASRS employer, or
 - b. While working as an active member for a different ASRS employer.
48. "Trustee-to-trustee transfer" means a transfer of assets to the ASRS as authorized in A.R.S. § 38-747(I), from a retirement program listed in R2-8-515(A) from which, at the time of the transfer, a member is not eligible to receive a distribution.
49. "Uniformed services" means the United States Army, Army Reserve, Army National Guard, Navy, Navy Reserve, Air Force, Air Force Reserve, Air Force National Guard, Marine Corps, Marine Corps Reserve, Coast Guard, Coast Guard Reserves, the National Oceanic and Atmospheric Administration, and the Public Health Service.
50. "United States" means the same as in A.R.S. § 1-215.

51. "Window credit" means overpayments made on previously purchased service credit by eligible members of the ASRS as provided by Laws 1997, Ch. 280, § 21, and Laws 2003, Ch. 164, § 3.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 2640, effective June 30, 2005 (Supp. 05-2). Amended by final rulemaking at 12 A.A.R. 4667, effective December 5, 2006 (Supp. 06-4). Amended by final rulemaking at 18 A.A.R. 3130, effective January 6, 2013 (Supp. 12-4).

R2-8-502. Request to Purchase Service Credit and Notification of Cost

- A.** An eligible member may request to purchase service credit verbally, in writing, or electronically. The eligible member shall provide the eligible member's mailing address and designate which category of service credit the eligible member is requesting to purchase.
- B.** The ASRS shall send a letter acknowledging the request to purchase service credit to the mailing address provided by the eligible member. The ASRS shall provide, with the acknowledgment letter, any form specified in this Article that corresponds to the category of service credit the eligible member requests to purchase and indicate in the acknowledgment letter the deadline for providing supporting documentation of service credit to the ASRS.
- C.** Except as provided in R2-8-519(A), the eligible member shall provide documentation of service credit as required by this Article within 90 days of the eligible member's request to purchase service credit. If the ASRS has not received complete and correct documents within 90 days of the request to purchase service credit, the ASRS shall cancel the eligible member's request to purchase service credit. The eligible member may make a new request to purchase service credit.
- D.** Upon receipt of the documentation required by this Article from the eligible member and if the eligible member's request to purchase service credit meets the requirements of this Article, the ASRS shall provide the following to the eligible member:
 1. A SP invoice stating the cost to purchase the amount of service credit the member is eligible to purchase and the date payment is due;
 2. A Service Purchase Payment Request form requesting the following information:
 - a. The member's name;
 - b. The member's Social Security number;
 - c. The member's mailing address;
 - d. The member's daytime telephone number;
 - e. ID number listed on the SP invoice;
 - f. Either the number of years or partial years of service credit the member wishes to purchase or the cost for the number of years or partial years of service the member wishes to purchase, not exceeding the years or partial years and cost specified on the SP Invoice;
 - g. If the member elects to pay for the service credit by trustee-to-trustee transfer, IRA rollover, distributed rollover contribution, or direct rollover, the anticipated number of rollovers or transfers;
 - h. If the member elects to pay by Irrevocable Payroll Deduction Authorization, the amount of money the member wishes to pay per pay period;
 - i. If the member elects to pay for the service credit by check, the check number and amount of the check;
 - j. If the member elects to pay any cost remaining at retirement or termination of employment with a ter-

mination pay distribution, the retirement date or last date of work;

- k. The member's signature and date of the signature; and
3. Other forms the member may need to complete the request for service credit purchase.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 2640, effective June 30, 2005 (Supp. 05-2). Amended by final rulemaking at 12 A.A.R. 4667, effective December 5, 2006 (Supp. 06-4). Amended by final rulemaking at 18 A.A.R. 3130, effective January 6, 2013 (Supp. 12-4).

R2-8-503. Requirements Applicable to All Service Credit Purchases

- A.** To purchase service credit at the amount provided in an SP invoice, an eligible member shall purchase the service credit by check or money order, or request an Irrevocable Payroll Deduction Authorization, rollover, transfer or termination pay distribution as specified in this Article, by the due date specified on the SP invoice.
- B.** An eligible member may purchase all of the service credit or a portion of the service credit. If the eligible member wishes to purchase only a portion of the service credit, the eligible member shall specify, on the Service Purchase Payment Request form identified in R2-8-502(D)(2):
 1. The dollar amount the eligible member wishes to purchase, up to the amount specified on the SP invoice, or
 2. The number of years or partial years the eligible member wishes to purchase, not exceeding the years or partial years specified on the SP invoice.
- C.** If the eligible member elects to purchase only a portion of the service credit, the cost and amount of service credit the eligible member identifies on the Service Purchase Payment Request form is only an estimate and may be more or less than the actual cost or amount of service credit purchased by the eligible member.
- D.** The eligible member shall not request to purchase additional service credit based on the SP invoice until the member has completed the purchase of the previously requested portion of service credit or cancel the request as specified in subsection (F).
- E.** ASRS shall not consider more than one active request at a time from a member to purchase service credit in a single category. The categories are:
 1. Leave of absence,
 2. Military service,
 3. Presidential Call-up service,
 4. Forfeited service, and
 5. Other public service.
- F.** An eligible member may cancel an active request to purchase a specific category of service credit verbally or in writing, and submit a new request in the same category of service credit for a different amount of service credit.
- G.** If an eligible member is entitled to a window credit, the eligible member may apply the window credit to purchase service credit. To apply a window credit to a purchase of service credit, the eligible member shall make a request to the ASRS in writing by the due date specified on the SP invoice and include the following information:
 1. The amount the member wants to apply,
 2. The member's signature, and
 3. The date of the member's signature.
- H.** The amount of service credit an eligible member may purchase and the benefits an eligible member may receive are subject to the limitations prescribed in A.R.S. § 38-747(E).

I. On or before the due date specified on the SP Invoice, ASRS shall extend the time for an eligible member to respond to an SP invoice as follows:

1. If the member notifies the ASRS of an ASRS error, the time is extended 30 days after the date the ASRS sends notification to the eligible member that the ASRS has corrected the error;
2. If an ASRS internal review is made of the member's service credit purchase request, the time is extended 30 days after the date ASRS sends notification to the member that the review is completed;
3. If the member appeals an issue regarding the SP invoice under Article 4 of this Chapter, the time is extended 30 days after the date ASRS sends notification to the member that a decision on the appeal has been made; or
4. If an unforeseeable event occurs that is outside of the member's control, such as an incapacitating illness of the member or death of an immediate family member, and the member notifies the ASRS of the event, the ASRS shall extend the time by up to six months, after a review of the unforeseeable event to determine the length of the extension.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 2640, effective June 30, 2005 (Supp. 05-2). Amended by final rulemaking at 12 A.A.R. 4667, effective December 5, 2006 (Supp. 06-4). Amended by final rulemaking at 18 A.A.R. 3130, effective January 6, 2013 (Supp. 12-4). Amended by final rulemaking at 18 A.A.R. 3130, effective January 6, 2013 (Supp. 12-4).

R2-8-504. Service Credit Calculation for Purchasing Service Credit

An eligible member who purchases service credit shall receive one month of credited service for one or more days of service in a calendar month.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 2640, effective June 30, 2005 (Supp. 05-2).

R2-8-505. Restrictions on Purchasing Overlapping Service Credit; Transfers

- A.** The ASRS shall not permit an eligible member to purchase service credit that, when added to credited service earned in any plan year, results in more than:
1. One year of credited service in any plan year, or
 2. One month of credited service in any one calendar month.
- B.** The restrictions in subsection (A) do not apply to service credit that an eligible member transfers from another retirement system to the ASRS as authorized in A.R.S. § 38-730 or A.R.S. Title 38, Chapter 5, Article 7, whether the eligible member requests the transfer before or after purchasing other service credit.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 2640, effective June 30, 2005 (Supp. 05-2).

R2-8-506. Cost Calculation for Purchasing Service Credit

- A.** For leave of absence service credit, military service credit, and other public service credit, the ASRS shall calculate, as of the date of the request to purchase service credit:
1. The actuarial present value of the future retirement benefit for the member including the service credit that the eligible member requests to purchase, and
 2. The actuarial present value of the future retirement benefit for the member without the service credit that the eligible member requests to purchase.

- B.** The cost for purchasing the service credit that the member requests to purchase is the difference between the actuarial present value in subsection (A)(1) and the actuarial present value in subsection (A)(2).

Historical Note

New Section made by final rulemaking at 11 A.A.R. 2640, effective June 30, 2005 (Supp. 05-2).

R2-8-507. Required Documentation and Calculations for Forfeited Service Credit

- A.** An eligible member who requests to purchase service credit for forfeited service under A.R.S. § 38-742 shall provide to the ASRS:
1. The eligible member's:
 - a. Full name and, if applicable, other names used while working for an ASRS employer for which the eligible member is requesting to purchase service credit;
 - b. Mailing address;
 - c. Telephone number, if applicable;
 - d. Social Security number;
 2. The name of each ASRS employer, if known, for which the eligible member is requesting to purchase service credit for forfeited service;
 3. The year the eligible member began working for each ASRS employer and the year the eligible member left each employment, if known; and
 4. The year the eligible member believes the ASRS returned retirement contributions to the member.
- B.** The amount the eligible member shall pay to purchase service credit for previously forfeited service is the amount of retirement contributions that the ASRS returned to the eligible member, plus interest on that amount from the date on the return of retirement contributions check to the date of redeposit at the interest rate determined by the Board as specified in A.R.S. § 38-742.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 2640, effective June 30, 2005 (Supp. 05-2). Amended by final rulemaking at 12 A.A.R. 4667, effective December 5, 2006 (Supp. 06-4).

R2-8-508. Required Documentation and Calculations for Leave of Absence Service Credit

- A.** An eligible member may request to purchase service credit for an approved leave of absence from an ASRS employer under A.R.S. § 38-744. To request to purchase service credit for an approved leave of absence the eligible member shall provide to the ASRS:
1. An Approved Leave of Absence form that includes:
 - a. The following information completed by the eligible member:
 - i. The eligible member's full name and, if applicable, other names used while working for the ASRS employer;
 - ii. The eligible member's Social Security number;
 - iii. The eligible member's mailing address;
 - iv. The eligible member's daytime telephone number;
 - v. A statement that the eligible member understands that up to one year of leave of absence service credit may be purchased for each approved leave of absence, if the eligible member returns to work for the employer that approved the leave of absence unless employment could not be resumed because of disability or nonavailability of a position;

- vi. A statement that the eligible member understands that the ASRS uses the actuarial present value calculation method to determine the cost of the service purchase request;
- vii. A statement that the eligible member authorizes the ASRS employer to provide any necessary personal information to ASRS in order to process this request; and
- viii. The member's dated signature; and
- b. The following information completed by the ASRS employer;
 - i. The beginning date and ending date of the approved leave of absence;
 - ii. The date the eligible member returned to work or a statement of why employment was not resumed;
 - iii. Name of the employer;
 - iv. The authorized employer representative's name;
 - v. The authorized employer representative's telephone number and, if applicable, fax number; and
 - vi. The authorized employer representative's dated signature verifying that the approved leave of absence benefited or was in the best interest of the employer; and
- 2. A copy of the guidelines referenced in A.R.S. § 38-744, if applicable.

- B. The amount the member shall pay to purchase service credit for leave of absence is determined as provided in R2-8-506.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 2640, effective June 30, 2005 (Supp. 05-2). Amended by final rulemaking at 12 A.A.R. 4667, effective December 5, 2006 (Supp. 06-4).

R2-8-509. Required Documentation and Calculations for Military Service Credit

- A. An eligible member may request to purchase military service credit under A.R.S. § 38-745(A) and (B). To request to purchase military service credit, the eligible member shall provide to the ASRS:
 - 1. The items listed in R2-8-507(A)(1);
 - 2. A copy of the eligible member's military service record; and
 - 3. A completed, signed, dated, and notarized Affidavit of Military Service form that contains:
 - a. The member's full name;
 - b. The member's Social Security number;
 - c. The branch of the uniformed services the member was in;
 - d. Whether the member was active duty or active reserve duty;
 - e. The years and months by fiscal year that the member was in active duty or active reserve duty for which the member wishes to purchase service credit;
 - f. Acknowledgement that the member has attached:
 - i. Proof of honorable discharge for each type of military service listed on the form; and
 - ii. The member's military service record that supports all of the service listed on the affidavit;
 - g. The following statements of understanding initialed by the member:
 - i. I understand that any person who knowingly makes any false statement or who falsifies or permits to be falsified any record of the retire-

ment plan with an intent to defraud the plan is guilty of a class 6 felony per Arizona Revised Statutes Section 38-793;

- ii. I understand this transaction is subject to audit and if any errors or misrepresentations are discovered as a result of this audit, my total credited service with the ASRS will be adjusted as necessary and if I am retired, my retirement benefit will also be adjusted;
- iii. I understand that the service listed on this affidavit does not include time that I either volunteered or was ordered into active duty military service as part of a Presidential Call-up. This service is purchased under Presidential Call-up and requires a Presidential Call-up form to be completed by your employer; and
- iv. I understand that any time I have listed on this affidavit for Reserve or National Guard time reflects the months that I attended at least one drill or assembly for each month listed.

- B. The amount the eligible member pays to purchase military service credit is determined as provided in R2-8-506.
- C. ASRS determines the amount of service credit an eligible member receives for active duty and active reserve duty time by the time listed on the Affidavit of Military Service form, if the service listed is supported by the information contained in the member's military service record.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 2640, effective June 30, 2005 (Supp. 05-2). Amended by final rulemaking at 12 A.A.R. 4667, effective December 5, 2006 (Supp. 06-4).

R2-8-510. Required Documentation and Calculations for Presidential Call-up Service Credit

- A. An eligible member or the eligible member's beneficiary who meets the requirements under A.R.S. § 38-745(C) shall receive up to 60 months of Presidential Call-up service under A.R.S. § 38-745(C) through (I). In order to determine the amount of contributions the ASRS employer owes to purchase service credit for Presidential Call-up service, the eligible member's ASRS employer shall provide to the ASRS a copy of the eligible member's military service record and a completed Military Call-up form that includes the following:
 - 1. The member's full name;
 - 2. The member's Social Security number;
 - 3. The start date of Presidential Call-up Service;
 - 4. The end date of Presidential Call-up Service;
 - 5. Whether the member received paid leave while on Presidential Call-up;
 - 6. The date the member returned to work for the ASRS employer;
 - 7. The salary for each fiscal year while the member is on Presidential Call-up, including any salary increases the eligible member would have received had the member not left employment due to Presidential Call-up, if applicable;
 - 8. The ASRS employer's name and address;
 - 9. The name of a contact individual for the ASRS employer, and that individual's business and fax telephone numbers;
 - 10. The contact individual's signature and date of signature;
 - 11. If applicable, the earlier of:
 - a. The date that the member was released from the hospital for injuries sustained as a result of participating in a Presidential Call-up; or

- b. The date that the member was hospitalized for one year for injuries sustained as a result of participating in a Presidential Call-up; and
- 12. A copy of the member's death certificate, if applicable.
- B.** An ASRS employer shall make the request to purchase service credit for Presidential Call-up service within 30 days after the member's active duty termination date.
- C.** The ASRS calculates the amount the ASRS employer pays to purchase Presidential Call-up service by multiplying the eligible member's salary at the time active duty commences, by the contribution rate in effect for the period of active duty, and by the years or partial years of service elapsing from the active duty commencement date through the active duty termination date. Included in the calculation are any salary increases the member would have received if the member had not left work to participate in a Presidential Call-up.
- D.** The ASRS shall send the ASRS employer a statement of cost for purchase of the Presidential Call-up service credit, based on the calculation in subsection (B). Within 90 days from the date on the ASRS statement of cost, the ASRS employer shall pay to the ASRS the amount on the statement. If the ASRS employer fails to make full payment within the 90 days, interest shall accrue on the unpaid balance at the assumed actuarial investment earnings rate approved by the Board in effect on the date of the statement of cost.
- E.** If an ASRS employer deducts retirement and long-term disability contributions from an eligible member's pay while the eligible member is on Presidential Call-up service, the ASRS shall return the contributions to the ASRS employer after the ASRS receives the information in subsection (A).
- F.** If an ASRS employer deducts retirement contributions from an eligible member's pay while the eligible member is on Presidential Call-up service, and the eligible member does not return to the ASRS employer after separation from active military service, the ASRS shall apply the retirement contributions to the member's credited service.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 2640, effective June 30, 2005 (Supp. 05-2). Amended by final rulemaking at 12 A.A.R. 4667, effective December 5, 2006 (Supp. 06-4).

R2-8-511. Required Documentation and Calculations for Other Public Service Credit

- A.** An eligible member who requests to purchase other public service credit under A.R.S. § 38-743 shall provide to the ASRS a completed Affidavit of Other Public Service form, signed and dated by the member, and notarized, that includes the following:
 - 1. The member's full name;
 - 2. The member's Social Security number;
 - 3. Other names used by the member during employment with the other public service employer, if applicable;
 - 4. The name and mailing address of the other public service employer;
 - 5. The position the member held while working for the other public service employer;
 - 6. A contact name and telephone number of an individual in the other public service employer's human resources department who can verify employment, if known;
 - 7. The years and months by fiscal year of other public service the member worked and wishes to purchase;
 - 8. If the other public service employer was a non-ASRS employer, a statement of whether the member participated in the non-ASRS employer's retirement plan;

- 9. If the member participated in a non-ASRS public service employer's retirement plan, the name of the retirement plan, identifying whichever one of the following applies:
 - a. The approximate date the member took a return of retirement contributions;
 - b. The plan is non-contributory and the member is not eligible for benefits from the plan; or
 - c. That, if not using all of the retirement contributions as a pre-tax rollover, the member will request a return of retirement contributions and forfeit all rights to any benefits from the plan and provide the ASRS with documentation that the member has forfeited all rights to benefits from the plan no later than the due date specified on the SP invoice; and
- 10. Acknowledgement that:
 - a. Knowingly making a false statement or falsifying or permitting falsification of any record of the ASRS with an intent to defraud ASRS is a Class 6 felony, pursuant to A.R.S. § 38-793;
 - b. The service purchase transaction is subject to audit and if any errors are discovered, the ASRS shall adjust a member's total credited service with the ASRS, or if the member is already retired, adjustments to the member's credited service will affect the member's retirement benefit; and
 - c. If an audit determines that the member is eligible for a benefit from the other public service employer's retirement plan, the member is required to take necessary steps to forfeit the benefit, and if the forfeiture is not completed within 90 days of being notified of the audit results, the service credit purchase listed on this application will be revoked and any funds paid to purchase the service credit will be refunded to the member.
- B.** The amount the member shall pay to purchase other public service credit is determined as provided in R2-8-506.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 2640, effective June 30, 2005 (Supp. 05-2). Amended by final rulemaking at 12 A.A.R. 4667, effective December 5, 2006 (Supp. 06-4).

R2-8-512. Purchasing Service Credit by Check, Cashier's Check, or Money Order

- A.** An eligible member may purchase service credit by check, cashier's check, or money order.
- B.** Within 30 days of the issue date on the SP invoice or PDA payoff letter, the member shall ensure that the ASRS receives the completed Service Purchase Payment Request form with the information specified in R2-8-502(D)(2) and a check, cashier's check, or money order made to the order of the Arizona State Retirement System in the amount to purchase the requested service credit.
- C.** If an eligible member purchases service credit by check, cashier's check, or money order in conjunction with one or more rollovers, trustee-to-trustee transfers, or termination pay, the member shall make payment within 30 days after the date the ASRS sends written confirmation that the ASRS received the final rollover, trustee-to-trustee transfer, or termination pay payment.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 2640, effective June 30, 2005 (Supp. 05-2). Amended by final rulemaking at 12 A.A.R. 4667, effective December 5, 2006 (Supp. 06-4).

R2-8-513. Purchasing Service Credit by Irrevocable Payroll Deduction Authorization

- A.** An eligible member may purchase service credit by Irrevocable Payroll Deduction Authorization.
- B.** By the due date specified on the SP invoice, the member shall ensure that the ASRS receives the completed Service Purchase Payment Request form with the information specified in R2-8-502(D)(2).
- C.** If the eligible member elects to pay for service credit by Irrevocable Payroll Deduction Authorization, ASRS shall prepare an Irrevocable Payroll Deduction Authorization and send it to the eligible member for signature. The member shall ensure that the ASRS receives the signed Irrevocable Payroll Deduction Authorization within 30 days after the date on the Irrevocable Payroll Deduction Authorization. The signed Irrevocable Payroll Deduction Authorization becomes irrevocable upon receipt by the ASRS.
- D.** At the time the eligible member signs the Irrevocable Payroll Deduction Authorization the eligible member may elect to use termination pay towards the balance of the Irrevocable Payroll Deduction Authorization if the eligible member terminates employment. If the eligible member chooses this option, the eligible member shall complete the Termination Pay Addendum to the Irrevocable Payroll Deduction Authorization and return it to the ASRS along with the remainder of the Irrevocable Payroll Deduction Authorization that includes the following:
 - 1. A statement that the member:
 - a. Understands and agrees that the member must continue working at least three full calendar months after the date of submission of the form before termination pay may be used on a pre-tax basis;
 - b. Understands that if the termination payment exceeds the balance owed on the Irrevocable Payroll Deduction Authorization, the overage will be returned to the ASRS employer to be distributed to the member; and
 - c. Elects to irrevocably agree to have termination pay that may be payable to the member upon termination of employment sent to the ASRS on a pre-tax basis and used toward any remaining balance of the Irrevocable Payroll Deduction Authorization if all scheduled payroll deductions have not been completed upon termination of service; and
 - 2. A statement that either all termination pay or a specified amount of termination pay is to be applied to the balance of the Irrevocable Payroll Deduction Authorization.
- E.** The ASRS shall:
 - 1. Charge interest on the unpaid balance at the assumed actuarial investment earnings rate approved by the Board in effect at the time the authorization was entered into;
 - 2. Limit the payroll deduction time period to a maximum of 20 years; and
 - 3. Require a minimum payment of \$10.00 per payroll period, or payment in an amount to purchase at least .001 year of service credit per payroll period, whichever is greater.
- F.** The ASRS shall transmit the Irrevocable Payroll Deduction Authorization to the active member's ASRS employer, and the ASRS employer shall implement the deduction on the first pay period after receiving the Irrevocable Payroll Deduction Authorization.
- G.** If a deduction is not made under an Irrevocable Payroll Deduction Authorization within six months after the member signs the authorization, the authorization lapses and the member may make another request, which is recalculated based on the

new request date unless the failure to begin deductions is due to an ASRS error.

- H.** A period of leave of absence, long-term disability, or Presidential Call-up shall not cancel the Irrevocable Payroll Deduction Authorization. The ASRS employer shall resume deductions immediately upon the member's return to that employment. The period during which the member is on leave of absence, on long-term disability, or leaves work because of a Presidential Call-up is not included in the 20-year payment time limitation under subsection (E)(2). If the member does not return to active working status, whether due to termination of employment or retirement, the member may elect to purchase the balance of unpaid service under the Irrevocable Payroll Deduction Authorization at the time of termination or retirement as specified in this Section.
- I.** Deductions made pursuant to an Irrevocable Payroll Deduction Authorization continue until the:
 - 1. Irrevocable Payroll Deduction Authorization is completed;
 - 2. Member retires, whether or not the member continues employment as allowed in A.R.S. §§ 38-766.01 and 38-764(J); or
 - 3. Member terminates all ASRS employment without transferring employment.
- J.** If a member retires or terminates employment from all ASRS employers without transferring employment as stated in R2-8-513.01 before all deductions are made as authorized by the Irrevocable Payroll Deduction Authorization, the member's purchase of service credit is canceled unless the member notifies the ASRS in writing during the period 14 days before to 14 days after retirement or termination from all ASRS employment of the intent to purchase the remaining amount due in a lump sum.
- K.** When the member notifies ASRS of retirement or termination from all ASRS employment and requests to pay off the Irrevocable Payroll Deduction Authorization, the ASRS shall send the member a PDA pay-off letter to the mailing address given by the member. The ASRS shall calculate the amount owed by the member and reduce the amount owed by any excess interest that the member has paid.
- L.** Within 30 days of the date of the PDA pay-off letter, the member shall ensure that the ASRS receives the completed SP Payment Request form with the information specified in R2-8-502(D)(2). The member may purchase the remaining service credit by one or more of the following methods:
 - 1. By check, cashier's check, or money order made out to the ASRS under R2-8-512;
 - 2. By making a request to the ASRS for a rollover or transfer under R2-8-514 and completing the rollover or transfer within 90 days of the date of the PDA pay-off letter; or
 - 3. By termination pay distribution under R2-8-519, if the member authorized this option at the time the member signed the Irrevocable Payroll Deduction Authorization.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 2640, effective June 30, 2005 (Supp. 05-2). Amended by final rulemaking at 12 A.A.R. 4667, effective December 5, 2006 (Supp. 06-4). Amended by final rulemaking at 18 A.A.R. 3130, effective January 6, 2013 (Supp. 12-4).

R2-8-513.01. Irrevocable Payroll Deduction Authorization and Transfer of Employment to a Different ASRS Employer

- A.** An Irrevocable Payroll Deduction Authorization continues if a member transfers employment.
- B.** An Irrevocable Payroll Deduction Authorization ends if a member terminates employment without having accepted an

offer to work for a new ASRS employer, and the member is not already an active member working for a different ASRS employer. The member shall then pay off the Irrevocable Payroll Deduction Authorization as specified in R2-8-513(J).

- C. If a retirement contribution is due from the new ASRS employer within 120 days from the member's termination date with the previous employer, there is a rebuttable presumption that there is a transfer of employment. If a retirement contribution is not received within 120 days, the Irrevocable Payroll Deduction Authorization terminates.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 4667, effective December 5, 2006 (Supp. 06-4).

R2-8-513.02 Termination Date

For the purpose of an Irrevocable Payroll Deduction Authorization, the date a member is considered terminated from an ASRS employer is:

1. For a member terminating employment, the member's last pay period end date with that ASRS employer;
2. For a member on Presidential Call-up who does not return to the same ASRS employer:
 - a. Ninety days from the date of separation from Presidential Call-up service;
 - b. Ninety days from the date released from the hospital, if injured while on Presidential Call-up service;
 - c. The date the member has been hospitalized for one year for injuries sustained as a result of participating in a Presidential Call-up; or
 - d. The date of the member's death as a result of participating in a Presidential Call-up;
3. For a member on leave of absence without pay who does not return to the same ASRS employer, the date the ASRS employer required the member to return to work;
4. For a member who is unable to work because of a disability, the later of:
 - a. The date the member's request for long-term disability benefits are denied;
 - b. The date the member no longer has sick leave and annual leave; or
 - c. For a member on long-term disability who does not return to the same ASRS employer or transfer employment, the date long-term disability benefits are terminated.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 4667, effective December 5, 2006 (Supp. 06-4).

R2-8-514. Purchasing Service Credit by Direct Rollover

- A. An eligible member may purchase service credit or pay off an Irrevocable Payroll Deduction Authorization by direct rollover at retirement or termination of employment without transferring employment.
- B. By the due date specified on the SP invoice, the member shall ensure that the ASRS receives the completed Service Purchase Payment Request form with the information specified in R2-8-502(D)(2).
- C. Upon receipt of the completed Service Purchase Payment Request form, the ASRS shall provide a Direct Rollover/Transfer Certification to Purchase Service Credit form, if the ASRS has not already provided the member with the form.
- D. The member shall ensure that the ASRS receives the Direct Rollover/Transfer Certification to Purchase Service Credit form completed by the member and the plan making the distribution within 90 days after the issue date of the SP Invoice.

- E. The information requested on the Direct Rollover/Transfer Certification to Purchase Service Credit form includes:

1. Member's full name;
 2. Member's Social Security number;
 3. Member's mailing address;
 4. Member's daytime telephone number;
 5. The amount of each rollover or transfer, if applicable;
 6. The account number of each plan, if applicable;
 7. The member's signature certifying that the member understands the requirements, limitations, and entitlements for the rollover/transfer that is being used to purchase service credit, and has read and understands the Direct Rollover/Transfer Certification to Purchase Service Credit form and any accompanying instructions and information sheets;
 8. The date the member signs the form;
 9. The authorized representative's name and title;
 10. The authorized representative's address;
 11. The authorized representative's telephone number;
 12. Certification by the authorized representative that:
 - a. The plan is either:
 - i. A qualified pension, profit sharing, or 401(k) plan described in IRC § 401(a), or a qualified annuity plan described in IRC § 403(a);
 - ii. A deferred compensation plan described in IRC § 457(b) maintained by a state of the United States, a political subdivision of a state of the United States, or an agency or instrumentality of a state of the United States;
 - iii. An annuity contract described in IRC § 403(b); or
 - iv. An IRA described in A.R.S. § 38-747(H)(3);
 - b. The rollover/transfer specified on the form from which the pre-tax funds are being rolled over or transferred is intended to satisfy the requirements of the applicable section of the Internal Revenue Code;
 - c. The authorized representative is not aware of any plan provision or any other reason that would cause the plan/IRA not to satisfy the applicable section of the Code; and
 - d. The funds will be sent to the ASRS as a direct plan rollover, IRA rollover, or a trustee-to-trustee transfer; and
 13. The date and signature of the authorized representative.
- F. The ASRS shall provide the member with written notification regarding the eligibility of the rollover.
- G. The member shall contact the plan administrator to have the funds distributed and transferred to the ASRS. Except as provided in subsection (H), unless the ASRS receives a check for the correct amount from the plan within 90 days of the issue date on the SP invoice, the ASRS shall cancel the request to purchase service credit as specified in R2-8-502(C).
- H. At the written request of the member, the ASRS shall provide an extension of 60 days in which the check may be received by the ASRS from the plan at the written request of the member, if:
1. The member has followed the procedure in this Article for requesting to purchase service credit,
 2. The member has responded to the ASRS correspondence within the time-frame set forth in this Article,
 3. The eligible plan has not provided to the ASRS the check to pay for the requested service credit purchase within 90 days of the date of the SP invoice, and
 4. The member makes the written request for extension before expiration of the 90 days.

- I. The member shall ensure that the ASRS receives a check from the plan, made payable to the ASRS, for an amount that does not exceed the amount specified on the SP Invoice.
- J. If the payment from the eligible plan exceeds the amount specified on the SP Invoice, the ASRS shall return the entire payment to the member.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 2640, effective June 30, 2005 (Supp. 05-2). Amended by final rulemaking at 12 A.A.R. 4667, effective December 5, 2006 (Supp. 06-4).

R2-8-515. Purchasing Service Credit by Trustee-to-Trustee Transfer

- A. An eligible member may purchase service credit or pay off an Irrevocable Payroll Deduction Authorization at retirement or termination of employment without transferring employment by a trustee-to-trustee transfer if the member participates in:
 1. A deferred compensation plan described in IRC § 457 that is maintained by:
 - a. The state of Arizona;
 - b. A political subdivision, agency, or instrumentality of the state of Arizona; or
 - c. A political subdivision entity of the state of Arizona;
 2. An annuity contract described in IRC § 403(b); or
 3. A retirement program qualified under IRC § 401(a) or 403(a).
- B. By the due date specified on the SP invoice, the ASRS shall receive from the member the completed Service Purchase Payment Request form described in R2-8-502(D)(2).
- C. Upon receipt of the completed Service Purchase Payment Request form, the ASRS shall provide a Direct Rollover/Transfer Certification to Purchase Service Credit form, if the ASRS has not already provided the member with the form.
- D. The member shall ensure that the member and the plan administrator complete the Direct Rollover/Transfer Certification to Purchase Service Credit form, containing all of the applicable information identified in R2-8-514(E), and ensure that the ASRS receives the form within 90 days after the issue date on the SP Invoice.
- E. The ASRS shall provide the member with written notification regarding the eligibility of the transfer.
- F. The member shall contact the plan administrator to have the funds transferred to the ASRS. Except as provided in subsection (G), unless the ASRS receives the check for the correct amount from the plan within 90 days of the issue date on the SP invoice, the ASRS shall cancel the request to purchase service credit as specified in R2-8-502(C).
- G. The ASRS shall provide an extension of 60 days in which the check may be received by the ASRS from the plan at the written request of the member, if:
 1. The member has followed the procedure under this Article for requesting to purchase service credit,
 2. The member has responded to the ASRS correspondence within the time-frame set forth in this Article,
 3. The eligible plan has not provided to the ASRS the check to pay for the requested service credit purchase within 90 days of the date of the SP invoice, and
 4. The member makes the written request for extension before expiration of the 90 days.
- H. The member shall ensure that the ASRS receives a check from the plan, made payable to the ASRS, for an amount that does not exceed the amount specified on the SP Invoice.
- I. If the payment from the eligible plan exceeds the amount specified on the SP Invoice, the ASRS shall return the entire pay-

ment to the member and notify the member of the correct amount due.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 2640, effective June 30, 2005 (Supp. 05-2). Amended by final rulemaking at 12 A.A.R. 4667, effective December 5, 2006 (Supp. 06-4).

R2-8-516. Purchasing Service Credit by Indirect IRA Rollover

- A. An eligible member may purchase service credit, or pay off an Irrevocable Payroll Deduction Authorization at retirement or termination of employment without transferring employment, by an indirect IRA rollover if the rollover purchase is completed within 60 days of the date of distribution of funds from the IRA account, as required by IRC § 408(d)(3)(A). The 60-day time limitation is exclusive of any other time limitations prescribed in this Article and the ASRS shall not extend the 60-day period.
- B. By the due date specified on the SP invoice, the member shall ensure that the ASRS receives the completed Service Purchase Payment Request form described in R2-8-502(D)(2).
- C. Upon the receipt of the completed Service Purchase Payment Request form and upon the member's request, the ASRS shall provide to the member an Indirect IRA Rollover Contribution form. The member shall complete the Indirect IRA Rollover Contribution form and ensure that the ASRS receives the form within 90 days after the issue date on the SP Invoice, along with:
 1. A copy of the distribution statement or check stub identifying it as an IRA distribution, showing the date of distribution and amount distributed; or
 2. The distribution check endorsed by the member made payable to the ASRS with documentation that it is an IRA distribution.
- D. The information requested on the Indirect IRA Rollover Contribution form includes:
 1. The member's full name,
 2. The member's Social Security number,
 3. The member's mailing address,
 4. The member's daytime telephone number,
 5. The member's signature certifying that the member understands the statements on the form regarding the distribution the member has received from the IRA and the requirements for an IRA rollover to the ASRS and agrees to the statements, and
 6. The date the member signs the form.
- E. The ASRS shall provide the member with written notification regarding the eligibility of the rollover contribution.
- F. After receiving notice from the ASRS that the rollover is an eligible rollover contribution, if the member has not sent payment for the purchase of service credit, the member shall submit payment for the service credit purchase. The member shall make payment by:
 1. The distribution check from the IRA made payable to the member and endorsed by the member to make it payable to the ASRS; or
 2. Direct payment by the member by check or money order to the ASRS, after the IRA distribution is deposited to the member's account.
- G. Except as provided in subsection (H), unless the ASRS receives payment from the member within 90 days of the issue date on the SP invoice, the ASRS shall cancel the request to purchase service credit as specified in R2-8-502(C).

- H.** The ASRS shall provide an extension of 60 days in which the check may be received by the ASRS under subsection (G) at the written request of the member, if:
1. The member has followed the procedure under this Article for requesting to purchase service credit,
 2. The member has responded to the ASRS correspondence within the time-frame set forth in this Article,
 3. The eligible plan has not provided the member with the check to pay for the requested service credit purchase within 90 days of the date of the SP invoice, and
 4. The member makes the written request for extension before expiration of the 90 days.
- I.** The member shall ensure that the ASRS receives a check made payable to the ASRS for an amount that does not exceed the amount specified on the SP Invoice.
- J.** If the payment exceeds the amount specified on the SP Invoice, the ASRS shall return the entire payment to the member.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 2640, effective June 30, 2005 (Supp. 05-2). Amended by final rulemaking at 12 A.A.R. 4667, effective December 5, 2006 (Supp. 06-4).

R2-8-517. Purchasing Service Credit by Distributed Rollover Contribution

- A.** An eligible member may purchase service credit with a distribution from a prior employer's eligible plan that has already been distributed to the member if the rollover purchase is completed within 60 days of the date of distribution to the member, as required by IRC §§ 402(c)(3)(A), 403(b)(8)(B), and 457(e)(16)(B). The 60-day time limitation is exclusive of any other time limitations prescribed in this Article, and the ASRS shall not extend the 60-day period. Eligible plans are:
1. A pension, profit sharing, or other qualified plan described in IRC § 401(a) and (k);
 2. A qualified annuity plan described in IRC § 403(a);
 3. A deferred compensation plan described in IRC § 457 and maintained by a state of the United States, or a political subdivision, agency, or instrumentality of a state of the United States; and
 4. A tax deferred annuity described in IRC § 403(b).
- B.** By the due date specified on the SP invoice, the member shall ensure that the ASRS receives the completed Service Purchase Payment Request form described in R2-8-502(D)(2).
- C.** When the ASRS receives the completed Service Purchase Payment Request form and upon the member's request, the ASRS shall provide a Certification by Eligible Plan Rollover Contribution form and Rollover Contribution form.
- D.** The information requested on the Certification by Eligible Plan Rollover Contribution form includes:
1. The member's dated signature;
 2. Member's full name;
 3. Member's Social Security number;
 4. Member's mailing address;
 5. Certification by the plan administrator that the plan is one of the plans described in subsection (A);
 6. Certification by the plan administrator that:
 - a. If the plan is described in either IRC § 401(a) or 403(a), the plan has received a determination letter from the Internal Revenue Service indicating that the plan is qualified under either IRC § 401(a) or 403(a);
 - b. If the plan is described in either IRC § 401(a) or 403(a), but has not received a determination letter from the Internal Revenue Service, the plan satisfies the requirements of IRC § 401(a) or 403(a) or is intended to satisfy the requirements of IRC § 401(a) or 403(a) and the plan administrator is not aware of any plan provision or any other reason that would disqualify the plan; or
- E.** The information requested on the Rollover Contribution form includes:
1. The member's Social Security number;
 2. The member's full name;
 3. The member's mailing address;
 4. The member's daytime telephone number;
 5. The member's signature certifying that:
 - a. The member has read the statements on the Rollover Contribution form regarding requirements for a rollover contribution, understands all the statements, and believes the statements, certifications, and any documents attached to the form to be true and correct to the best of the member's knowledge and belief; and
 - b. The member understands that:
 - i. The ASRS assumes no responsibility for ensuring that the member makes a timely rollover contribution to the ASRS or that the amount rolled over constitutes a valid rollover contribution;
 - ii. The member accepts full responsibility for ensuring that the rollover contribution is an eligible rollover contribution before making the contribution to the ASRS;
 - iii. If the ASRS accepts the rollover contribution and it is later determined that the contribution was an invalid rollover contribution, the ASRS will distribute the invalid contribution directly to the member; and
 - iv. Any invalid rollover contributions returned to the member may decrease the member's benefits and the Internal Revenue Service and state taxing authorities may require the member to pay taxes, penalties, and interest on the returned contributions; and
 6. The date the member signed the form.
- F.** The member shall ensure that the ASRS receives the Certification by Eligible Plan Rollover Contribution form signed and dated by the plan administrator, the Rollover Contribution form signed and dated by the member, and a copy of the distribution statement showing the:
1. Date of the distribution;
 2. Amount of the distribution; and
 3. Amount of taxes withheld, if any.

- G. The ASRS shall provide the member with written notification regarding the eligibility of the rollover.
- H. The member shall make payment by:
 1. The distribution check from the eligible plan made payable to the member and endorsed by the member to make it payable to the ASRS; or
 2. Direct payment by the member by check or money order to the ASRS, after the eligible plan distribution is deposited to the member's personal financial account.
- I. Except as provided in subsection (J), unless the ASRS receives the check from the plan within 90 days of the issue date on the SP invoice, the ASRS shall cancel the request to purchase service credit as specified in R2-8-502(C).
- J. At the written request of the member, the ASRS shall provide an extension of 60 days in which the check may be received by the ASRS from the plan under subsection (I), if:
 1. The member has followed the procedure under this Article for requesting to purchase service credit,
 2. The member has responded to the ASRS correspondence within the time-frame set forth in this Article,
 3. The eligible plan has not provided to the member with the check to pay for the requested service credit purchase within 90 days of the date of the SP invoice, and
 4. The member makes the written request for extension before expiration of the 90 days.
- K. The member shall ensure that the ASRS receives a check, made payable to the ASRS, for an amount that does not exceed the amount specified in the written notification identified in subsection (G).
- L. If the payment from the eligible plan exceeds the amount specified in the written notification identified in subsection (G) the ASRS shall return the entire payment to the member.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 2640, effective June 30, 2005 (Supp. 05-2). Amended by final rulemaking at 12 A.A.R. 4667, effective December 5, 2006 (Supp. 06-4).

R2-8-518. Repealed

Historical Note

New Section made by final rulemaking at 11 A.A.R. 2640, effective June 30, 2005 (Supp. 05-2). Amended by final rulemaking at 12 A.A.R. 4667, effective December 5, 2006 (Supp. 06-4). Repealed by final rulemaking at 18 A.A.R. 3130, effective January 6, 2013 (Supp. 12-4).

R2-8-519. Purchasing Service Credit by Termination Pay Distribution

- A. To purchase service credit using termination pay distribution, an eligible member shall, no more than six months before the date the eligible member plans to retire or terminate employment, request to purchase service credit as specified in R2-8-502 and specify that the member wants to use termination pay distribution to pay for the service credit. Upon receipt of the acknowledgement letter identified in R2-8-502, the eligible member shall provide documentation for service credit as required by this Article, within 30 days of the eligible member's request to purchase service credit.
- B. Upon receipt of the documentation required by this Article from the eligible member and if the eligible member's request to purchase service credit meets the requirements of this Article, the ASRS shall provide a:
 1. SP invoice stating the cost to purchase the requested amount of service credit and the date the payment is due, and
 2. Service Purchase Payment Request form as described in R2-8-502(D)(2).
- C. By the due date specified on the SP invoice, the member shall ensure that the ASRS receives the completed Service Purchase Payment Request form.
- D. Upon receipt of the Service Purchase Request form, if the member indicates the member wishes to purchase service credit by termination pay distribution, the ASRS shall send the member a Termination Pay Authorization for the Purchase of Service Credit form to complete and return within the time limitation specified in subsection (E) that includes:
 1. Member's full name,
 2. Member's Social Security number,
 3. Member's daytime telephone number,
 4. The Request ID number listed on the SP invoice,
 5. Name of ASRS employer,
 6. Whether the member elects to use all termination pay or a specific amount of termination pay to purchase service credit,
 7. Signature of the member, certifying that the member understands that:
 - a. The member is required to continue working at least three full calendar months after the date the member submits the Termination Pay Authorization for the Purchase of Service Credit form before termination pay may be used on a pre-tax basis;
 - b. If the member terminates employment more than six months after the date on the SP invoice, the member may purchase the service credit at a newly calculated rate and possibly at a higher cost;
 - c. The Termination Pay Authorization for the Purchase of Service Credit form is binding and irrevocable;
 - d. The member's employer is required to make payment directly to the ASRS after mandatory deductions are made, and the member does not have the option of receiving the funds directly from the employer;
 - e. The ASRS shall apply service credit to the member's account upon the receipt of payments authorized by the member by the Termination Pay Authorization for the Purchase of Service Credit form;
 - f. If the member elects to purchase with termination pay only a portion of the service credit that the member is entitled to purchase, the member may be eligible to use other forms of payment to purchase additional service credit. However, using other forms of payment to purchase additional service credit does not alter, amend, or revoke the terms of the Termination Pay Authorization for the Purchase of Service Credit form;
 - g. It is the member's responsibility to ensure that the member's employer properly deducts termination pay, as provided the Termination Pay Authorization for the Purchase of Service Credit form; and
 - h. The amount of termination pay the member is allowed to apply to purchase service credit is subject to federal laws.
- E. In addition to the other time limitations in this Section, to apply termination pay to a service purchase the eligible member shall complete and sign the Termination Pay Authorization for the Purchase of Service Credit form, and the member shall ensure that the ASRS receives the Termination Pay Authorization for the Purchase of Service Credit form at least three full calendar months before the member retires or terminates employment.

- F. The ASRS shall not apply a termination pay distribution to a service credit purchase covered by an Irrevocable Payroll Deduction Authorization in effect at the time of termination unless the eligible member signed a Termination Pay Addendum to the Irrevocable Payroll Deduction Authorization specified in R2-8-513(D) at the time the member signed the Irrevocable Payroll Deduction Authorization.
- G. If a member elects to use all of the member's available termination pay to purchase service credit, ASRS shall not apply any other form of payment to the service credit purchase until the ASRS receives the termination pay.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 2640, effective June 30, 2005 (Supp. 05-2). Amended by final rulemaking at 12 A.A.R. 4667, effective December 5, 2006 (Supp. 06-4).

R2-8-520. Termination of Employment and Request Return of Retirement Contributions or Death of Member While Purchasing Service Credit by an Irrevocable Payroll Deduction Authorization

- A. If a member terminates employment without transferring employment as specified in R2-8-513.01 while purchasing service credit by an Irrevocable Payroll Deduction Authorization and requests return of retirement contributions, the ASRS shall return any payments made for the purchase of service credit including interest earned on those payments as determined by the Board.
- B. If a member dies while purchasing service credit, the ASRS shall credit the member's account with:
1. The service credit for which the ASRS received payment before the member's death,
 2. Interest earned on payment through the date of distribution at the valuation rate established by the Board, and
 3. All service purchase payments.
- C. If a member dies while purchasing service credit, the ASRS shall not permit the survivor to purchase the remaining balance.
- D. The ASRS shall not refund interest charged as part of an Irrevocable Payroll Deduction Authorization as specified in R2-8-513(E)(1).

Historical Note

New Section made by final rulemaking at 11 A.A.R. 2640, effective June 30, 2005 (Supp. 05-2). Amended by final rulemaking at 12 A.A.R. 4667, effective December 5, 2006 (Supp. 06-4).

R2-8-521. Adjustment of Errors

- A. If the ASRS determines an error has been made in the information provided by the member or in the calculations made by the ASRS, the ASRS shall make an adjustment, including, but limited to, increasing or decreasing a member's total credited service with the ASRS and increasing or decreasing the payment amount.
- B. If the ASRS determines that a member is receiving or is eligible to receive retirement benefits from another public employee retirement system that makes the member ineligible to purchase service credit for the same period, the ASRS shall revoke that purchase of service credit, and return any payments made, less any interest payments made, if applicable.
- C. The ASRS shall notify the member in writing of any adjustments.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 2640, effective June 30, 2005 (Supp. 05-2).

ARTICLE 6. PUBLIC PARTICIPATION IN RULEMAKING

R2-8-601. Definitions

The following definitions apply to this Article unless otherwise specified:

1. "ASRS" has the same meaning as in A.R.S. § 38-711.
2. "Day" means a calendar day, and excludes the:
 - a. Day of the act or event from which a designated period of time begins to run; and
 - b. Last day of the period if a Saturday, Sunday, or official state holiday.
3. "Rulemaking record" means a file the ASRS maintains as specified in A.R.S. § 41-1029.
4. "Oral proceeding" means a public gathering the ASRS holds for the purpose of receiving comment and answering questions about a proposed rule as specified in A.R.S. § 41-1023.
5. "Presiding officer" means an individual selected by the ASRS Director to oversee oral proceedings.
6. "Substantive policy statement" has the same meaning as in A.R.S. § 41-1001.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 964, effective March 7, 2006 (Supp. 06-1).

R2-8-602. Reviewing Agency Rulemaking Record and Directory of Substantive Policy Statements

Except on a state holiday, an individual may review a rulemaking record or the directory of substantive policy statements at the Phoenix office of the ASRS, Monday through Friday, from 8:00 a.m. until 5:00 p.m.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 964, effective March 7, 2006 (Supp. 06-1).

R2-8-603. Petition for Rulemaking

- A. An individual submitting a petition to the ASRS to make or amend a rule under A.R.S. § 41-1033 shall include the following in the petition:
1. The name and current address of the individual submitting the petition;
 2. An identification of the rule to be made or amended;
 3. The suggested language of the rule;
 4. The reason why a new rule should be made or a current rule should be amended with supporting information, including:
 - a. An identification of the persons who would be affected by the rule and how the persons would be affected; and
 - b. If applicable, statistical data with references to attached exhibits;
 5. The signature of the individual submitting the petition; and
 6. The date the individual signs the petition.
- B. The ASRS shall send a written notice of the ASRS's decision regarding the Petition for Rulemaking to the individual within 30 days of receipt of the petition.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 964, effective March 7, 2006 (Supp. 06-1).

R2-8-604. Review of a Rule, Agency Practice, or Substantive Policy Statement

- A. An individual submitting a petition to the ASRS under A.R.S. § 41-1033 requesting that the ASRS review an agency practice or substantive policy statement that the individual alleges constitutes a rule shall include the following in the petition:

1. The name and current address of the individual submitting the petition,
 2. The reason the individual alleges that the agency practice or substantive policy statement constitutes a rule,
 3. The signature of the individual submitting the petition, and
 4. The date the individual signs the petition.
- B.** The individual who submits a petition under subsection (A) shall attach a copy of the substantive policy statement or a description of the agency practice to the petition.
- C.** The ASRS shall send a written notice of the ASRS's decision regarding the petition to the individual within 30 days of receipt of the petition.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 964, effective March 7, 2006 (Supp. 06-1).

R2-8-605. Objection to Rule Based Upon Economic, Small Business and Consumer Impact

- A.** An individual submitting an objection to a rule based upon the economic, small business and consumer impact under A.R.S. § 41-1056.01 shall include the following in the objection:
1. The name and current address of the individual submitting the objection;
 2. Identification of the rule;
 3. Either evidence that the actual economic, small business and consumer impact:
 - a. Significantly exceeded the impact estimated in the economic, small business and consumer impact statement submitted during the making of the rule with supporting information attached as exhibits; or
 - b. Was not estimated in the economic, small business and consumer impact statement submitted during the making of the rule and that actual impact imposes a significant burden on persons subject to the rule with supporting information attached as exhibits;
 4. The signature of the individual submitting the objection; and
 5. The date the individual signs the objection.
- B.** The ASRS shall respond to the objection as specified in A.R.S. § 41-1056.01(C).

Historical Note

New Section made by final rulemaking at 12 A.A.R. 964, effective March 7, 2006 (Supp. 06-1).

R2-8-606. Oral Proceedings

- A.** An individual requesting an oral proceeding under A.R.S. § 41-1023(C) shall submit a written request to the ASRS that includes:
1. The name and current address of the individual making the request;
 2. If applicable, the name of the public or private organization, partnership, corporation or association, or the name of the governmental entity the individual represents; and
 3. Reference to the proposed rule including, if known, the date and issue of the Arizona Administrative Register in which the Notice of Proposed Rulemaking was published.
- B.** The ASRS shall record an oral proceeding by either electronic or stenographic means and any CDs, cassette tapes, transcripts, lists, speaker slips, and written comments received shall become part of the official record.
- C.** A presiding officer shall perform the following acts on behalf of the ASRS when conducting an oral proceeding as prescribed under A.R.S. § 41-1023:

1. Provide a method for individuals who attend the oral proceeding to voluntarily note their attendance;
 2. Provide a speaker slip that includes space for:
 - a. An individual's name,
 - b. The person the individual represents, if applicable,
 - c. The rule the individual wishes to comment on or has a question about, and
 - d. The approximate length of time the individual wishes to speak;
 3. Open the proceeding by identifying the rules to be considered, the location, date, time, purpose of the proceeding, and the agenda;
 4. Explain the background and general content of the proposed rulemaking;
 5. Provide for public comment as specified in A.R.S. § 41-1023(D); and
 6. Close the oral proceeding by announcing the location where written public comments are to be sent and specifying the close of record date and time.
- D.** A presiding officer may limit comments to a reasonable time period, as determined by the presiding officer. Oral comments may be limited to prevent undue repetition.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 964, effective March 7, 2006 (Supp. 06-1).

R2-8-607. Petition for Delayed Effective Date

- A.** An individual who wishes to delay the effective date of a rule under A.R.S. § 41-1032 shall file a petition with the ASRS prior to the proposed rule's close of record date identified in the Notice of Proposed Rulemaking. The petition shall contain the:
1. Name and current address of the individual submitting the petition;
 2. Identification of the proposed rule;
 3. Need for the delay, specifying the undue hardship or other adverse impact that may result if the request for a delayed effective date is not granted;
 4. Reason why the public interest will not be harmed by the delayed effective date;
 5. Signature of the individual submitting the petition; and
 6. Date the individual signs the petition.
- B.** The ASRS shall send a written notice of the ASRS's decision to the individual within 30 days of receipt of the Petition for Delayed Effective Date.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 964, effective March 7, 2006 (Supp. 06-1).

ARTICLE 7. CONTRIBUTIONS NOT WITHHELD

R2-8-701. Definitions

The following definitions apply to this Article unless otherwise specified:

1. "218 agreement" means a written agreement between the state, political subdivision, or political subdivision entity and the Social Security Administration, under the provisions of § 218 of the Social Security Act, to provide Social Security and Medicare or Medicare-only coverage to employees of the state, political subdivision, or political subdivision entity.
2. "Active member" has the same meaning as in A.R.S. § 38-711.
3. "ASRS" has the same meaning as in A.R.S. § 38-711.
4. "ASRS employer" means this state, a political subdivision, or a political subdivision entity that has:
 - a. Signed a 218 agreement,

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- b. Applied to become a member of ASRS, and
- c. Been approved for membership by the Board.
- 5. "Authorized employer representative" means an individual who has legal power to bind the ASRS employer in its transactions with the ASRS.
- 6. "Board" has the same meaning as in A.R.S. § 38-711.
- 7. "Director" means the Director appointed by the Board as provided in A.R.S. § 38-715.
- 8. "Documentation" means a pay stub, completed W-2 form, completed Verification of Contributions Not Withheld form, employer letter or spreadsheet, completed State Personnel Action Form, Social Security Earnings Report, employment contract, payroll record, timesheet, or other ASRS employer-provided form that includes:
 - a. Whether the employee was covered under the ASRS employer's 218 agreement,
 - b. The number of hours worked or length of time the member was employed by the ASRS employer, or
 - c. The compensation paid to the member by the ASRS employer.
- 9. "Eligible service" means employment with an ASRS employer:
 - a. That is no more than 15 years before the date the ASRS receives written credible evidence that less than the correct amount of contributions were paid into the ASRS or the ASRS otherwise determines that less than the correct amount of contributions were made as specified in A.R.S. § 38-738(C); and
 - b. In which the member:
 - i. Until 6/30/92, worked a minimum of 20 hours per week for at least five months in a fiscal year for any one or more ASRS employers;
 - ii. From 7/1/92 to 7/1/99, worked a minimum of 20 hours per week for at least 20 weeks in a fiscal year for any one or more ASRS employers; or
 - iii. From 7/1/99 to the present, worked a minimum of 20 hours per week for at least 20 weeks in a service year for at least one ASRS employer.
- 10. "Fiscal year" means from July 1 of one year through June 30 of the next year.
- 11. "Member" has the same meaning as in A.R.S. § 38-711.
- 12. "Person" has the same meaning as in A.R.S. § 1-215.
- 13. "Political subdivision" has the same meaning as in A.R.S. § 38-711.
- 14. "Political subdivision entity" has the same meaning as in A.R.S. § 38-711.
- 15. "Service year" has the same meaning as in A.R.S. § 38-711.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 4793, effective December 5, 2006 (Supp. 06-4).

R2-8-702. General Information

- A. Verified eligible service that occurred more than 15 years before the date ASRS receives the information identified in R2-8-704(A)(1) is considered public service credit as provided in A.R.S. § 38-738(D), and is not applied under this Article.
- B. The ASRS employer shall pay the ASRS employer's portion of the contributions the ASRS determines is owed under R2-8-706 whether or not:
 - 1. The member has withdrawn contributions as specified in R2-8-115; or
 - 2. The member pays the member's portion of the contributions.

- C. The person who initiates the claim that contributions were not withheld for eligible service has the burden to prove a contribution error was made.
- D. ASRS shall not waive payment of contributions or interest owed under this Article.
- E. If a member is not able to establish eligibility for service credit for which contributions were not withheld, but is able to establish a period of employment by an ASRS employer the member may request to purchase service credit for that period under A.R.S. § 38-743 and Article 5 of this Chapter.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 4793, effective December 5, 2006 (Supp. 06-4).

R2-8-703. ASRS Employer's Discovery of Error

If an ASRS employer determines that contributions have not been withheld for a member for a period of eligible service, the ASRS employer shall notify ASRS in writing, and shall provide ASRS with the member's full name, Social Security number, months, years, and hours per week worked, the compensation each fiscal year for the time periods worked, and the member's position title and status at the time contributions should have been withheld.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 4793, effective December 5, 2006 (Supp. 06-4).

R2-8-704. Member's Discovery of Error

- A. If a member believes that an ASRS employer has not withheld contributions for the member for a period of eligible service, the member shall:
 - 1. Provide the ASRS employer with documentation of the member's claim and request that the ASRS employer provide a letter that includes the information in the Verification of Contributions Not Withheld form or complete a Verification of Contributions Not Withheld form that includes:
 - a. The member's full name;
 - b. Other names used by the member;
 - c. The member's Social Security number;
 - d. Whether the position was covered under the ASRS employer's 218 agreement;
 - e. The position title the member held at the time the contributions should have been withheld;
 - f. The eligibility of the member at the time the contributions should have been withheld;
 - g. The following statements of understanding and agreements to be initialed by the authorized employer representative filling out the form:
 - i. I understand it is my responsibility to verify the accuracy of the information I am providing on this form. I understand any individual who knowingly makes a false statement, or who falsifies or permits to be falsified any record of the ASRS with an intent to defraud the ASRS, is guilty of a Class 6 felony pursuant to A.R.S. § 38-793; and
 - ii. I understand that, based on the information provided on this form, the ASRS may determine that contributions are owed on behalf of the member listed on this form, and the ASRS employer may incur a substantial financial obligation;
 - h. The months worked, the hours per week worked, and the compensation earned by the member, by fiscal year;
 - i. The name of the ASRS employer;

- j. The printed name and signature of the authorized employer representative;
 - k. The daytime telephone number of the authorized employer representative;
 - l. The title of the authorized employer representative; and
 - m. The date the authorized employer representative signed the form;
2. Provide the ASRS with the completed Verification of Contributions Not Withheld form; and
 3. If the ASRS employer refuses to fill out the Verification of Contributions Not Withheld form, or if the member disputes the information the ASRS employer completes on the form, provide the ASRS with the documentation the member believes supports the allegation that contributions should have been withheld, that includes proof:
 - a. That the employee was covered under the ASRS employer's 218 agreement,
 - b. Of the number of hours worked,
 - c. Of the length of time the member was employed by the ASRS employer, and
 - d. Of the compensation paid to the member by the ASRS employer.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 4793, effective December 5, 2006 (Supp. 06-4).

R2-8-705. ASRS' Discovery of Error

If the ASRS determines, as specified in A.R.S. § 38-738(B)(7), that contributions have not been withheld for a member for a period of eligible service, the ASRS shall notify the member and the ASRS employer in writing and shall request the following information:

1. The months, years and hours per week worked;
2. The compensation earned by the member each fiscal year for the time periods worked; and
3. The member's position title at the time contributions should have been withheld.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 4793, effective December 5, 2006 (Supp. 06-4).

R2-8-706. Determination of Contributions Not Withheld

- A. Upon receipt of the information listed in R2-8-703, R2-8-704, or R2-8-705, the ASRS shall review the information to determine whether or not member contributions should have been withheld by the ASRS employer, the length of time those contributions should have been withheld, and the amount of contributions that should have been withheld.
- B. Except for returning to work under A.R.S. § 38-766.01, the presence of a contract between a member and the ASRS employer does not alter the contribution requirements of A.R.S. §§ 38-736 and 38-737.
- C. If there is any discrepancy between the documentation provided by the ASRS employer and the documentation provided by the member, a document used in the usual course of business prepared at the time in question is controlling.
- D. The ASRS shall provide to the ASRS employer and the member a written statement that includes:
 1. The dates of eligible service for which contributions were not withheld,
 2. The dollar amount of contributions that should have been made,
 3. The dollar amount of the contributions to be paid by the ASRS employer,
 4. The interest on the ASRS employer contributions and member contributions to be paid by the ASRS employer,

5. The dollar amount of contributions to be paid by the member, and
6. To the member, the various payment options that may apply, as specified in R2-8-512 through R2-8-519.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 4793, effective December 5, 2006 (Supp. 06-4).

R2-8-707. Submission of Payment

- A. Within 90 calendar days after the ASRS notifies the ASRS employer in writing of the amount due, the ASRS employer shall pay all ASRS employer contributions, including accrued interest on both the ASRS employer and member contributions, from the date the contributions were due to the date the ASRS notifies the ASRS employer of the amount due. An ASRS employer who makes payment under A.R.S. § 38-738(B)(3) is not liable for additional interest that may accrue as a result of a member's failure to remit payment required by A.R.S. § 38-738(B)(1). If the ASRS does not receive full payment of the ASRS employer's amount due within 90 calendar days after the ASRS notifies the ASRS employer of the amount due, interest on the amount not paid, as provided in A.R.S. § 38-738(B)(3), will accrue from the 91st day until the ASRS employer pays the full amount.
- B. An ASRS employer may pay the amount the ASRS employer believes may be due at any time before ASRS's notification of the amount due in order to prevent the accrual of interest after the date of the payment. Any amount the ASRS employer pays that the ASRS determines is not owed shall be refunded to the ASRS employer.
- C. A member may purchase eligible service for which contributions were not withheld in accordance with the requirements of Article 5 of this Chapter for purchase of service credit. If the ASRS does not receive full payment of the ASRS employee's amount due within 90 calendar days after the ASRS notifies the member that the ASRS received the ASRS employer's full payment, interest on the amount not paid, as provided in A.R.S. § 38-738(B)(1), will accrue from the 91st day until the member pays the full amount.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 4793, effective December 5, 2006 (Supp. 06-4).

R2-8-708. Dispute of an ASRS Determination Regarding Contributions Not Withheld

- A. If a member or the ASRS employer disputes an ASRS determination regarding contributions not withheld, that party may request in writing that the Director review the ASRS determination. Within 30 calendar days of receiving the request for the review of the ASRS determination, the Director shall review and either approve or amend the ASRS determination, and send to the member and the ASRS employer written notice of the Director's decision.
- B. If the member or the ASRS employer disputes the Director's decision, that party may obtain a hearing by filing a Request for a Hearing with the Board, in accordance with Article 4 of this Chapter, within 30 calendar days after receiving notice of the Director's determination. The party filing the request shall provide the name of the other party.
- C. The burden of producing evidence is on the party challenging the determination.
- D. If the ASRS Board determines that the service is eligible, the ASRS shall send both the ASRS employer and the member a written statement, as specified in R2-8-706(D), and the:
 1. Decision of the Board;

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2. Correct amount due as determined by the Board, if applicable;
 3. Additional amount of interest due from the losing party, from the 91st day after the initial notification of the amount due to the date of the decision; and
 4. Notification that interest shall continue to accrue on the total amount due at the rate specified in A.R.S. § 38-738(B) until the date payment is received by the ASRS.
- E.** If the ASRS Board determines that the service is not eligible, ASRS shall send both the ASRS employer and the member the decision of the Board.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 4793, effective December 5, 2006 (Supp. 06-4).

R2-8-709. Nonpayment of Contributions

- A.** A member receives service credit only for the portion of service the ASRS has determined is eligible and that the member has paid for.
- B.** A member does not receive service credit until both the ASRS employer and member portions of the contributions have been paid.
- C.** If the ASRS employer does not pay, the ASRS shall take any steps legally authorized to collect payment. Any steps the ASRS may take to collect payment are separate from any action a member may elect to take against the ASRS employer.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 4793, effective December 5, 2006 (Supp. 06-4).

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Supplement to the

Arizona Administrative Code

The official compilation of Arizona Rules

Arizona Secretary of State's Office

Public Services Division

1700 W. Washington Street, Fl 7.

Phoenix, AZ 85007

Replacement Check List

For rules filed within the

4th Calendar Quarter

October 1 - December 31, 2012

Code Release Number: Supp. 12-4

Within the stated calendar quarter, this Title contains all rules made, amended, repealed, renumbered, and recodified, or rules that have expired or were terminated due to an agency being eliminated under sunset law. These rules were either certified by the Governor's Regulatory Review Council or the Attorney General's Office, or exempt from the rulemaking process, and filed with the Office of the Secretary of State. Refer to the historical notes for more information. Please note that some rules you are about to remove may still be in effect after the publication date of this Supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

Follow the instructions to replace the updated Chapters.

TITLE 3. AGRICULTURE

Chapter 9. Department of Agriculture - Agricultural Councils and Commissions

Sections, Parts, Exhibits, Tables or Appendices modified

R3-9-601

REMOVE Supp. 11-4

Pages: 1 - 9

REPLACE with Supp. 12-4

Pages: 1 - 9

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TITLE 3. AGRICULTURE**CHAPTER 9. DEPARTMENT OF AGRICULTURE
AGRICULTURAL COUNCILS AND COMMISSIONS**

Chapter 9 heading amended by final rulemaking at 5 A.A.R. 4439, effective November 3, 1999 (Supp. 99-4).

Former Title 3, Chapter 9, Articles 1 through 7, Sections 3-9-101 through R3-9-703, renumbered to Title 3, Chapter 2, Articles 1 through 7, Sections 3-2-101 through R3-2-703 (Supp. 91-4).

**ARTICLE 1. ARIZONA ICEBERG LETTUCE RESEARCH
COUNCIL**

Article 1, consisting of Sections R3-9-101 through R3-9-106, made by final rulemaking at 12 A.A.R. 208, effective March 11, 2006 (Supp. 06-1).

Section	
R3-9-101.	Definitions
R3-9-102.	Elections
R3-9-103.	Hearings and Rehearings
R3-9-104.	Annual Report
R3-9-105.	Records
R3-9-106.	Grants

**ARTICLE 2. ARIZONA GRAIN RESEARCH AND
PROMOTION COUNCIL**

(Authority: A.R.S. § 3-581 et seq.)

Article 2, consisting of Section R3-9-201, renumbered from Title 3, Chapter 13, Article 2, Section R3-13-201 (Supp. 91-4).

Section	
R3-9-201.	Definitions
R3-9-202.	Fees; Grain Assessment and Refund
R3-9-203.	Hearings
R3-9-204.	Records
R3-9-205.	Grants

**ARTICLE 3. ARIZONA COTTON RESEARCH AND
PROTECTION COUNCIL**

(Authority: A.R.S. § 3-1083)

Article 3, consisting of Section R3-9-301, renumbered from Title 3, Chapter 12, Article 2, Section R3-12-201 (Supp. 91-4).

Section	
R3-9-301.	Ginning and Remittance Forms
R3-9-302.	Non-Bt Cotton Acreage Registration Form

ARTICLE 4. EXPIRED

Article 4, consisting of Sections R3-9-401 through R3-9-405, formerly the rules for the Arizona Wine Commission expired under A.R.S. § 41-1056(E). The rules are no longer authorized as the Commission was terminated on July 1, 2004, under A.R.S. § 41-3004.18. The statutes under which the Commission operated, A.R.S. §§ 3-551 through 3-557, added by Laws 1993, Ch. 40, § 1, were repealed on January 1, 2005, by A.R.S. § 41-3004.18. Accordingly, under A.R.S. § 41-1011(C), the rules of this agency have been removed from the Code. The rescinded Article is on file in the Office of the Secretary of State (Supp. 05-2).

Article 4, consisting of Sections R3-9-401 through R3-9-405, made by final rulemaking at 9 A.A.R. 519, effective February 5, 2003 (Supp. 03-1).

Section	
R3-9-401.	Expired
R3-9-402.	Expired
R3-9-403.	Expired
R3-9-404.	Expired
R3-9-405.	Expired

ARTICLE 5. ARIZONA CITRUS RESEARCH COUNCIL

Article 5, consisting of Sections R3-9-501 through R3-9-505, made by final rulemaking at 9 A.A.R. 5548, effective December 2, 2004 (Supp. 03-4).

Section	
R3-9-501.	Definitions
R3-9-502.	Elections
R3-9-503.	Hearings
R3-9-504.	Annual Report
R3-9-505.	Records
R3-9-506.	Grants

**ARTICLE 6. LEAFY GREENS FOOD SAFETY
COMMITTEE**

Article 6, consisting of Sections R3-9-601 through R3-9-606, made by exempt rulemaking at 16 A.A.R. 2282, effective October 28, 2010 (Supp. 10-4).

Section	
R3-9-601.	Definitions
R3-9-602.	Best Practices; LGMA Compliance
R3-9-603.	Service Mark Usage
R3-9-604.	Loss of Use of Service Mark
R3-9-605.	Violation Levels; Repeated Violations
R3-9-606.	Corrective Action Plans

**ARTICLE 1. ARIZONA ICEBERG LETTUCE RESEARCH
COUNCIL****R3-9-101. Definitions**

In addition to the definitions in A.R.S. § 3-526, the following terms apply to this Article:

1. "AILRC" means the Arizona Iceberg Lettuce Research Council.
2. "Authorized signature" means the signature of an individual authorized to receive funds on behalf of the applicant and responsible for the execution of the applicant's project.
3. "Awardee" means a successful applicant to whom the AILRC awards grant funds for research on a specific project.
4. "Department" means the Arizona Department of Agriculture.
5. "Governmental unit" means any department, commission, council, board, bureau, committee, institution, agency, government corporation, or other establishment or official of the executive branch or corporation commission of this state, another state, or the federal government.
6. "Grant" means an award of financial support to an applicant according to A.R.S. § 3-526.02(B) and (C)(5).
7. "Grant award agreement" means a document that advises an applicant of the amount of money awarded following receipt by the AILRC of the applicant's signed acceptance.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 208, effective March 11, 2006 (Supp. 06-1). Amended by final

rulemaking at 14 A.A.R. 3658, effective November 8, 2008 (Supp. 08-3).

R3-9-102. Elections

- A.** The AILRC shall elect officers as specified in A.R.S. § 3-526.02(A)(2) during the first quarter of each calendar year.
- B.** Officers continue in office until the next annual election.
- C.** An officer may be reelected successively.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 208, effective March 11, 2006 (Supp. 06-1).

R3-9-103. Hearings and Rehearings

- A.** The AILRC shall follow the Uniform Administrative Procedure Act, A.R.S. Title 41, Chapter 6, Article 10, for a hearing before the AILRC.
- B.** A party may file a motion for rehearing or review under A.R.S. § 41-1092.09.
- C.** The AILRC shall grant a rehearing or review of a decision for any of the following causes materially affecting the moving party's rights:
 - 1. The decision is not justified by the evidence or is contrary to law;
 - 2. There is newly discovered material evidence that could not with reasonable diligence have been discovered and produced at the original proceeding;
 - 3. One or more of the following deprived the party of a fair hearing:
 - a. Irregularity or abuse of discretion in the conduct of the proceeding;
 - b. Misconduct of the AILRC, the administrative law judge, or the prevailing party; or
 - c. Accident or surprise that could not have been prevented by ordinary prudence; or
 - 4. Excessive or insufficient sanction.
- D.** The AILRC may grant a rehearing or review to any or all of the parties. The rehearing or review may cover all or part of the issues for any of the reasons stated in subsection (C). An order granting a rehearing or review shall particularly state the grounds for granting the rehearing or review, and the rehearing or review shall cover only the grounds stated.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 208, effective March 11, 2006 (Supp. 06-1).

R3-9-104. Annual Report

The AILRC shall prepare a report according to A.R.S. § 3-526.02(A)(5), by October 31 of each year.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 208, effective March 11, 2006 (Supp. 06-1).

R3-9-105. Records

The AILRC shall retain records required by A.R.S. § 3-526.02(A)(4). A person may review records at the AILRC's office, Monday through Friday, except an Arizona legal holiday, during the hours of 8 a.m. to 5 p.m. Upon request, the AILRC shall provide a copy of the records according to A.R.S. § 39-121 et seq.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 208, effective March 11, 2006 (Supp. 06-1).

R3-9-106. Grants

- A.** Grant application process.
 - 1. The AILRC shall award grants according to the competitive grant solicitation requirements of this Article.

- 2. The AILRC shall post the grant application and manual on the AILRC's web site at least four weeks before the due date of a grant application.
- 3. The AILRC shall ensure that the grant application manual contains the following items:
 - a. Grant topics related to AILRC programs specified by A.R.S. § 3-526.02(B) and (C)(5);
 - b. A statement that the information contained in an application is not confidential;
 - c. A statement that the AILRC funding source is primarily from per carton assessments on iceberg lettuce grown in Arizona;
 - d. An application form including sections about the description of the grant project, scope of work to be performed, an authorized signature line, and a sample budget form;
 - e. A statement that the applicant shall not include overhead expenses in the budget for the proposed project;
 - f. The criteria that the AILRC shall use to evaluate an application;
 - g. The date and time by which the applicant shall submit an application;
 - h. The anticipated date of the AILRC award;
 - i. A copy of the AILRC grant solicitation rules; and
 - j. Any other information necessary for the grant application.
- 4. The AILRC shall not consider an application received by the AILRC after the due date and time.
- B.** Criteria. The AILRC shall consider the following when reviewing a grant application and deciding whether to award AILRC funds:
 - 1. The applicant's successful completion of prior research projects,
 - 2. The extent to which the proposed project identifies solutions to current issues facing the iceberg lettuce industry,
 - 3. The extent to which the proposed project addresses future issues facing the iceberg lettuce industry,
 - 4. The extent to which the proposed project addresses the findings of any industry surveys conducted within the previous year,
 - 5. The appropriateness of the budget request in achieving the project objectives,
 - 6. The appropriateness of the proposal time-frame to the stated project objectives, and
 - 7. Relevant experience and qualifications of the applicant.
- C.** Public participation.
 - 1. The AILRC shall make all applications available for public inspection by the business day following the application due date.
 - 2. Before awarding a grant, the AILRC shall discuss and evaluate grant applications and proposed projects at a meeting conducted under A.R.S. § 38-431 et seq.
- D.** Evaluation of grant applications.
 - 1. The AILRC may allow applicants to make oral or written presentations at the public meeting if time, applicant availability, and meeting space permit.
 - 2. The AILRC may modify an applicant's proposed project in awarding funding.
 - 3. The AILRC shall notify an applicant in writing of the AILRC's decision to fund, modify, or deny funding for a proposed project within 10 business days of the AILRC decision. The AILRC shall notify applicants by the U.S. Postal Service, commercial delivery, electronic mail, or facsimile.
- E.** Awards and project monitoring.

1. Before releasing grant funds, the AILRC shall execute a grant award agreement with the awardee. The awardee shall agree to accept the grant's legal requirements and conditions and authorize the AILRC to monitor the progress of the project by signing a grant award agreement.
 2. The AILRC shall pay no more than 50% of the grant in the initial payment to the awardee.
 3. During the term of the project, the awardee shall inform the AILRC of changes to the awardee's address, telephone number, or other contact information.
 4. The AILRC may require an interim written report or oral presentation from the awardee during the pendency of the project.
 5. The AILRC shall not award grant funds remaining after the initial payment until the awardee submits to the AILRC:
 - a. A final research report, and
 - b. An invoice for actual final project expenses not exceeding the remaining portion of the award.
 6. The AILRC shall make research findings and reports resulting from any grant awarded by the AILRC available to Arizona iceberg lettuce producers.
- F. Repayment.** If the awardee does not complete the project as specified in the grant award agreement, the awardee shall return all unexpended grant funds within 30 days after receipt of a written request by the AILRC.
- G. Governmental units.**
1. The AILRC may request one or more governmental units to submit grant applications as prescribed in subsection (G)(3), without regard to subsections (A), (E)(2), and (E)(5).
 2. The AILRC may issue grants to governmental units without regard to subsections (A), (E)(2), and (E)(5).
 3. A governmental unit may apply to the AILRC for a grant when there is no pending request for grant applications under subsection (A) under the following conditions:
 - a. The application shall include a description of the project, the scope of work to be performed, a budget that does not include overhead expenses, and an authorized signature.
 - b. The application shall be available for public inspection upon receipt by the AILRC.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 208, effective March 11, 2006 (Supp. 06-1). Amended by final rulemaking at 14 A.A.R. 3658, effective November 8, 2008 (Supp. 08-3).

ARTICLE 2. ARIZONA GRAIN RESEARCH AND PROMOTION COUNCIL

R3-9-201. Definitions

In addition to the definitions in A.R.S. § 3-581, the following term applies to this Article:

"AGRPC" means the Arizona Grain Research and Promotion Council.

"Department" means the Arizona Department of Agriculture.

Historical Note

Adopted effective August 28, 1986 (Supp. 86-4). Section R3-9-201 renumbered from R3-13-201 (Supp. 91-4). Amended effective December 22, 1993 (Supp. 93-4). Former Section R3-9-201 renumbered to R3-9-202; new Section R3-9-201 made by final rulemaking at 9 A.A.R. 31, effective December 11, 2002 (Supp. 02-4). Amended by final rulemaking at 14 A.A.R. 3661, effective November 8, 2008 (Supp. 08-3).

R3-9-202. Fees; Grain Assessment and Refund

- A.** The AGRPC shall annually prescribe the fee to be assessed per hundredweight of grain sold in Arizona within the limitations established under A.R.S. § 3-587.
- B.** The person who pays the fee required under subsection (A) shall ensure that:
1. The grain assessment fee is remitted to the AGRPC; and
 2. The following information is provided to the AGRPC on a form obtained from the Department:
 - a. First buyer's name, address, and telephone number;
 - b. Report date and months covered by the report;
 - c. Total amount remitted to the AGRPC for the reporting period;
 - d. Producer's name, address, and telephone number;
 - e. Type of grain and tonnage by grain type; and
 - f. First buyer's or designee's signature.
- C. Refund.**
1. A producer may request a refund as prescribed under A.R.S. § 3-592 and shall provide the following information to the AGRPC on a form obtained from the Department:
 - a. Producer's name, address, telephone number, and signature;
 - b. Name of the first buyer;
 - c. Amount of grain sold subject to the refund request; and
 - d. First buyer's or designee's notarized signature confirming the purchase, funds withheld, and date remitted to the AGRPC.
 2. An executive committee member shall authorize a refund as prescribed in A.R.S. § 3-592 if the person requesting the refund complies with the requirements of subsection (B)(1).

Historical Note

Section R3-9-202 renumbered from R3-9-201 and amended by final rulemaking at 9 A.A.R. 31, effective December 11, 2002 (Supp. 02-4). Amended by final rulemaking at 14 A.A.R. 3661, effective November 8, 2008 (Supp. 08-3).

R3-9-203. Hearings

- A.** The AGRPC shall use the uniform administrative procedures of A.R.S. Title 41, Chapter 6, Article 10 to govern any hearing before the AGRPC required under A.R.S. § 3-591.
- B.** A party may file a motion for rehearing or review under A.R.S. § 41-1092.09.
- C.** The AGRPC shall grant a rehearing or review of an administrative law decision for any of the following causes materially affecting the moving party's rights:
1. The decision is not justified by the evidence or is contrary to law;
 2. There is newly discovered material evidence that could not with reasonable diligence have been discovered and produced at the original proceeding;
 3. One or more of the following deprived the party of a fair hearing:
 - a. Irregularity or abuse of discretion in the conduct of the proceeding;
 - b. Misconduct of the AGRPC, the administrative law judge, or the prevailing party; or
 - c. Accident or surprise which could not have been prevented by ordinary prudence; or
 4. Excessive or insufficient sanction.
- D.** The AGRPC may grant a rehearing or review to any or all of the parties. The rehearing or review may cover all or part of the issues for any of the reasons stated in subsection (C). An

order granting a rehearing or review shall particularly state the grounds for granting the rehearing or review, and the rehearing or review shall cover only the grounds stated.

Historical Note

New Section made by final rulemaking at 9 A.A.R. 31, effective December 11, 2002 (Supp. 02-4). Amended by final rulemaking at 14 A.A.R. 3661, effective November 8, 2008 (Supp. 08-3).

R3-9-204. Records

The Department shall retain the AGRPC's records as prescribed in A.R.S. § 3-586. A record may be reviewed at the Department's main office, Monday through Friday, except an Arizona legal holiday, during the hours of 8:00 a.m. to 5:00 p.m. A copy of a record will be provided according to the provisions of A.R.S. § 39-121 et seq.

Historical Note

New Section made by final rulemaking at 9 A.A.R. 31, effective December 11, 2002 (Supp. 02-4). Amended by final rulemaking at 14 A.A.R. 3661, effective November 8, 2008 (Supp. 08-3).

R3-9-205. Grants

A. Definitions.

"Authorized signature" means the signature of an individual authorized to receive funds on behalf of an applicant and responsible for the execution of the applicant's project.

"Awardee" means an applicant to whom the AGRPC awards grant funds for a proposed project.

"Governmental unit" means any department, commission, council, board, bureau, committee, institution, agency, government corporation, or other establishment or official of the executive branch or corporation commission of this state, another state, or the federal government.

"Grant" means an award of financial support to an applicant according to A.R.S. § 3-584(C)(5).

"Grant award agreement" means a document advising an applicant of the amount of money awarded following receipt by the AGRPC of the applicant's signed acceptance of the award.

B. Grant application process.

1. The AGRPC shall award grants according to the competitive grant solicitation requirements of this Article.
2. The AGRPC shall post the grant application and manual on the AGRPC's web site at least four weeks before the due date of a grant application.
3. The AGRPC shall ensure that the grant application and manual contain the following items:
 - a. Grant topics related to AGRPC projects specified in A.R.S. § 3-584(C)(5);
 - b. A statement that the information contained in a grant application is not confidential;
 - c. A statement that the AGRPC funding source is primarily from assessments on the seed of barley and wheat of all classes produced in Arizona for use as food, feed, or seed or produced for any industrial or commercial use;
 - d. An application form including sections about the description of the grant project, scope of work to be performed, an authorized signature line, and a sample budget form;
 - e. A statement that the applicant shall not include overhead expenses in the budget for the proposed project;

- f. The criteria that the AGRPC shall use to evaluate an application;
- g. The date and time by which the applicant shall submit an application;
- h. The anticipated date of the AGRPC award;
- i. A copy of this Section consisting of grant solicitation procedures and requirements; and
- j. Any other information necessary for the grant application.

4. The AGRPC shall not evaluate an application received by the AGRPC after the due date and time.

C. Criteria. The AGRPC shall consider the following when reviewing a grant application and deciding whether to award AGRPC funds:

1. The applicant's successful completion of prior research projects, if applicable;
2. The extent to which the proposed project identifies solutions to current issues facing the grain industry;
3. The extent to which the proposed project addresses future issues facing the grain industry;
4. The extent to which the proposed project addresses the findings of any industry surveys conducted within the previous year;
5. The appropriateness of the budget request in achieving the project objectives;
6. The appropriateness of the proposal time-frame to the stated project objectives; and
7. Relevant experience and qualifications of the applicant.

D. Public participation.

1. The AGRPC shall make all applications available for public inspection by the business day following the application due date.
2. Before awarding a grant, the AGRPC shall discuss, evaluate, and make a decision on grant applications and proposed projects at a meeting conducted under A.R.S. § 38-431 et seq.

E. Evaluation of grant applications.

1. The AGRPC may allow applicants to make oral or written presentations at the public meeting if time, applicant availability, and meeting space permit.
2. The AGRPC may modify an applicant's proposed project in awarding funding.
3. The AGRPC shall notify an applicant in writing of the AGRPC's decision to fund, modify, or deny funding for a proposed project within 10 business days of the AGRPC decision. The AGRPC shall notify applicants by the U.S. Postal Service, commercial delivery, electronic mail, or facsimile.

F. Awards and project monitoring.

1. Before releasing grant funds, the AGRPC shall execute a grant award agreement with the awardee. The awardee shall agree to accept the grant's legal requirements and conditions and authorize the AGRPC to monitor the progress of the project by signing the grant award agreement.
2. The AGRPC shall pay no more than 50% of the grant in the initial payment to the awardee.
3. During the term of the project, the awardee shall inform the AGRPC of changes to the awardee's address, telephone number, or other contact information.
4. The AGRPC may require an interim written report or oral presentation from the awardee during the term of the project.
5. The AGRPC shall not award the grant funds remaining after the initial payment until the awardee submits to the AGRPC:
 - a. A final research report, and

- b. An invoice for actual final project expenses not exceeding the remaining portion of the grant funds.
- 6. The AGRPC shall make research findings and reports resulting from any grant awarded by the AGRPC available to Arizona grain producers.
- G. Repayment. If the awardee does not complete the project as specified in the grant award agreement, the awardee shall return all unexpended grant funds within 30 days after receipt of a written request by the AGRPC.
- H. Governmental units.
 - 1. The AGRPC may request one or more governmental units to submit grant applications as prescribed in subsection (H)(3), without regard to subsections (B), (F)(2), and (F)(5).
 - 2. The AGRPC may issue grants to governmental units without regard to subsections (B), (F)(2), and (F)(5).
 - 3. A governmental unit may apply to the AGRPC for a grant when there is no pending request for grant applications under subsection (B) under the following conditions:
 - a. The application shall include a description of the project, the scope of work to be performed, a budget that does not include overhead expenses, and an authorized signature.
 - b. The application shall be available for public inspection upon receipt by the AGRPC.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 4684, effective February 3, 2007 (Supp. 06-4). Amended by final rulemaking at 14 A.A.R. 3661, effective November 8, 2008 (Supp. 08-3).

ARTICLE 3. ARIZONA COTTON RESEARCH AND PROTECTION COUNCIL

R3-9-301. Ginning and Remittance Forms

- A. Each September the Arizona Cotton Research and Protection Council shall send the ginning and remittance report forms and a fee schedule to the operator of each gin for which a report was made during the previous year. A gin operator who has not submitted a report in the previous year may obtain the report forms and a fee schedule from the Arizona Cotton Research and Protection Council office.
- B. Each gin operator who gins for Arizona producers during the current crop year shall complete the following reports and submit them with the appropriate fees, to the Arizona Cotton Research and Protection Council within the times specified below:
 - 1. On or before February 15 of each year:
 - a. The name and number of the reporting gin;
 - b. The business mailing address, telephone number, and county of the reporting gin;
 - c. The name of the authorized agent for the gin;
 - d. The crop year;
 - e. The name and mailing address of each crop producer;
 - f. The Farm Service Agency (FSA) farm number;
 - g. An estimate of the number of bales to be ginned by March 15 from cotton grown at or below 2,700 feet elevation; and
 - h. An estimate of the number of bales to be ginned by March 15 from cotton grown above 2,700 feet elevation;
 - 2. On or before March 15 of each year:
 - a. The information in subsections (B)(1)(a) through (f),
 - b. The total number of bales actually ginned and the certification number issued by the Department for

- meeting the tillage deadline for cotton grown at or below 2,700 feet elevation, and
- c. The total number of bales actually ginned from cotton grown above 2,700 feet elevation.

Historical Note

Adopted as an emergency effective September 10, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-5). Emergency expired. Adopted as a permanent rule effective March 7, 1985 (Supp. 85-2). Amended subsection (A) as an emergency effective November 5, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 85-6). Amended subsection (A) as permanent action effective February 5, 1986 (Supp. 86-1). Amended subsection (A) effective September 24, 1986 (Supp. 86-5). Former Section R3-12-201 repealed and a new Section R3-12-201 adopted effective December 2, 1987 (Supp. 87-4). Section 3-9-301 renumbered from R3-12-201 (Supp. 91-4). Section repealed, new Section adopted effective April 4, 1994 (Supp. 94-2). Amended by final rulemaking at 5 A.A.R. 4439, effective November 3, 1999 (Supp. 99-4).

R3-9-302. Non-Bt Cotton Acreage Registration Form

- A. Each December the Arizona Cotton Research and Protection Council shall mail the Non-Bt Cotton Acreage Registration Form and a fee schedule to cotton producers who certify cotton acreage with the Farm Service Agency during the year. A producer who did not certify cotton acreage with the Farm Service Agency may obtain the report form and a fee schedule from the Arizona Cotton Research and Protection Council office.
- B. Within 30 days after the tillage deadline in R3-4-204 a producer shall complete and submit Non-Bt Cotton Acreage Registration Form to the Arizona Cotton Research and Protection Council. The producer shall provide the following information:
 - 1. The producer name, mailing address, telephone and facsimile number;
 - 2. The Farm Service Agency farm number;
 - 3. The cultural zone;
 - 4. The crop year;
 - 5. The intended non-Bt cotton acreage.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 4741, effective January 1, 2005 (Supp. 04-4).

ARTICLE 4. EXPIRED

Article 4, consisting of Sections R3-9-401 through R3-9-405, formerly the rules for the Arizona Wine Commission expired under A.R.S. § 41-1056(E). The rules are no longer authorized as the Commission was terminated on July 1, 2004, under A.R.S. § 41-3004.18. The statutes under which the Commission operated, A.R.S. §§ 3-551 through 3-557, added by Laws 1993, Ch. 40, § 1, were repealed on January 1, 2005, by A.R.S. § 41-3004.18. Accordingly, under A.R.S. § 41-1011(C), the rules of this agency have been removed from the Code. The rescinded Article is on file in the Office of the Secretary of State (Supp. 05-2).

Article 4, consisting of Sections R3-9-401 through R3-9-405, made by final rulemaking at 9 A.A.R. 519, effective February 5, 2003 (Supp. 03-1).

R3-9-401. Expired

Historical Note

New Section made by final rulemaking at 9 A.A.R. 519, effective February 5, 2003 (Supp. 03-1). Section expired under A.R.S. § 41-1056(E). The agency terminated on

July 1, 2004, under A.R.S. § 41-3004.18 and the related statutes were repealed on January 1, 2005, by A.R.S. § 41-3004.18 (Supp. 05-2).

R3-9-402. Expired

Historical Note

New Section made by final rulemaking at 9 A.A.R. 519, effective February 5, 2003 (Supp. 03-1). Section expired under A.R.S. § 41-1056(E). The agency terminated on July 1, 2004, under A.R.S. § 41-3004.18 and the related statutes were repealed on January 1, 2005, by A.R.S. § 41-3004.18 (Supp. 05-2).

R3-9-403. Expired

Historical Note

New Section made by final rulemaking at 9 A.A.R. 519, effective February 5, 2003 (Supp. 03-1). Section expired under A.R.S. § 41-1056(E). The agency terminated on July 1, 2004, under A.R.S. § 41-3004.18 and the related statutes were repealed on January 1, 2005, by A.R.S. § 41-3004.18 (Supp. 05-2).

R3-9-404. Expired

Historical Note

New Section made by final rulemaking at 9 A.A.R. 519, effective February 5, 2003 (Supp. 03-1). Section expired under A.R.S. § 41-1056(E). The agency terminated on July 1, 2004, under A.R.S. § 41-3004.18 and the related statutes were repealed on January 1, 2005, by A.R.S. § 41-3004.18 (Supp. 05-2).

R3-9-405. Expired

Historical Note

New Section made by final rulemaking at 9 A.A.R. 519, effective February 5, 2003 (Supp. 03-1). Section expired under A.R.S. § 41-1056(E). The agency terminated on July 1, 2004, under A.R.S. § 41-3004.18 and the related statutes were repealed on January 1, 2005, by A.R.S. § 41-3004.18 (Supp. 05-2).

ARTICLE 5. ARIZONA CITRUS RESEARCH COUNCIL

Article 5, consisting of Sections R3-9-501 through R3-9-505, made by final rulemaking at 9 A.A.R. 5548, effective December 2, 2004 (Supp. 03-4).

R3-9-501. Definitions

“Department” means the Arizona department of agriculture. A.R.S. § 3-468(3).

Historical Note

New Section made by final rulemaking at 9 A.A.R. 5548, effective December 2, 2004 (Supp. 03-4).

R3-9-502. Elections

- A.** The Council shall elect officers during the first quarter of each calendar year.
- B.** Officers shall continue in office until the next annual election is held.
- C.** An officer may be successively reelected.

Historical Note

New Section made by final rulemaking at 9 A.A.R. 5548, effective December 2, 2004 (Supp. 03-4).

R3-9-503. Hearings

- A.** The Council shall use the uniform administrative procedures of A.R.S. Title 41, Chapter 6, Article 10 to govern any hearing before the Council.

- B.** A party may file a motion for rehearing or review under A.R.S. § 41-1092.09.

- C.** The Council shall grant a rehearing or review of an administrative law decision for any of the following causes materially affecting the moving party's rights:

1. The decision is not justified by the evidence or is contrary to law;
2. There is newly discovered material evidence that could not with reasonable diligence have been discovered and produced at the original proceeding;
3. One or more of the following deprived the party of a fair hearing:
 - a. Irregularity or abuse of discretion in the conduct of the proceeding;
 - b. Misconduct of the Council, the administrative law judge, or the prevailing party; or
 - c. Accident or surprise that could not have been prevented by ordinary prudence; or
4. Excessive or insufficient sanction.

- D.** The Council may grant a rehearing or review to any or all of the parties. The rehearing or review may cover all or part of the issues for any of the reasons stated in subsection (C). An order granting a rehearing or review shall particularly state the grounds for granting the rehearing or review, and the rehearing or review shall cover only the grounds stated.

Historical Note

New Section made by final rulemaking at 9 A.A.R. 5548, effective December 2, 2004 (Supp. 03-4).

R3-9-504. Annual Report

The Council shall prepare an annual report as prescribed under A.R.S. § 3-468.02(A)(5), by October 31.

Historical Note

New Section made by final rulemaking at 9 A.A.R. 5548, effective December 2, 2004 (Supp. 03-4).

R3-9-505. Records

The Department shall retain the Council's records as authorized by A.R.S. § 3-468.02(A)(4). A record may be reviewed at the Department's main office, Monday through Friday, except an Arizona legal holiday, during the hours of 8:00 a.m. to 5:00 p.m. A copy of a record shall be provided according to the provisions of A.R.S. § 39-121 et seq.

Historical Note

New Section made by final rulemaking at 9 A.A.R. 5548, effective December 2, 2004 (Supp. 03-4).

R3-9-506. Grants

A. Definitions.

1. “ACRC” means the Arizona Citrus Research Council.
2. “Authorized signature” means the signature of an individual authorized to receive funds on behalf of the applicant and responsible for the execution of the applicant's project.
3. “Awardee” means a successful applicant to whom the ACRC awards grant funds for research on a specific project.
4. “Governmental unit” means any department, commission, council, board, bureau, committee, institution, agency, government corporation, or other establishment or official of the executive branch or corporation commission of this state, another state, or the federal government.
5. “Grant” means an award of financial support to an applicant according to A.R.S. § 3-468.02(B) and (C)(5).

6. "Grant award agreement" means a document advising the applicant of the amount of money awarded following receipt by the ACRC of the applicant's signed acceptance.
- B. Grant application process.**
1. The ACRC shall award grants according to the competitive grant solicitation requirements of this Article.
 2. The ACRC shall post the grant application and manual on the ACRC's web site at least four weeks before the due date of a grant application.
 3. The ACRC shall ensure that the grant application manual contains the following items:
 - a. Grant topics related to ACRC programs specified by A.R.S. § 3-468.02(B) and (C)(5);
 - b. A statement that the information contained in an application is not confidential;
 - c. A statement that the ACRC funding source is primarily from per carton assessments on citrus grown in Arizona;
 - d. An application form including sections about the description of the grant project, scope of work to be performed, an authorized signature line, and a sample budget form;
 - e. A statement that the applicant shall not include overhead expenses in the budget for the proposed project;
 - f. The criteria that the ACRC shall use to evaluate an application;
 - g. The date and time by which the applicant shall submit an application;
 - h. The anticipated date of the ACRC award;
 - i. A copy of the ACRC grant solicitation rules; and
 - j. Any other information necessary for the grant application.
 4. The ACRC shall not consider an application received by the ACRC after the due date and time.
- C. Criteria.** The ACRC shall consider the following when reviewing a grant application and deciding whether to award ACRC funds:
1. The applicant's successful completion of prior research projects,
 2. The extent to which the proposed project identifies solutions to current issues facing the citrus industry,
 3. The extent to which the proposed project addresses future issues facing the citrus industry,
 4. The extent to which the proposed project addresses the findings of any industry surveys conducted within the previous year,
 5. The appropriateness of the budget request in achieving the project objectives,
 6. The appropriateness of the proposal time-frame to the stated project objectives, and
 7. Relevant experience and qualifications of the applicant.
- D. Public participation.**
1. The ACRC shall make all applications available for public inspection by the business day following the application due date.
 2. Before awarding a grant, the ACRC shall discuss and evaluate grant applications and proposed projects at a meeting conducted under A.R.S. § 38-431 et seq.
- E. Evaluation of grant applications.**
1. The ACRC may allow applicants to make oral or written presentations at the public meeting if time, applicant availability, and meeting space permit.
 2. The ACRC may modify an applicant's proposed project in awarding funding.
3. The ACRC shall notify an applicant in writing of the ACRC's decision to fund, modify, or deny funding for a proposed project within 10 business days of the ACRC decision. The ACRC shall notify applicants by the U.S. Postal Service, commercial delivery, electronic mail, or facsimile.
- F. Awards and project monitoring.**
1. Before releasing grant funds, the ACRC shall execute a grant award agreement with the awardee. The awardee shall agree to accept the grant's legal requirements and conditions and authorize the ACRC to monitor the progress of the project by signing a grant award agreement.
 2. The ACRC shall pay no more than 50% of the grant in the initial payment to the awardee.
 3. During the term of the project, the awardee shall inform the ACRC of changes to the awardee's address, telephone number, or other contact information.
 4. The ACRC may require an interim written report or oral presentation from the awardee during the pendency of the project.
 5. The ACRC shall not award the grant funds remaining after the initial payment until the awardee submits to the ACRC:
 - a. A final research report, and
 - b. An invoice for actual final project expenses not exceeding the remaining portion of the award.
 6. The ACRC shall make research findings and reports resulting from any grant awarded by the ACRC available to Arizona citrus producers.
- G. Repayment.** If the awardee does not complete the project as specified in the grant award agreement, the awardee shall return all unexpended grant funds within 30 days after receipt of written request by the ACRC.
- H. Governmental units.**
1. The ACRC may request one or more governmental units to submit grant applications as prescribed in subsection (H)(3), without regard to subsections (B), (F)(2), and (F)(5).
 2. The ACRC may issue grants to governmental units without regard to subsections (B), (F)(2), and (F)(5).
 3. A governmental unit may apply to the ACRC for a grant when there is no pending request for grant applications under subsection (B) under the following conditions:
 - a. The application shall include a description of the project, the scope of work to be performed, a budget that does not include overhead expenses, and an authorized signature.
 - b. The application shall be available for public inspection upon receipt by the ACRC.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 176, effective March 11, 2006 (Supp. 06-1). Amended by final rulemaking at 14 A.A.R. 3665, effective November 8, 2008 (Supp. 08-3).

**ARTICLE 6. LEAFY GREENS FOOD SAFETY
COMMITTEE**

R3-9-601. Definitions

"Act" means A.R.S. Title 3, Chapter 3, Article 1.

"Auditor" or "Inspector" means a state or federal agricultural regulatory agency or their designee(s), or a private entity contracted by the Committee to perform inspections authorized by the Act.

"Best practices" means the "Commodity Specific Food Safety Guidelines for the Production and Harvest of Lettuce and

Leafy Greens: Version 6 – Arizona” dated August 1, 2012. This document is incorporated by reference, does not include any later amendments or editions, and is available for review online at <http://www.arizonaleafygreens.org/members/resources/> and at the Arizona Department of Agriculture, 1688 W. Adams St., Phoenix, Arizona 85007.

“Committee” means the Leafy Greens Food Safety Committee established pursuant to the Marketing Agreement.

“LGMA” or “Marketing Agreement” means the Arizona Leafy Green Products Shipper Marketing Agreement, as amended effective October 1, 2011, that was approved pursuant to the Act. This document is incorporated by reference, does not include any later amendments or editions, and is available for review online at <http://www.azlgma.gov/members/resources.asp> and at the Arizona Department of Agriculture, 1688 W. Adams, Phoenix, Arizona 85007.

“SOP” means standard operating procedure.

Historical Note

New Section made by exempt rulemaking at 16 A.A.R. 2282, effective October 28, 2010 (Supp. 10-4). Amended by exempt rulemaking at 17 A.A.R. 1767, effective August 1, 2011 (Supp. 11-3). Amended by exempt rulemaking at 17 A.A.R. 2569, effective November 29, 2011 (Supp. 11-4). Amended by exempt rulemaking at 18 A.A.R. 2928, effective August 1, 2012 (Supp. 12-4).

R3-9-602. Best Practices; LGMA Compliance

- A. Signatories shall comply with the best practices, maintain a trace-back system, and be subject to periodic audit by an auditor.
- B. Signatories shall only buy, consign, or otherwise accept or handle leafy green products (grown in Arizona) from a shipper or producer who is in compliance with the best practices (including recordkeeping requirements), maintains a trace-back system, and is subject to periodic audit by an auditor.
- C. When the best practices require a SOP, there must be an appropriate SOP and that SOP must be followed.

Historical Note

New Section made by exempt rulemaking at 16 A.A.R. 2282, effective October 28, 2010 (Supp. 10-4). Amended by exempt rulemaking at 17 A.A.R. 2569, effective November 29, 2011 (Supp. 11-4).

R3-9-603. Service Mark Usage

- A. A signatory’s compliance with the LGMA and R3-9-602 is a condition precedent and subsequent to the signatory’s privilege to use the service mark.
- B. An authorized signatory may use the service mark on all bills of lading and on other documents.
- C. A signatory shall:
 1. Use the service mark without reference to a private brand or label.
 2. Provide reasonable assurances that the signatory has a system in place to comply with this Section, maintain records sufficient to audit the system for the duration of the LGMA, and make those records available to the Committee upon request.
- D. A signatory shall not:
 1. Use the service mark on packaging or product or as a certification mark to certify product.
 2. Use the service mark as the signatory’s own mark or as the exclusive representation of its business entity.
 3. Insert within or overlap the boundaries of the service mark with the signatory’s name or trademark.

4. Alter the service mark in any way other than proportionately adjusting the size of the service mark.

Historical Note

New Section made by exempt rulemaking at 16 A.A.R. 2282, effective October 28, 2010 (Supp. 10-4). Amended by exempt rulemaking at 17 A.A.R. 2569, effective November 29, 2011 (Supp. 11-4).

R3-9-604. Loss of Use of Service Mark

- A. A signatory will lose the privilege to use the service mark if the signatory:
 1. Commits a flagrant violation or repeated major deviation;
 2. Fails to comply with R3-9-603;
 3. Has not paid assessments due for the prior fiscal year; or
 4. Withdraws from participation in the LGMA pursuant to Article XVI, section C of the LGMA.
- B. The first flagrant violation or repeated major deviation will result in a suspension of the privilege to use the service mark for a minimum two-week period.
- C. A flagrant violation or repeated major deviation following the first flagrant violation or repeated major deviation will result in an indefinite suspension of the privilege to use the service mark.
- D. A flagrant violation or repeated major deviation following a suspension pursuant to subsection (C) will result in an indefinite revocation of the privilege to use the service mark. The privilege to use the service mark will not be restored to the signatory for a minimum of two years unless the signatory demonstrates to the satisfaction of the auditor and the Committee a significant change in management and brand.
- E. A signatory whose privilege to use the service mark is suspended or revoked pursuant to subsections (B) through (D) shall not use the service mark until the signatory has undergone at least one new audit without the finding of any major deviations or flagrant violations and has evidenced that the signatory has corrected any minor deviations found.
- F. At least two weeks of any suspension of the privilege to use the service mark under subsections (B) through (D) must occur between December 1 and March 31.
- G. The Committee may accelerate the progression of penalties under this Section if the signatory’s product seriously affects a person’s health and the signatory handled the product with intentional, knowing or reckless disregard for the signatory’s obligations under the LGMA and best practices.
- H. A signatory will not lose the privilege to use the service mark under subsections (A)(1) and (2) without an opportunity for a hearing under A.R.S. Title 41, Chapter 6, Article 10, except if the Committee finds that the public health, safety or welfare imperatively requires emergency action, and incorporates a finding to that effect in its order, the Committee may order summary suspension of a signatory’s privilege to use the service mark.
- I. A signatory that loses the privilege to use the mark under subsection (A)(3) must pay all assessments due from prior fiscal years, including penalties and interest, before regaining the privilege to use the service mark.
- J. The Committee may publish a list of signatories whose privilege to use the service mark has been suspended.

Historical Note

New Section made by exempt rulemaking at 16 A.A.R. 2282, effective October 28, 2010 (Supp. 10-4). Amended by exempt rulemaking at 17 A.A.R. 2569, effective November 29, 2011 (Supp. 11-4).

R3-9-605. Violation Levels; Repeated Violations

- A.** Violations of R3-9-602 fall into four levels: flagrant violations, major deviations, minor deviations, and minor infractions. The Committee or its designee shall determine the level of a violation consistent with this Section.
- B.** A flagrant violation occurs when a signatory buys, consigns, or otherwise accepts or handles a leafy green product and knows or should have known the product was grown, packed, shipped, processed or handled in violation of R3-9-602 and the violation:
1. Significantly increases the risk of delivering unsafe product into commerce;
 2. Affects the integrity of the LGMA's food safety program; or
 3. In the Committee's judgment, merits more serious treatment than a major deviation based on the consideration of, as relevant:
 - a. The position of the employee responsible for the violation,
 - b. Whether the employee responsible for the violation knowingly committed the violation,
 - c. The circumstances surrounding the violation,
 - d. Whether the signatory took prompt corrective action,
 - e. Whether the signatory has committed the same or a similar violation previously, and
 - f. Any other relevant facts.
- C.** A major deviation is a violation of R3-9-602 that may inhibit the maintenance of food safety, but that does not necessarily result in unsafe product.
- D.** The following violations constitute at least major deviations and are potentially flagrant violations:
1. Falsification of any record for any reason;
 2. Spitting in the field;
 3. Unclean sanitation facilities, including the presence of soiled toilet paper;
 4. Failure to:
 - a. Properly wash hands after using a restroom or returning to the field;
 - b. Follow the best practices with respect to feces or fecal matter found in the field;
 - c. Follow the best practices with respect to the use of compost or animal manure, including creating and maintaining proper records related to that use;
 - d. Have a trace-back system;
 - e. Sanitize gloves and knives;
 - f. Follow a work health practices program concerning the transfer of human pathogens by workers; or
 - g. Provide a Compliance Plan, as defined in the best practices, to an auditor;
5. Refusing an audit; and
 6. Conditions for which an automatic "unsatisfactory" would be assessed by USDA if performing a GAP/GHP audit.
- E.** Violations constituting flagrant violations or major deviations are not limited to those listed in subsection (D).
- F.** A minor deviation is a violation of R3-9-602 that the signatory can correct within five business days of the audit and that does not necessarily increase the risk of a food borne illness.
- G.** A minor infraction is a violation of R3-9-602 that the signatory corrects before the auditor leaves the audited premises and that does not necessarily increase the risk of a food borne illness.
- H.** The Marketing Committee or its designee may assess a signatory with a major deviation if an auditor discovers several minor deviations or minor infractions of the same type or if a signatory fails to timely submit a corrective action plan.
- I.** Repeated major violations are limited to violations occurring during the current and prior fiscal year.

Historical Note

New Section made by exempt rulemaking at 16 A.A.R. 2282, effective October 28, 2010 (Supp. 10-4). Amended by exempt rulemaking at 17 A.A.R. 2569, effective November 29, 2011 (Supp. 11-4).

R3-9-606. Corrective Action Plans

- A.** A signatory who commits a flagrant violation, major deviation, or minor deviation must correct the violation and submit a corrective action plan to the Marketing Committee or its designee within five business days of receipt of the audit report noting the violation. If the Marketing Committee or its designee rejects the corrective action plan, the signatory has 24 hours to submit a revised corrective action plan.
- B.** In the case of a flagrant violation or major deviation, once the Marketing Committee or its designee accepts the signatory's corrective action plan, an auditor will perform an unannounced audit of the signatory within three business days.
- C.** The signatory shall comply with the corrective action plan.
- D.** Notwithstanding subsection (A), in the case of a violation that creates an immediate danger to public health, the signatory shall submit a correction action plan immediately and take necessary action to minimize the threat to public health.

Historical Note

New Section made by exempt rulemaking at 16 A.A.R. 2282, effective October 28, 2010 (Supp. 10-4).

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Supplement to the

Arizona Administrative Code

The official compilation of Arizona Rules

Arizona Secretary of State's Office

Public Services Division

1700 W. Washington Street, Fl 7.

Phoenix, AZ 85007

Replacement Check List

For rules filed within the

4th Calendar Quarter

October 1 - December 31, 2012

Code Release Number: Supp. 12-4

Within the stated calendar quarter, this Title contains all rules made, amended, repealed, renumbered, and recodified, or rules that have expired or were terminated due to an agency being eliminated under sunset law. These rules were either certified by the Governor's Regulatory Review Council or the Attorney General's Office, or exempt from the rulemaking process, and filed with the Office of the Secretary of State. Refer to the historical notes for more information. Please note that some rules you are about to remove may still be in effect after the publication date of this Supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

Follow the instructions to replace the updated Chapters.

TITLE 4. PROFESSIONS AND OCCUPATIONS

Chapter 23. Board of Pharmacy

Sections, Parts, Exhibits, Tables or Appendices modified

R4-23-110, R4-23-303, R4-23-304, R4-23-620, and R4-23-1005

REMOVE Supp. 11-4

Pages: 1 - 77

REPLACE with Supp. 12-4

Pages: 1 - 77

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Board of Pharmacy

TITLE 4. PROFESSIONS AND OCCUPATIONS**CHAPTER 23. BOARD OF PHARMACY**

Authority: A.R.S. § 32-1904 et seq.

ARTICLE 1. ADMINISTRATION

Section

- R4-23-101. General
- R4-23-102. Meetings
- R4-23-103. Repealed
- R4-23-104. Repealed
- R4-23-105. Repealed
- R4-23-106. Repealed
- R4-23-107. Repealed
- R4-23-108. Repealed
- R4-23-109. Repealed
- R4-23-110. Definitions
- R4-23-111. Notice of Hearing
- R4-23-112. Ex Parte Communications
- R4-23-113. Motions
- R4-23-114. Computing Time
- R4-23-115. Filing Documents
- R4-23-116. Continuing or Expediting a Hearing; Reconvening a Hearing
- R4-23-117. Vacating a Hearing
- R4-23-118. Prehearing Conference
- R4-23-119. Subpoenas
- R4-23-120. Telephonic Testimony
- R4-23-121. Rights and Responsibilities of Parties
- R4-23-122. Conduct of Hearing
- R4-23-123. Failure of Party to Appear for Hearing
- R4-23-124. Witnesses; Exclusion from Hearing
- R4-23-125. Proof
- R4-23-126. Disruptions
- R4-23-127. Hearing Record
- R4-23-128. Rehearing or Review and Appeal of Decision
- R4-23-129. Notice of Judicial Appeal; Transmitting the Transcript

ARTICLE 2. PHARMACIST LICENSURE

Section

- R4-23-201. General
- R4-23-202. Licensure by Examination
- R4-23-203. Licensure by Reciprocity
- R4-23-204. Continuing Education Requirements
- R4-23-205. Fees

ARTICLE 3. INTERN TRAINING AND PHARMACY INTERN PRECEPTORS

Section

- R4-23-301. Intern Licensure
- R4-23-302. Training Site and Pharmacy Intern Preceptors
- R4-23-303. Training Time
- R4-23-304. Reports
- R4-23-305. Miscellaneous Intern Training Provisions

ARTICLE 4. PROFESSIONAL PRACTICES

Section

- R4-23-401. Time-frames for Board Approvals and Special Requests
- R4-23-402. Pharmacist, Graduate Intern, and Pharmacy Intern
- R4-23-403. Repealed
- R4-23-404. Unethical Practices
- R4-23-405. Change of Responsibility
- R4-23-406. Repealed
- R4-23-407. Prescription Requirements

- R4-23-408. Computer Records
- R4-23-409. Returning Drugs and Devices
- R4-23-410. Current Good Compounding Practices
- R4-23-411. Pharmacist-administered or Pharmacy or Graduate Intern-administered Immunizations
- R4-23-412. Emergency Refill Prescription Dispensing
- R4-23-413. Temporary Recognition of Nonresident Licensure
- R4-23-414. Reserved
- R4-23-415. Impaired Licensees - Treatment and Rehabilitation
- R4-23-416. Reserved through
- R4-23-420. Reserved
- R4-23-421. Repealed
- R4-23-422. Repealed
- R4-23-423. Repealed
- R4-23-424. Repealed
- R4-23-425. Repealed
- R4-23-426. Repealed
- R4-23-427. Repealed
- R4-23-428. Repealed
- R4-23-429. Repealed

ARTICLE 5. CONTROLLED SUBSTANCES PRESCRIPTION MONITORING PROGRAM

Article 5, consisting of Sections R4-23-501 and R4-23-502, recodified to Article 8 at 9 A.A.R. 4011, effective August 18, 2003 (Supp. 03-3).

Section

- R4-23-501. Controlled Substances Prescription Monitoring Program Registration
- R4-23-502. Requirements for Data Format and Transmission
- R4-23-503. Access to Controlled Substances Prescription Monitoring Program Data
- R4-23-504. Computerized Central Database Tracking System Task Force
- R4-23-505. Reports
- R4-23-506. Repealed

ARTICLE 6. PERMITS AND DISTRIBUTION OF DRUGS

Section

- R4-23-601. General Provisions
- R4-23-602. Permit Application Process and Time-frames
- R4-23-603. Nonprescription Drugs, Retail
- R4-23-604. Resident Drug Manufacturer
- R4-23-605. Resident Drug Wholesaler Permit
- R4-23-606. Pharmacy Permit, Community, Hospital, and Limited Service
- R4-23-607. Nonresident Permits
- R4-23-608. Change of Personnel and Responsibility
- R4-23-609. Pharmacy Area of Community Pharmacy
- R4-23-610. Community Pharmacy Personnel and Security Procedures
- R4-23-611. Pharmacy Facilities
- R4-23-612. Equipment
- R4-23-613. Procedure for Discontinuing a Pharmacy
- R4-23-614. Automated Storage and Distribution System
- R4-23-615. Mechanical Storage and Counting Device for a Drug in Solid, Oral Dosage Form
- R4-23-616. Mechanical Counting Device for a Drug in Solid, Oral Dosage Form

- R4-23-617. Temporary Pharmacy Facilities or Mobile Pharmacies
 R4-23-618. Reserved
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 R4-23-620. Continuous Quality Assurance Program
 R4-23-621. Shared Services
 R4-23-622. Reserved through
 R4-23-650. Reserved
 R4-23-651. Definitions
 R4-23-652. Hospital Pharmacy Permit
 R4-23-653. Personnel: Professional or Technician
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 R4-23-657. Security
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 R4-23-659. Administration of Drugs
 R4-23-660. Investigational Drugs
 R4-23-661. Repealed
 R4-23-662. Repealed
 R4-23-663. Repealed
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 R4-23-665. Reserved through
 R4-23-669. Reserved
 R4-23-670. Sterile Pharmaceutical Products
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 R4-23-672. Limited-service Correctional Pharmacy
 R4-23-673. Limited-service Mail-order Pharmacy
 R4-23-674. Limited-service Long-term Care Pharmacy
 R4-23-675. Limited-service Sterile Pharmaceutical Products Pharmacy
 R4-23-676. Reserved through
 R4-23-680. Reserved
 R4-23-681. General Requirements for Limited-service Nuclear Pharmacy
 R4-23-682. Limited-service Nuclear Pharmacy
 R4-23-683. Reserved through
 R4-23-690. Reserved
 R4-23-691. Repealed
 R4-23-692. Compressed Medical Gas Distributor
 R4-23-693. Compressed Medical Gas Supplier

ARTICLE 7. NON-PHARMACY LICENSED OUTLETS - GENERAL PROVISIONS

- Section
 R4-23-701. Long-term Care Facilities Pharmacy Services: Consultant Pharmacist
 R4-23-701.01. Long-term Care Facilities Pharmacy Services: Provider Pharmacy
 R4-23-701.02. Long-term Care Facilities Pharmacy Services: Emergency Drugs
 R4-23-701.03. Long-term Care Facilities Pharmacy Services: Emergency Drug Prescription Order
 R4-23-702. Repealed
 R4-23-703. Assisted Living Facilities
 R4-23-704. Repealed
 R4-23-705. Repealed
 R4-23-706. Repealed
 R4-23-707. Repealed
 R4-23-708. Repealed

- R4-23-709. Repealed

ARTICLE 8. DRUG CLASSIFICATION

Article 8, consisting of Sections R4-23-801 and R4-23-802, recodified from Article 5 at 9 A.A.R. 4011, effective August 18, 2003 (Supp. 03-3).

Article 8, consisting of Sections R4-23-801 through R4-23-804, repealed effective November 4, 1998 (Supp. 98-4).

Section

- R4-23-801. Dietary Supplements
 R4-23-802. Veterinary
 R4-23-803. Repealed
 R4-23-804. Repealed

ARTICLE 9. PENALTIES AND MISCELLANEOUS

Section

- R4-23-901. Penalty for violations

ARTICLE 10. UNIFORM CONTROLLED SUBSTANCES AND DRUG OFFENSES

Section

- R4-23-1001. Repealed
 R4-23-1002. Repealed
 R4-23-1003. Records and Order Forms
 R4-23-1004. Repealed
 R4-23-1005. Substances Excepted from the Schedules of Controlled Substances
 R4-23-1006. Substances Excepted from Drug Offenses

ARTICLE 11. PHARMACY TECHNICIANS

Article 11, consisting of R4-23-1101 through R4-23-1105, made by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1).

Section

- R4-23-1101. Licensure and Eligibility
 R4-23-1102. Pharmacy Technician Licensure
 R4-23-1103. Pharmacy Technician Trainee Licensure
 R4-23-1104. Pharmacy Technicians and Pharmacy Technician Trainees
 R4-23-1105. Pharmacy Technician Training Program
 R4-23-1106. Continuing Education Requirements

ARTICLE 12. PRESCRIPTION MEDICATION DONATION PROGRAM

Article 12, consisting of R4-23-1201 through R4-23-1211, made by final rulemaking at 14 A.A.R. 4320, effective January 3, 2009 (Supp. 08-4).

Section

- R4-23-1201. Eligibility Requirements for Participation in the Program
 R4-23-1202. Donating Medications
 R4-23-1203. Eligible Prescription Medications
 R4-23-1204. Eligibility Requirements to Receive Donated Prescription Medications
 R4-23-1205. Donor Form
 R4-23-1206. Recipient Form
 R4-23-1207. Recordkeeping
 R4-23-1208. Handling Fee
 R4-23-1209. Policies and Procedures
 R4-23-1210. Dispensing Donated Prescription Medications
 R4-23-1211. Responsibilities of the Physician-in-charge or Pharmacist-in-charge of a Participating Physician's Office, Pharmacy, or Health Care Institution

Board of Pharmacy

ARTICLE 1. ADMINISTRATION**R4-23-101. General**

- A.** 4 A.A.C. 23 applies to all actions and proceedings of the Board and shall be deemed a part of the record in any Board action or proceeding without formal introduction of, or reference to the rules. A party to a Board action is deemed to have knowledge of the rules. The Board office shall provide a copy of the rules:

1. To each license applicant who submits a completed application packet; and
2. To each permit applicant during the final compliance inspection after the Board approves the permit application.

- B.** The Board, within its jurisdiction, may, in the interest of justice, excuse the failure of any person to comply with the rules.
- C.** The Board, within its jurisdiction, may grant an extension of time within which to comply with any rule when it deems the extension to be in the interest of justice.

Historical Note

Former Rules 1.1000, 1.1200, and 1.1300; Amended effective August 23, 1978 (Supp. 78-4). Amended by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1); Historical Note updated (Supp. 06-2).

R4-23-102. Meetings

- A.** The Board shall hold not less than four meetings per fiscal year to conduct general business and interview permit and license applicants.
- B.** A special meeting of the Board may be held at any time subject to the call of the President or a majority of the Board members and in compliance with the notification requirements of A.R.S. § 38-431.02.

Historical Note

Former Rules 1.2100, 1.2200, 1.2300, and 1.2400. Amended by final rulemaking at 7 A.A.R. 2143, effective May 1, 2001 (Supp. 01-2).

R4-23-103. Repealed**Historical Note**

Former Rules 1.3100, 1.3200, 1.3300, and 1.3400; Amended subsection (C) effective August 9, 1983 (Supp. 83-4). Section repealed by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1); Historical Note updated (Supp. 06-2).

R4-23-104. Repealed**Historical Note**

Former Rules 1.4011, 1.4110, 1.4120, 1.4200, 1.4210, 1.4220, 1.4300, 1.4400, 1.5500, 1.5600, 1.5700, and 1.4500; Amended effective August 23, 1978 (Supp. 78-5); Amended by deleting subsection (B) and renumbering subsections (C) through (J) as subsections (B) through (I) effective August 9, 1983 (Supp. 83-4). Amended effective February 8, 1991 (Supp. 91-1). Section repealed by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1); Historical Note updated (Supp. 06-2).

R4-23-105. Repealed**Historical Note**

Former Rules 1.5100, 1.5200, 1.5300, and 1.5400; Amended subsection (B) effective August 9, 1983 (Supp. 83-4). Section repealed by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1); Historical Note updated (Supp. 06-2).

R4-23-106. Repealed**Historical Note**

Former Rules 1.5800 and 1.5900. Section repealed by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1); Historical Note updated (Supp. 06-2).

R4-23-107. Repealed**Historical Note**

Former Rules 1.5910, 1.5920, 1.5921, and 1.5922. Section repealed by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1); Historical Note updated (Supp. 06-2).

R4-23-108. Repealed**Historical Note**

Former Rule 1.5930. Section repealed by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1); Historical Note updated (Supp. 06-2).

R4-23-109. Repealed**Historical Note**

Former Rules 1.7100, 1.7200, and 1.7300. Amended effective July 14, 1977 (Supp. 77-4). Amended effective February 8, 1991 (Supp. 91-1). Section repealed by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1); Historical Note updated (Supp. 06-2).

R4-23-110. Definitions

In addition to definitions in A.R.S. § 32-1901, the following definitions apply to 4 A.A.C. 23:

“Active ingredient” means any component that furnishes pharmacological activity or other direct effect in the diagnosis, cure, mitigation, treatment, or prevention of disease or that affects the structure or any function of the body of man or other animals. The term includes those components that may undergo chemical change in the manufacture of the drug, that are present in the finished drug product in a modified form, and that furnish the specified activity or effect.

“AHCCCS” means the Arizona Health Care Cost Containment System.

“Annual family income” means the combined yearly gross earned income and unearned income of all adult individuals within a family unit.

“Approved course in pharmacy law” means a continuing education activity that addresses practice issues related to state or federal pharmacy statutes, rules, or regulations.

“Approved Provider” means an individual, institution, organization, association, corporation, or agency that is approved by the Accreditation Council for Pharmacy Education (ACPE) in accordance with ACPE’s policy and procedures or by the Board as meeting criteria indicative of the ability to provide quality continuing education.

“Authentication of product history” means identifying the purchasing source, the ultimate fate, and any intermediate handling of any component of a radiopharmaceutical or other drug.

“Automated storage and distribution system” means a mechanical system that performs operations or activities other than counting, compounding, or administration, relative to the storage, packaging, or distributing of drugs or devices and that collects, controls, and maintains all transaction information.

“Batch” means a specific quantity of drug that has uniform character and quality, within specified limits, and is produced

according to a single manufacturing order during the same cycle of manufacture.

“Beyond-use date” means:

A date determined by a pharmacist and placed on a prescription label at the time of dispensing to indicate a time beyond which the contents of the prescription are not recommended to be used; or

A date determined by a pharmacist and placed on a compounded pharmaceutical product’s label at the time of preparation as specified in R4-23-410(B)(3)(d), R4-23-410(I)(6)(e), or R4-23-410(J)(1)(d) to indicate a time beyond which the compounded pharmaceutical product is not recommended to be used.

“Biological safety cabinet” means a containment unit suitable for the preparation of low to moderate risk agents when there is a need for protection of the product, personnel, and environment, consistent with National Sanitation Foundation (NSF) standards, published in the National Sanitation Foundation Standard 49, Class II (Laminar Flow) Biohazard Cabinetry, NSF International P. O. Box 130140, Ann Arbor, MI, revised June 1987 edition, (and no future amendments or editions), incorporated by reference and on file with the Board.

“Care-giver” means a person who cares for someone who is sick or disabled or an adult who cares for an infant or child and includes a patient’s husband, wife, son, daughter, mother, father, sister, brother, legal guardian, nurse, or medical practitioner.

“Community pharmacy” means any place under the direct supervision of a pharmacist where the practice of pharmacy occurs or where prescription orders are compounded and dispensed other than a hospital pharmacy or a limited service pharmacy.

“Component” means any ingredient used in compounding or manufacturing drugs in dosage form, including an ingredient that may not appear in the finished product.

“Compounding and dispensing counter” means a pharmacy counter working area defined in this Section where a pharmacist or a graduate intern, pharmacy intern, pharmacy technician, or pharmacy technician trainee under the supervision of a pharmacist compounds, mixes, combines, counts, pours, or prepares and packages a prescription medication to dispense an individual prescription order or prepackages a drug for future dispensing.

“Computer system” means an automated data-processing system that uses a programmable electronic device to store, retrieve, and process data.

“Computer system audit” means an accounting method, involving multiple single-drug usage reports and audits, used to determine a computer system’s ability to store, retrieve, and process original and refill prescription dispensing information.

“Contact hour” means 50 minutes of participation in a continuing education activity sponsored by an Approved Provider.

“Container” means:

A receptacle, as described in the official compendium or the federal act, that is used in manufacturing or compounding a drug or in distributing, supplying, or dispensing the finished dosage form of a drug; or

A metal receptacle designed to contain liquefied or vaporized compressed medical gas and used in manufac-

turing, transfilling, distributing, supplying, or dispensing a compressed medical gas.

“Continuing education” means a structured learning process required of a licensee to maintain licensure that includes study in the general areas of socio-economic and legal aspects of health care; the properties and actions of drugs and dosage forms; etiology, characteristics and therapeutics of disease status; or pharmacy practice.

“Continuing education activity” means continuing education obtained through an institute, seminar, lecture, conference, workshop, mediated instruction, programmed learning course, or postgraduate study in an accredited college or school of pharmacy.

“Continuing education unit” or “CEU” means 10 contact hours of participation in a continuing education activity sponsored by an Approved Provider.

“Continuous quality assurance program” or “CQA program” means a planned process designed by a pharmacy permittee to identify, evaluate, and prevent medication errors.

“Correctional facility” has the same meaning as in A.R.S. §§ 13-2501 and 31-341.

“CRT” means a cathode ray tube or other mechanism used to view information produced or stored by a computer system.

“CSPMP” means the Controlled Substances Prescription Monitoring Program established under A.R.S. Title 36, Chapter 28.

“Current good compounding practices” means the minimum standards for methods used in, and facilities or controls used for, compounding a drug to ensure that the drug has the identity and strength and meets the quality and purity characteristics it is represented to possess.

“Current good manufacturing practice” means the minimum standard for methods used in, and facilities or controls used for manufacturing, processing, packing, or holding a drug to ensure that the drug meets the requirements of the federal act as to safety, and has the identity and strength and meets the quality and purity characteristics it is represented to possess.

“Cytotoxic” means a pharmaceutical that is capable of killing living cells.

“Day” means a calendar day unless otherwise specified.

“DEA” means the Drug Enforcement Administration as defined in A.R.S. § 32-1901.

“Declared disaster areas” means areas designated by the governor or by a county, city, or town under A.R.S. § 32-1910 as those areas that have been adversely affected by a natural disaster or terrorist attack and require extraordinary measures to provide adequate, safe, and effective health care for the affected population.

“Delinquent license” means a pharmacist, pharmacy intern, graduate intern, or pharmacy technician license the Board suspends for failure to renew or pay all required fees on or before the date the renewal is due.

“Dietary supplement” means a product (other than tobacco) that:

Is intended to supplement the diet that contains one or more of the following dietary ingredients: a vitamin, a mineral, an herb or other botanical, an amino acid, a dietary substance for use by man to supplement the diet by increasing the total daily intake, or a concentrate,

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metabolite, constituent, extract, or combinations of these ingredients;

Is intended for ingestion in pill, capsule, tablet, or liquid form;

Is not represented for use as a conventional food or as the sole item of a meal or diet; and

Is labeled as a “dietary supplement.”

“Digital signature” has the same meaning as in A.R.S. § 41-132(E).

“Dispensing pharmacist” means a pharmacist who, in the process of dispensing a prescription medication after the complete preparation of the prescription medication and before delivery of the prescription medication to a patient or patient’s agent, verifies, checks, and initials the prescription medication label, as required in R4-23-402(A).

“Drug sample” means a unit of a prescription drug that a manufacturer provides free of charge to promote the sale of the drug.

“Earned income” means monetary payments received by an individual as a result of work performed or rental property owned or leased by the individual, including:

Wages,

Commissions and fees,

Salaries and tips,

Profit from self-employment,

Profit from rent received from a tenant or boarder, and

Any other monetary payments received by an individual for work performed or rental of property.

“Electronic signature” has the same meaning as in A.R.S. § 44-7002.

“Eligible patient” means a patient who a pharmacist determines is eligible to receive an immunization using professional judgment after consulting with the patient regarding the patient’s current health condition, recent health condition, and allergies.

“Extreme emergency” means the occurrence of a fire, water leak, electrical failure, public disaster, or other catastrophe constituting an imminent threat of physical harm to pharmacy personnel or patrons.

“Family unit” means:

A group of individuals residing together who are related by birth, marriage, or adoption; or

An individual who:

Does not reside with another individual; or

Resides only with another individual or group of individuals to whom the individual is unrelated by birth, marriage, or adoption.

“FDA” means the Food and Drug Administration, a federal agency within the United States Department of Health and Human Services, established to set safety and quality standards for foods, drugs, cosmetics, and other consumer products.

“Health care decision maker” has the same meaning as in A.R.S. § 12-2291.

“Health care institution” has the same meaning as in A.R.S. § 36-401.

“Immediate notice” means a required notice sent by mail, facsimile, or electronic mail to the Board Office within 24 hours.

“Immunizations training program” means an immunization training program for pharmacists, pharmacy interns, and graduate interns that meets the requirements of R4-23-411(E).

“Inactive ingredient” means any component other than an “active ingredient” present in a drug.

“Internal test assessment” means performing quality assurance or other procedures necessary to ensure the integrity of a test.

“ISO Class 5 environment” means an atmospheric environment that complies with the ISO/TC209 International Cleanroom Standards, specifically ANSI/ISO-14644-1:1999: Cleanrooms and associated controlled environments--Part 1: Classification of air cleanliness, first edition dated May 1, 1999, (and no future amendments or editions), incorporated by reference and on file in the Board office.

“ISO Class 7 environment” means an atmospheric environment that complies with the ISO/TC209 International Cleanroom Standards, specifically ANSI/ISO-14644-1:1999: Cleanrooms and associated controlled environments--Part 1: Classification of air cleanliness, first edition dated May 1, 1999, (and no future amendments or editions), incorporated by reference and on file in the Board office.

“Licensed health care professional” means an individual who is licensed and regulated under A.R.S. Title 32, Chapter 7, 11, 13, 14, 15, 16, 17, 18, 25, 29, or 35.

“Limited-service correctional pharmacy” means a limited-service pharmacy, as defined in A.R.S. § 32-1901, that:

Holds a current Board permit under A.R.S. § 32-1931;

Is located in a correctional facility; and

Uses pharmacists, interns, and support personnel to compound, produce, dispense, and distribute drugs.

“Limited-service long-term care pharmacy” means a limited-service pharmacy, as defined in A.R.S. § 32-1901, that holds a current Board-issued permit and dispenses prescription medication or prescription-only devices to patients in long-term care facilities.

“Limited-service mail-order pharmacy” means a limited-service pharmacy, as defined in A.R.S. § 32-1901, that holds a current Board permit under A.R.S. § 32-1931 and dispenses a majority of its prescription medication or prescription-only devices by mailing or delivering the prescription medication or prescription-only device to an individual by the United States mail, a common or contract carrier, or a delivery service.

“Limited-service nuclear pharmacy” means a limited-service pharmacy, as defined in A.R.S. § 32-1901, that holds a current Board permit under A.R.S. § 32-1931 and provides radiopharmaceutical services.

“Limited-service pharmacy permittee” means a person who holds a current limited-service pharmacy permit in compliance with A.R.S. §§ 32-1929, 32-1930, 32-1931, and A.A.C. R4-23-606.

“Limited-service sterile pharmaceutical products pharmacy” means a limited-service pharmacy, as defined in A.R.S. § 32-1901, that holds a current Board permit under A.R.S. § 32-1931 and dispenses a majority of its prescription medication or prescription-only devices as sterile pharmaceutical products.

“Long-term care consultant pharmacist” means a pharmacist providing consulting services to a long-term care facility.

“Long-term care facility” or “LTCF” means a nursing care institution as defined in A.R.S. § 36-401 or an assisted living facility that:

Provides 24-hour, seven-day a week licensed nursing services to resident patients; and

Is licensed by the Arizona Department of Health Services.

“Lot” means a batch or any portion of a batch of a drug, or if a drug produced by a continuous process, an amount of drug produced in a unit of time or quantity in a manner that assures its uniformity. In either case, a lot is identified by a distinctive lot number and has uniform character and quality with specified limits.

“Lot number” or “control number” means any distinctive combination of letters or numbers, or both, from which the complete history of the compounding or manufacturing, control, packaging, and distribution of a batch or lot of a drug can be determined.

“Low-income subsidy” means Medicare-provided assistance that may partially or fully cover the costs of drugs and is based on the income of an individual and, if applicable, the individual’s spouse.

“Materials approval unit” means any organizational element having the authority and responsibility to approve or reject components, in-process materials, packaging components, and final products.

“Mechanical counting device for a drug in solid, oral dosage form” means a mechanical device that counts drugs in solid, oral dosage forms for dispensing and includes an electronic balance when used to count drugs.

“Mechanical storage and counting device for a drug in solid, oral dosage form” means a mechanical device that stores and counts and may package or label drugs in solid, oral dosage forms for dispensing.

“Mediated instruction” means information transmitted via intermediate mechanisms such as audio or video tape or telephone transmission.

“Medical practitioner-patient relationship” means that before prescribing, dispensing, or administering a prescription-only drug, prescription-only device, or controlled substance to a person, a medical practitioner, as defined in A.R.S. § 32-1901, shall first conduct a physical examination of that person or have previously conducted a physical examination. This subdivision does not apply to:

A medical practitioner who provides temporary patient supervision on behalf of the patient’s regular treating medical practitioner;

Emergency medical situations as defined in A.R.S. § 41-1831;

Prescriptions written to prepare a patient for a medical examination; or

Prescriptions written, prescription-only drugs, prescription-only devices, or controlled substances issued for use by a county or tribal public health department for immunization programs, emergency treatment, in response to an infectious disease investigation, public health emergency, infectious disease outbreak or act of bioterrorism.

For purposes of this subsection, “bioterrorism” has the same meaning as in A.R.S. § 36-781.

“Medicare” means a federal health insurance program established under Title XVIII of the Social Security Act.

“Medication error” means any unintended variation from a prescription or medication order. Medication error does not include any variation that is corrected before the medication is dispensed to the patient or patient’s care-giver, or any variation allowed by law.

“Mobile pharmacy” means a pharmacy that is self propelled or movable by another vehicle that is self propelled.

“MPJE” means Multistate Pharmacy Jurisprudence Examination, a Board-approved national pharmacy law examination written and administered in cooperation with NABP.

“NABP” means National Association of Boards of Pharmacy.

“NABPLEX” means National Association of Boards of Pharmacy Licensure Examination.

“NAPLEX” means North American Pharmacist Licensure Examination.

“Order” means either of the following:

A prescription order as defined in A.R.S. § 32-1901; or

A medication order as defined in A.A.C. R4-23-651.

“Other designated personnel” means a non-pharmacist individual who is permitted in the pharmacy area, for a limited time, under the direct supervision of a pharmacist, to perform non-pharmacy related duties, such as trash removal, floor maintenance, and telephone or computer repair.

“Outpatient” means an individual who is not a residential patient in a health care institution.

“Outpatient setting” means a location that provides medical treatment to an outpatient.

“Patient profile” means a readily retrievable, centrally located information record that contains patient demographics, allergies, and medication profile.

“Pharmaceutical patient care services” means the provision of drug selection, drug utilization review, drug administration, drug therapy monitoring, and other drug-related patient care services intended to achieve outcomes related to curing or preventing a disease, eliminating or reducing a patient’s symptoms, or arresting or slowing a disease process, by identifying and resolving or preventing potential and actual drug-related problems.

“Pharmaceutical product” means a medicinal drug.

“Pharmacy counter working area” means a clear and continuous working area that contains no major obstacles such as a desktop computer, computer monitor, computer keyboard, external computer drive device, printer, facsimile machine, pharmacy balance, typewriter, or pill-counting machine, but may contain individual documents or prescription labels, pens, prescription blanks, refill log, pill-counting tray, spatula, stapler, or other similar items necessary for the prescription-filling process.

“Pharmacy law continuing education” means a continuing education activity that addresses practice issues related to state or federal pharmacy statutes, rules, or regulations, offered by an Approved Provider.

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“Pharmacy permittee” means a person who holds a current pharmacy permit that complies with A.R.S. §§ 32-1929, 32-1930, 32-1931, 32-1934, and R4-23-606 and R4-23-652.

“Physician” means a medical practitioner licensed under A.R.S. Title 32, Chapter 13 or 17.

“Physician-in-charge” means a physician who is responsible to the Board for all aspects of a prescription medication donation program required in A.R.S. § 32-1909 and operated in the physician’s office or in a health care institution.

“Poverty level” means the annual family income for a family unit of a particular size, as specified in the poverty guidelines updated annually in the *Federal Register* by the U.S. Department of Health and Human Services.

“Precursor chemical” means a precursor chemical I as defined in A.R.S. § 13-3401(26) and a precursor chemical II as defined in A.R.S. § 13-3401(27).

“Prepackaged drug” means a drug that is packaged in a frequently prescribed quantity, labeled in compliance with A.R.S. §§ 32-1967 and 32-1968, stored, and subsequently dispensed by a pharmacist or a graduate intern or pharmacy intern under the supervision of a pharmacist, who verifies at the time of dispensing that the drug container is properly labeled, in compliance with A.R.S. § 32-1968, for the patient.

“Prep area” means a specified area either within an ISO class 7 environment or adjacent to but outside an ISO class 7 environment that:

Allows the assembling of necessary drugs, supplies, and equipment for compounding sterile pharmaceutical products, but does not allow the use of paper products such as boxes or bulk drug storage;

Allows personnel to don personnel protective clothing, such as gown, gloves, head cover, and booties before entering the clean compounding area; and

Is a room or a specified area within a room, such as an area specified by a line on the floor.

“Primary care provider” means the medical practitioner who is treating an individual for a disease or medical condition.

“Proprietor” means the owner of a business permitted by the Board under A.R.S. §§ 32-1929, 32-1930, 32-1931, and 32-1934.

“Provider pharmacy” means a pharmacy that contracts with a long-term care facility to supply prescription medication or other services for residents of a long-term care facility.

“Radiopharmaceutical” means any drug that emits ionizing radiation and includes:

Any nonradioactive reagent kit, nuclide generator, or ancillary drug intended to be used in the preparation of a radiopharmaceutical, but does not include drugs such as carbon-containing compounds or potassium-containing salts, that contain trace quantities of naturally occurring radionuclides; and

Any biological product that is labeled with a radionuclide or intended to be labeled with a radionuclide.

“Radiopharmaceutical quality assurance” means performing and interpreting appropriate chemical, biological, and physical tests on radiopharmaceuticals to determine the suitability of the radiopharmaceutical for use in humans and animals. Radiopharmaceutical quality assurance includes internal test

assessment, authentication of product history, and appropriate record retention.

“Radiopharmaceutical services” means procuring, storing, handling, compounding, preparing, labeling, quality assurance testing, dispensing, distributing, transferring, recordkeeping, and disposing of radiochemicals, radiopharmaceuticals, and ancillary drugs. Radiopharmaceutical services include quality assurance procedures, radiological health and safety procedures, consulting activities associated with the use of radiopharmaceuticals, and any other activities required for the provision of pharmaceutical care.

“Red C stamp” means a device used with red ink to imprint an invoice with a red letter C at least one inch high, to make an invoice of a Schedule III through IV controlled substance, as defined in A.R.S. § 36-2501, readily retrievable, as required by state and federal rules.

“Refill” means other than the original dispensing of the prescription order, dispensing a prescription order in the same quantity originally ordered or in multiples of the originally ordered quantity when specifically authorized by the prescriber, if the refill is authorized by the prescriber:

In the original prescription order;

By an electronically transmitted refill order that the pharmacist promptly documents and files; or

By an oral refill order that the pharmacist promptly documents and files.

“Regulated chemical” means the same as in A.R.S. § 13-3401(30).

“Remodel” means to alter structurally the pharmacy area or location.

“Remote drug storage area” means an area that is outside the premises of the pharmacy, used for the storage of drugs, locked to deny access by unauthorized persons, and secured against the use of force.

“Resident” means:

An individual admitted to and living in a long-term care facility,

An individual who has a place of habitation in Arizona and lives in Arizona as other than a tourist, or

A person who owns or operates a place of business in Arizona.

“Responsible person” means the owner, manager, or other employee who is responsible to the Board for a permitted establishment’s compliance with the laws and administrative rules of this state and of the federal government pertaining to distribution of drugs, devices, precursor chemicals, and regulated chemicals. Nothing in this definition relieves other individuals from the responsibility to comply with state and federal laws and administrative rules.

“Score transfer” means the process that enables an applicant to take the NAPLEX in a jurisdiction and be eligible for licensure by examination in other jurisdictions.

“Security features” means the attributes incorporated into the paper of a prescription order, referenced in A.R.S. § 32-1968(A)(4), that are approved by the Board or its staff and that includes one or more of the following features that attempt to prevent duplication or aid the authentication of a paper document: laid lines, enhanced laid lines, thermochromic ink, artificial watermark, fluorescent ink, chemical void, persistent

void, penetrating numbers, high-resolution border, high-resolution latent images, micro-printing, prismatic printing, embossed images, abrasion ink, holograms, and foil stamping.

“Shared order filling” means the following:

Preparing, packaging, compounding, or labeling an order, or any combination of these functions, that are performed by:

A person with a current Arizona Board license, located at an Arizona pharmacy, on behalf of and at the request of another resident or nonresident pharmacy; or

A person, located at a nonresident pharmacy, on behalf of and at the request of an Arizona pharmacy; and

Returning the filled order to the requesting pharmacy for delivery to the patient or patient’s care-giver or, at the request of this pharmacy, directly delivering the filled order to the patient.

“Shared order processing” means the following:

Interpreting the order, performing order entry verification, drug utilization review, drug compatibility and drug allergy review, final order verification, and when necessary, therapeutic intervention, or any combination of these order processing functions, that are performed by:

A pharmacist or intern, under pharmacist supervision, with a current Arizona Board license, located at an Arizona pharmacy, on behalf of and at the request of another resident or nonresident pharmacy; or

A pharmacist or intern, under pharmacist supervision, located at a nonresident pharmacy, on behalf of and at the request of an Arizona pharmacy; and

After order processing is completed, returning the processed order to the requesting pharmacy for order filling and delivery to the patient or patient’s care-giver or, at the request of this pharmacy, returning the processed order to another pharmacy for order filling and delivery to the patient or patient’s care-giver.

“Shared services” means shared order filling or shared order processing, or both.

“Sight-readable” means that an authorized individual is able to examine a record and read its information from a CRT, microfiche, microfilm, printout, or other method acceptable to the Board or its designee.

“Single-drug audit” means an accounting method that determines the numerical and percentage difference between a drug’s beginning inventory plus purchases and ending inventory plus sales.

“Single-drug usage report” means a computer system printout of original and refill prescription order usage information for a single drug.

“Standard-risk sterile pharmaceutical product” means a sterile pharmaceutical product compounded from sterile commercial drugs using sterile commercial devices or a sterile pharmaceutical otic or ophthalmic product compounded from non-sterile ingredients.

“State of emergency” means a governmental declaration issued under A.R.S. § 32-1910 as a result of a natural disaster or terrorist attack that results in individuals being unable to refill existing prescriptions.

“Sterile pharmaceutical product” means a medicinal drug free from living biological organisms.

“Strength” means:

The concentration of the drug substance (for example, weight/weight, weight/volume, or unit dose/volume basis); or

The potency, that is, the therapeutic activity of a drug substance as indicated by bioavailability tests or by controlled clinical data (expressed, for example, in terms of unity by reference to a standard).

“Substantial-risk sterile pharmaceutical product” means a sterile pharmaceutical product compounded as a parenteral or injectable dosage form from non-sterile ingredients.

“Supervision” means a pharmacist is present, assumes legal responsibility, and has direct oversight of activities relating to acquiring, preparing, distributing, administering, and selling prescription medications by pharmacy interns, graduate interns, pharmacy technicians, or pharmacy technician trainees and when used in connection with the intern training requirements means that, in a pharmacy where intern training occurs, a pharmacy intern preceptor assumes the primary responsibility of teaching the intern during the entire period of the training.

“Supplying” means selling, transferring, or delivering to a patient or a patient’s agent one or more doses of:

A nonprescription drug in the manufacturer’s original container for subsequent use by the patient, or

A compressed medical gas in the manufacturer’s or compressed medical gas distributor’s original container for subsequent use by the patient.

“Support personnel” means an individual, working under the supervision of a pharmacist, trained to perform clerical duties associated with the practice of pharmacy, including cashing, bookkeeping, pricing, stocking, delivering, answering non-professional telephone inquiries, and documenting third-party reimbursement. Support personnel shall not perform the tasks of a pharmacist, pharmacy intern, graduate intern, pharmacy technician, or pharmacy technician trainee.

“Temporary pharmacy facility” means a facility established as a result of a declared state of emergency to temporarily provide pharmacy services within or adjacent to declared disaster areas.

“Tourist” means an individual who is living in Arizona but maintains a place of habitation outside of Arizona and lives outside of Arizona for more than six months during a calendar year.

“Transfill” means a manufacturing process by which one or more compressed medical gases are transferred from a bulk container to a properly labeled container for subsequent distribution or supply.

“Unearned income” means monetary payment received by an individual that is not compensation for work performed or rental of property owned or leased by the individual, including:

Unemployment insurance,

Workers’ compensation,

Disability payments,

Payments from the Social Security Administration,

Payments from public assistance,

Periodic insurance or annuity payments,

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Retirement or pension payments,
 Strike benefits from union funds,
 Training stipends,
 Child support payments,
 Alimony payments,
 Military family allotments,
 Regular support payments from a relative or other individual not residing in the household,
 Investment income,
 Royalty payments,
 Periodic payments from estates or trusts, and
 Any other monetary payments received by an individual that are not:

As a result of work performed or rental of property owned by the individual,

Gifts,

Lump-sum capital gains payments,

Lump-sum inheritance payments,

Lump-sum insurance payments, or

Payments made to compensate for personal injury.

“Verified signature” or “signature verifying” means in relation to a Board license or permit application or report, form, or agreement, the hand-written or electronic signature of an individual who, by placing a hand-written or electronic signature on a hard-copy or electronic license or permit application or report, form, or agreement agrees with and verifies that the statements and information within or attached to the license or permit application or report, form, or agreement are true in every respect and that inaccurate reporting can result in denial or loss of a license or permit or report, form, or agreement.

“Veteran” means an individual who has served in the United States Armed Forces.

“Wholesale distribution” means distribution of a drug to a person other than a consumer or patient, but does not include:

Selling, purchasing, or trading a drug or offering to sell, purchase, or trade a drug for emergency medical reasons. For purposes of this Section, “emergency medical reasons” includes transferring a prescription drug by a community or hospital pharmacy to another community or hospital pharmacy to alleviate a temporary shortage;

Selling, purchasing, or trading a drug, offering to sell, purchase, or trade a drug, or dispensing a drug as specified in a prescription;

Distributing a drug sample by a manufacturers’ or distributors’ representative; or

Selling, purchasing, or trading blood or blood components intended for transfusion.

“Wholesale distributor” means any person engaged in wholesale distribution of drugs, including: manufacturers; repackers; own-label distributors; private-label distributors; jobbers; brokers; warehouses, including manufacturers’ and distributors’ warehouses, chain drug warehouses, and wholesale drug warehouses; independent wholesale drug traders; and retail pharmacies that conduct wholesale distributions in the amount of at least 5% of gross sales.

Historical Note

Adopted effective August 24, 1992 (Supp. 92-2).
 Amended effective December 18, 1992 (Supp. 92-4).
 Amended effective November 1, 1993 (Supp. 93-4).
 Amended effective April 1, 1995; filed with the Secretary of State January 31, 1995 (Supp. 95-1). Amended effective April 5, 1996 (Supp. 96-2). Amended effective July 8, 1997; amended effective August 5, 1997 (Supp. 97-3).
 Amended effective January 12, 1998 (Supp. 98-1).
 Amended effective July 7, 1998 (Supp. 98-3). Amended by final rulemaking at 5 A.A.R. 862, effective March 3, 1999 (Supp. 99-1). Amended by final rulemaking at 5 A.A.R. 4441, effective November 2, 1999 (Supp. 99-4). Amended by final rulemaking at 6 A.A.R. 4589, effective November 14, 2000 (Supp. 00-4). Amended by final rulemaking at 7 A.A.R. 646, effective January 11, 2001 (Supp. 01-1). Amended by final rulemaking at 8 A.A.R. 409 and 8 A.A.R. 646, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 8 A.A.R. 416, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 8 A.A.R. 1256, effective March 7, 2002 (Supp. 02-1). Amended by final rulemaking at 8 A.A.R. 4052, effective November 9, 2002 (Supp. 02-3). Amended by final rulemaking at 8 A.A.R. 4898 and 8 A.A.R. 4902, effective January 5, 2003 (Supp. 02-4). Amended by final rulemaking at 9 A.A.R. 1064, effective May 4, 2003 (Supp. 03-1). Amended by final rulemaking at 9 A.A.C. 5030, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 10 A.A.R. 3391, effective October 2, 2004 (Supp. 04-3). Amended by final rulemaking at 10 A.A.R. 3967, effective November 13, 2004 (Supp. 04-3). Amended by final rulemaking at 10 A.A.R. 4356, effective December 4, 2004 (Supp. 04-4). Amended by final rulemaking at 11 A.A.R. 2258, effective August 6, 2005 (Supp. 05-2). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3). Amended by final rulemaking at 12 A.A.R. 3981, effective December 4, 2006 (Supp. 06-4). Amended by final rulemaking at 13 A.A.R. 520, effective April 7, 2007 (Supp. 07-1). Amended by final rulemaking at 13 A.A.R. 440, effective April 7, 2007 (Supp. 07-1). Amended by final rulemaking at 13 A.A.R. 3477, effective December 1, 2007 (Supp. 07-4). Amended by final rulemaking at 14 A.A.R. 3405, effective October 4, 2008; amended by final rulemaking at 14 A.A.R. 3410, effective October 4, 2008 (Supp. 08-3). Amended by final rulemaking at 14 A.A.R. 4400, effective January 3, 2009; amended by final rulemaking at 14 A.A.R. 4320, effective January 3, 2009 (Supp. 08-4). Amended by final rulemaking at 18 A.A.R. 2603, effective December 2, 2012 (Supp. 12-4). Amended by final rulemaking at 18 A.A.R. 2609, effective December 2, 2012 (Supp. 12-4).

R4-23-111. Notice of Hearing

- A.** Except as provided in A.R.S. § 32-1928(B), the Board shall revoke, suspend, place on probation, or fine a licensee or permittee only after:
 1. Notice is served under this Section, and
 2. A hearing is conducted under R4-23-122.
- B.** The Board shall give notice of hearing to a party at least 30 days before the date set for the hearing in the manner described in R4-23-115(E) and (F). The notice shall include:
 1. A statement of the date, time, place, and nature of the hearing;

2. A statement of the legal authority and jurisdiction for the hearing;
3. A reference to the particular section or sections of statute and rule involved; and
4. A statement of the violation or issue asserted by the Board.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

R4-23-112. Ex Parte Communications

A party shall not communicate, either directly or indirectly, with a Board member about any substantive issue in a pending matter unless:

1. All parties are present;
2. It is during a scheduled proceeding, where an absent party fails to appear after proper notice; or
3. It is by written motion with copies to all parties.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

R4-23-113. Motions

- A. Purpose.** A party requesting a ruling from the Board shall file a motion. Motions may be made for rulings such as:
 1. Continuing or expediting a hearing under R4-23-116;
 2. Vacating a hearing under R4-23-117;
 3. Scheduling a prehearing conference under R4-23-118;
 4. Quashing a subpoena under R4-23-119;
 5. Requesting telephonic testimony under R4-23-120; and
 6. Reconsidering a previous order under R4-23-121.
- B. Form.** Unless made during a prehearing conference or hearing, motions shall be made in writing and shall conform to the requirements of R4-23-115. All motions, whether written or oral, shall state the factual and legal grounds supporting the motion, and the requested action.
- C. Time limits.** Absent good cause, or unless otherwise provided by law or these rules, written motions shall be filed with the Board office at least 15 days before the hearing. A party demonstrates good cause by showing that the grounds for the motion could not have been known in time, using reasonable diligence and:
 1. A ruling on the motion will further administrative convenience, expedition or economy; or
 2. A ruling on the motion will avoid undue prejudice to any party.
- D. Response to motion.** A party shall file a written response stating any objection to the motion within five days of service, or as directed by the Board.
- E. Oral argument.** A party may request oral argument when filing a motion or response. If necessary to develop a complete record, the Board shall grant oral argument.
- F. Rulings.** Rulings on motions, other than those made during a prehearing conference or the hearing, shall be in writing and served on all parties.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

R4-23-114. Computing Time

In computing any time period, the Board shall exclude the day from which the designated time period begins to run. The Board shall include the last day of the period unless it falls on a Saturday, Sunday, or legal holiday. When the time period is 10 days or less, the Board shall exclude Saturdays, Sundays, and legal holidays.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

R4-23-115. Filing Documents

- A. Docket.** The Board shall open a docket for each hearing. All documents filed in a matter with the Board shall be date stamped on the day received by the Board office and entered in the docket.
- B. Definition.** "Documents" include papers such as complaints, answers, motions, responses, notices, and briefs.
- C. Form.** A party shall state on the document the name and address of each party served and how service was made under subsection (E). A document shall contain the Board caption and the Board's docket number.
- D. Signature.** A document filed with the Board shall be signed by the party or the party's attorney. A signature constitutes a certification that the signer has read the document, has a good faith basis for submission of the document, and that it is not filed for the purpose of delay or harassment.
- E. Filing and service.** A copy of a document filed with the Board shall be served on all parties. Filing with the Board office and service shall be completed by personal delivery; first-class, certified, or express mail; or facsimile.
- F. Date of filing and service.** A document is filed with the Board on the date it is received by the Board office, as established by the Board office's date stamp on the face of the document. A copy of a document is served on a party as follows:
 1. On the date it is personally served,
 2. Five days after it is mailed by first-class or express mail,
 3. On the date of the return receipt if it is mailed by certified mail, or
 4. On the date indicated on the facsimile transmission.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

R4-23-116. Continuing or Expediting a Hearing; Reconvening a Hearing

- A. Continuing or expediting a hearing.** When ruling on a motion to continue or expedite, the Board shall consider such factors as:
 1. The time remaining between the filing of the motion and the hearing date;
 2. The position of other parties;
 3. The reasons for expediting the hearing or for the unavailability of the party, representative, or counsel on the date of the scheduled hearing;
 4. Whether testimony of an unavailable witness can be taken telephonically or by deposition; and
 5. The status of settlement negotiations.
- B. Reconvening a hearing.** The Board may recess a hearing and reconvene at a future date by a verbal ruling.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

R4-23-117. Vacating a Hearing

The Board shall vacate a calendared hearing and return the matter to the Board office for further action, if:

1. The parties agree to vacate the hearing;
2. The Board dismisses the matter;
3. The non-Board party withdraws the appeal; or
4. Facts demonstrate to the Board that it is appropriate to vacate the hearing for the purpose of informal disposition, or if the action will further administrative convenience.

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nience, expedition, and economy and does not conflict with law or cause undue prejudice to any party.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

R4-23-118. Prehearing Conference

- A.** Procedure. The Board may hold a prehearing conference. The conference may be held telephonically. The Board may issue a prehearing order outlining the issues to be discussed.
- B.** Record. The Board may record any agreements reached during a prehearing conference by electronic or mechanical means, or memorialize them in an order.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

R4-23-119. Subpoenas

- A.** Form. A party shall request a subpoena in writing from the Board and shall include:
 - 1. The caption and docket number of the matter;
 - 2. A list or description of any documents sought;
 - 3. The full name and home or business address of the custodian of the documents sought or all persons to be subpoenaed;
 - 4. The date, time, and place to appear or to produce documents pursuant to the subpoena; and
 - 5. The name, address, and telephone number of the party, or the party's attorney, requesting the subpoena.
- B.** The Board may require a brief statement of the relevance of testimony or documents.
- C.** Service of subpoena. Any person who is not a party and is at least 18 years of age may serve a subpoena. The person shall serve the subpoena by delivering a copy to the person to be served. The person serving the subpoena shall provide proof of service by filing with the Board office a certified statement of the date and manner of service and the names of the persons served.
- D.** Objection to subpoena. A party, or the person served with a subpoena who objects to the subpoena, or any portion of it, may file an objection with the Board. The objection shall be filed within five days after service of the subpoena, or at the outset of the hearing if the subpoena is served fewer than five days before the hearing.
- E.** Quashing, modifying subpoenas. The Board shall quash or modify a subpoena if:
 - 1. It is unreasonable or oppressive, or
 - 2. The desired testimony or evidence may be obtained by an alternative method.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

R4-23-120. Telephonic Testimony

The Board may grant a motion for telephonic testimony if:

- 1. Personal attendance by a party or witness at the hearing will present an undue hardship for the party or witness;
- 2. Telephonic testimony will not cause undue prejudice to any party; and
- 3. The proponent of the telephonic testimony pays for any cost of obtaining the testimony telephonically.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

R4-23-121. Rights and Responsibilities of Parties

- A.** Generally. A party may present testimony and documentary evidence and argument with respect to the contested issue and may examine and cross-examine witnesses.
- B.** Preparation. A party shall have all witnesses, documents, and exhibits available on the date of the hearing.
- C.** Exhibits. A party shall provide a copy of each exhibit to all other parties at the time the exhibit is offered to the Board, unless the exhibit was previously provided to all other parties.
- D.** Responding to orders. A party shall comply with an order issued by the Board concerning the conduct of a hearing. Unless an objection is made orally during a pre-hearing conference or hearing, a party shall file a motion requesting the Board to reconsider the order.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

R4-23-122. Conduct of Hearing

- A.** Public access. Unless otherwise provided by law, all hearings are open to the public and may be conducted in an informal manner as prescribed in A.R.S. § 41-1092 et seq.
- B.** Opening. The Board shall begin the hearing by reading the caption, stating the nature and scope of the hearing, and identifying the parties, counsel, and witnesses for the record.
- C.** Stipulations. The Board shall enter into the record any stipulation, settlement agreement, or consent order entered into by any of the parties before or during the hearing.
- D.** Opening statements. The party with the burden of proof may make an opening statement at the beginning of a hearing. All other parties may make statements in a sequence determined by the Board.
- E.** Order of presentation. After opening statements, the party with the burden of proof shall begin the presentation of evidence, unless the parties agree otherwise or the Board determines that requiring another party to proceed first would be more expeditious or appropriate, and would not prejudice any other party. Copies of documentary evidence may be received in the discretion of the Board. Upon request, parties shall be given an opportunity to compare the copy with the original.
- F.** Examination. A party shall conduct direct and cross examination of witnesses in the order and manner determined by the Board to expedite and ensure a fair hearing. The Board shall make rulings necessary to prevent argumentative, repetitive, or irrelevant questioning and to expedite the examination to the extent consistent with the disclosure of all relevant testimony and information. The Board may take notice of judicially cognizable facts. In addition, the Board may take notice of generally recognized technical or scientific facts within the Board's or its staff's specialized knowledge. A party shall be notified either before or during the hearing or by reference in preliminary reports of the material the Board notices. The Board may use the Board's or its staff's experience, technical competence, and specialized knowledge in the evaluation of the evidence.
- G.** Closing argument. When all evidence has been received, parties shall have the opportunity to present closing oral argument, in a sequence determined by the Board. The Board may permit or require closing oral argument to be supplemented by written memoranda. The Board may permit or require written memoranda to be submitted simultaneously or sequentially, within time periods the Board may prescribe.
- H.** Conclusion of hearing. Unless otherwise provided by the Board, the hearing is concluded upon the submission of all evidence, the making of final argument, and the issuing of a final decision or order of the Board.

- I.** Decisions and orders. Unless otherwise provided by law, any final decisions or order adverse to a party in a hearing shall be in writing or stated in the record. Any final decision shall include findings of fact and conclusions of law, separately stated. Findings of fact shall be accompanied by a concise and explicit statement of the underlying facts supporting the findings. Unless otherwise provided by law, each party shall be notified either personally or by mail to the party's last known address of record of any decision or order. Upon request, a copy of the decision or order shall be delivered or mailed to each party and to each party's attorney of record.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

R4-23-123. Failure of Party to Appear for Hearing

If a party fails to appear at a hearing, the Board may proceed with the presentation of the evidence of the appearing party, or vacate the hearing and return the matter to the Board office for any further action.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

R4-23-124. Witnesses; Exclusion from Hearing

All witnesses at the hearing shall testify under oath or affirmation. At the request of a party, or at the discretion of the Board, the Board may exclude witnesses who are not parties from the hearing room so that they cannot hear the testimony of other witnesses.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

R4-23-125. Proof

- A.** Standard of proof. Unless otherwise provided by law, the standard of proof is a preponderance of the evidence.
- B.** Burden of proof. Unless otherwise provided by law:
1. The party asserting a claim, right, or entitlement has the burden of proof;
 2. A party asserting an affirmative defense has the burden of establishing the affirmative defense; and
 3. The proponent of a motion shall establish the grounds to support the motion.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

R4-23-126. Disruptions

A person shall not interfere with access to or from the hearing room, or interfere, or threaten interference with the hearing. If a person interferes, threatens interference, or disrupts the hearing, the Board may order the disruptive person to leave or be removed.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

R4-23-127. Hearing Record

- A.** Maintenance. The Board shall maintain the official administrative record of a matter.
- B.** Transfer of record. Any party requesting a copy of the administrative record or any portion of the administrative record shall make a request to the Board office and shall pay the reasonable costs of duplication.
- C.** Release of exhibits. Exhibits shall be released:
1. Upon the order of a court of competent jurisdiction; or

2. Upon motion of the party who submitted the exhibits if the time for judicial appeal has expired and no appeal is pending.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

R4-23-128. Rehearing or Review and Appeal of Decision

- A.** The Board shall provide for a rehearing and review of its decisions under A.R.S. Title 41, Chapter 6, Article 10, and this Section. For purposes of these rules, the terms "contested case" and "party" are defined in A.R.S. § 41-1001.
- B.** A party to a contested case shall exhaust the party's administrative remedies by filing a motion for rehearing or review within 30 days after the service of the Board decision that is subject to rehearing or review in order to be eligible for judicial review under A.R.S. Title 12, Chapter 7, Article 6. The Board shall notify a party in its decision, that is subject to rehearing or review, that the party may file a motion for rehearing or review, and that failure to file a motion for rehearing or review within 30 days after service of the decision has the effect of prohibiting the party from seeking judicial review of the Board's decision.
- C.** A party may amend a motion for rehearing or review at any time before the Board rules on the motion.
- D.** The Board may grant a rehearing or review for any of the following reasons materially affecting a party's rights:
1. Irregularity in the proceedings of the Board, or any order or abuse of discretion, that deprived the moving party of a fair hearing;
 2. Misconduct of the Board, its staff, its hearing officer, or the prevailing party;
 3. Accident or surprise that could not have been prevented by ordinary prudence;
 4. Newly discovered material evidence that could not, with reasonable diligence, have been discovered and produced at the hearing;
 5. Excessive or insufficient penalty;
 6. Error in the admission or rejection of evidence or other errors of law occurring at the hearing or during the progress of the proceedings;
 7. That the Board's decision is a result of passion or prejudice; or
 8. That the findings of fact or decision is not justified by the evidence or is contrary to law.
- E.** The Board may affirm or modify a decision or grant a rehearing to all or any of the parties on all or part of the issues for any of the reasons in subsection (D). An order modifying a decision or granting a rehearing shall specify with particularity the grounds for the order.
- F.** If a motion for rehearing or review is based upon affidavits, they shall be served with the motion. An opposing party may, within 15 days after service, serve opposing affidavits. The Board may extend this period for a maximum of 20 days, for good cause as described in subsection (I).
- G.** Not later than 10 days after the date of a decision, after giving parties notice and an opportunity to be heard, the Board may grant a rehearing or review on its own initiative for any reason for which it might have granted relief on the motion of a party. The Board may grant a motion for rehearing or review, timely served, for a reason not stated in the motion.
- H.** If a rehearing is granted, the Board shall hold the rehearing within 60 days after the order granting the rehearing is issued.
- I.** The Board may extend all time limits listed in this Section upon a showing of good cause. A party demonstrates good cause by showing that the grounds for the party's motion or

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other action could not have been known in time, using reasonable diligence, and a ruling on the motion will:

1. Further administrative convenience, expedition, or economy; or
2. Avoid undue prejudice to any party.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

R4-23-129. Notice of Judicial Appeal; Transmitting the Transcript

- A. Notification to the Board office. Within 10 days of filing a complaint for judicial review of a final administrative decision of the Board, the party shall file a copy of the complaint with the Board office. The Board office shall then transmit the administrative record to the Superior Court.
- B. Transcript. A party requesting a transcript shall arrange for transcription at the party's expense. The Board office shall make a copy of the audio taped record available to the transcriber. The party arranging for transcription shall deliver the transcript, certified by the transcriber under oath to be a true and accurate transcription of the audio taped record, to the Board office, together with one unbound copy.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

ARTICLE 2. PHARMACIST LICENSURE**R4-23-201. General**

- A. License required. Before practicing as a pharmacist in Arizona, a person shall possess a valid pharmacist license issued by the Board. There is no temporary licensure.
- B. Methods of licensure. Licensure as a pharmacist shall be either:
 1. By practical examination, using paper and pencil written testing, computer adaptive testing, or other Board-approved testing method; or
 2. By reciprocity.
- C. Practicing pharmacist holding a delinquent license. Before the Board reinstates an Arizona pharmacist license, a pharmacist, whose Arizona pharmacist license is delinquent for five or more years and who is practicing pharmacy outside the Board's jurisdiction with a pharmacist license issued by another jurisdiction, shall:
 1. Pass the MPJE or other Board-approved jurisprudence examination,
 2. Pay all delinquent annual renewal fees, and
 3. Pay penalty fees.
- D. Non-practicing pharmacist holding a delinquent license. Before the Board reinstates an Arizona pharmacist license, a pharmacist, whose Arizona pharmacist license is delinquent for five or more years and who did not practice pharmacy within the last 12 months before seeking reinstatement, shall:
 1. Complete the requirements in subsection (C), and
 2. Appear before the Board to furnish satisfactory proof of fitness to be licensed as a pharmacist.

Historical Note

Former Rules 2.1100, 2.1310, 2.1320, and 2.1400. Amended effective August 23, 1978 (Supp. 78-4). Amended by deleting subsection (E) effective April 20, 1982 (Supp. 82-2). Amended subsections (C) and (D) effective August 12, 1988 (Supp. 88-3). Amended effective February 8, 1991 (Supp. 91-1). Amended effective January 12, 1998 (Supp. 98-1). Amended by final rulemaking at 10 A.A.R. 4356, effective December 4,

2004 (Supp. 04-4).

R4-23-202. Licensure by Examination

- A. Eligibility. To be eligible for licensure as a pharmacist by examination, a person shall:
 1. Have an undergraduate degree in pharmacy from a school or college of pharmacy whose professional degree program, at the time the person graduates, is accredited by the American Council on Pharmaceutical Education; or
 2. Qualify under the requirements of A.R.S. § 32-1922(D); and
 3. Complete not less than 1500 hours of intern training as specified in R4-23-303.
- B. Application.
 1. An applicant for licensure by examination shall file with the Board office:
 - a. A completed application for licensure by examination form,
 - b. A completed NAPLEX registration form or ensure receipt of an official NABP score transfer report through the Board office online computer link with NABP indicating the applicant's score on the NAPLEX taken in another jurisdiction, and
 - c. A completed MPJE registration form.
 2. The Board office shall deem an application or registration form received on the date that the Board office stamps on the form when the Board office receives the form. The Board office shall deem a score transfer received on the date that the NABP transmits the applicant's official NABP score transfer report through the online computer link to the Board office.
 3. An applicant for licensure by examination shall:
 - a. Make application on a form furnished by the Board, and
 - b. Submit with the application for licensure by examination form:
 - i. The documents specified in the application form, and
 - ii. The application fee specified in R4-23-205(C) made payable to the Arizona State Board of Pharmacy by money order or certified or personal check.
 4. An applicant for licensure by examination shall:
 - a. Register for NAPLEX and MPJE on forms furnished by the Board or NABP; and
 - b. Submit with the registration forms:
 - i. The documents specified in the registration forms, and
 - ii. The application fee specified by and made payable to NABP by money order, certified check, or bank draft.
 5. The Board shall deem an application for licensure by examination or a NAPLEX or MPJE registration to be invalid after 12 months from the date the Board office determines an application or registration form is complete. An applicant whose application or registration form is invalid and who wishes to continue licensure procedures, shall submit a new application or registration form and fee.
- C. Passing grade; notification; re-examination.
 1. To pass the required examinations, an applicant shall obtain a score of at least 75 on both the NAPLEX and MPJE.
 2. The Board office shall:
 - a. Retrieve an applicant's NAPLEX and MPJE score from the NABP online database no later than two weeks after the applicant's examination date; and

- b. Mail an applicant's NAPLEX and MPJE score to the applicant no later than seven days after the Board office receives the applicant's score from NABP.
- 3. An applicant who fails the NAPLEX or MPJE may apply to retake the examination within the 12-month period defined in subsection (B)(5). An applicant applying to retake an examination shall submit to the Board office a completed NAPLEX or MPJE registration form and pay the examination fee specified by and made payable to NABP by money order, certified check, or bank draft. An applicant who fails the NAPLEX or MPJE three times shall petition the Board for permission before retaking the examination.
- D. NAPLEX score transfer.**
 - 1. An applicant who receives a passing score on the NAPLEX taken in another jurisdiction shall, within 12 months from the date the Board office receives the applicant's official NABP score transfer report from the NABP, make application for licensure according to subsection (B). After 12 months, an applicant may reapply for licensure in this state under the provisions of subsection (B) or R4-23-203(B).
 - 2. An applicant who takes the NAPLEX in another jurisdiction and fails the examination may apply for licensure in this state under the provisions of subsection (B).
- E. Licensure.** The Board office shall issue a certificate of licensure to a successful applicant upon receipt of the licensure fee specified in R4-23-205(A)(1)(a). The Board office shall:
 - 1. Provide a receipt for payment of the licensure fee to an applicant who delivers a payment in person, or
 - 2. Mail a receipt for payment of the licensure fee to an applicant within one working day of receiving the payment by mail or other delivery service.
- F. Time-frames for licensure by examination.**
 - 1. The Board office shall complete an administrative completeness review within 20 days from the date of receipt of an application or registration form.
 - a. The Board office shall issue a written notice of administrative completeness to the applicant if no deficiencies are found in the application or registration form.
 - b. If the application or registration form is incomplete, the Board office shall provide the applicant with a written notice that includes a comprehensive list of the missing information. The 20-day time-frame for the Board office to finish the administrative completeness review is suspended from the date the notice of incompleteness is served until the applicant provides the Board office with all missing information.
 - c. If the Board office does not provide the applicant with notice regarding administrative completeness, the application or registration form shall be deemed complete 20 days after receipt by the Board office.
 - 2. An applicant with an incomplete application or registration form shall submit all of the missing information within 30 days of service of the notice of incompleteness.
 - a. If an applicant cannot submit all missing information within 30 days of service of the notice of incompleteness, the applicant may send a written request for an extension to the Board office postmarked or delivered no later than 30 days from service of the notice of incompleteness.
 - b. The written request for an extension shall document the reasons the applicant is unable to meet the 30-day deadline.
 - 3. The Board office shall review the request for an extension of the 30-day deadline and grant the request if the Board office determines that an extension of the deadline will enable the applicant to assemble and submit the missing information. An extension shall be for no more than 30 days. The Board office shall notify the applicant in writing of its decision to grant or deny the request for an extension. An applicant who requires an additional extension shall submit an additional written request according to this subsection.
 - 4. If an applicant fails to submit a complete application or registration form within the time allowed, the Board office shall close the applicant's file. An applicant whose file is closed and who later wishes to obtain a license shall apply again according to subsection (B).
 - 5. The Board office shall complete a substantive review of the applicant's qualifications in no more than 20 days from the date on which the administrative completeness review of an application or registration form is complete.
 - a. If an applicant is found to be ineligible for licensure by examination, the Board office shall issue a written notice of denial to the applicant.
 - b. If an applicant is found to be eligible to take the NAPLEX, the Board office shall issue a written notice of eligibility to the applicant and the NABP.
 - c. If an applicant is found to be eligible to take the MPJE, the Board office shall issue a written notice of eligibility to the applicant and the NABP.
 - d. If the Board office finds deficiencies during the substantive review of an application or registration form, the Board office shall issue a written request to the applicant for additional documentation.
 - e. The 20-day time-frame for a substantive review of eligibility to take the NAPLEX or MPJE is suspended from the date of a written request for additional documentation until the date that all documentation is received. The applicant shall submit the additional documentation according to subsection (F)(2).
 - f. If the applicant and the Board office mutually agree in writing, the 20-day substantive review time-frame may be extended once for no more than 10 days.
- 5. For the purpose of A.R.S. § 41-1072 et seq., the Board establishes the following time-frames for licensure by examination.
 - a. Administrative completeness review time-frame: 20 days.
 - b. Substantive review time-frame: 20 days.
 - c. Overall time-frame: 40 days.

Historical Note

Former Rules 2.2100, 2.2200, 2.2300, 2.2400, 2.2500, 2.2600, 2.2700, 2.2800, 2.2910, 2.2920, 2.2930, 2.3000, 2.3010, 2.3100; Amended effective August 23, 1978 (Supp. 78-5). Amended effective June 10, 1981 (Supp. 81-3). Former Section R4-23-202 repealed, new Section R4-23-202 adopted effective July 24, 1985 (Supp. 85-4). Amended effective March 13, 1991 (Supp. 91-1). Amended effective January 12, 1998 (Supp. 98-1). Amended by final rulemaking at 8 A.A.R. 409 and 8 A.A.R. 646, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 10 A.A.R. 4356, effective

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tive December 4, 2004 (Supp. 04-4). Amended by final rulemaking at 12 A.A.R. 4689, effective February 3, 2007 (Supp. 06-4). Amended by final rulemaking at 14 A.A.R. 3605, effective November 8, 2008 (Supp. 08-3).

R4-23-203. Licensure by Reciprocity**A. Eligibility.** A person is eligible for licensure by reciprocity who:

1. Is licensed as a pharmacist in a jurisdiction that provides reciprocity to Arizona licensees;
2. Has passed the NABPLEX or NAPLEX with a score of 75 or better or was licensed by examination in another jurisdiction having essentially the same standards for licensure as this state at the time the pharmacist was licensed;
3. Provides evidence to the Board of having completed the required secondary and professional education and training specified in R4-23-202(A);
4. Has engaged in the practice of pharmacy for at least one year or has met the internship requirements of Article 3 within the year immediately before the date of application; and
5. Has actively practiced as a pharmacist for 400 or more hours within the last calendar year or has an Arizona graduate intern license and has completed 400 hours of internship training in a Board-approved internship training site.

B. Application.

1. An applicant for licensure by reciprocity shall file with the Board office:
 - a. A completed application for licensure by reciprocity form; and
 - b. A completed MPJE registration form.
2. The Board office shall deem an application or registration form received on the date that the Board office stamps on the application or registration form when the Board office receives the form.
3. An applicant for licensure by reciprocity shall:
 - a. Make application on a form furnished by the Board, and
 - b. Submit with the application for licensure by reciprocity form:
 - i. The documents specified in the application form, and
 - ii. The reciprocity and application fee specified in R4-23-205(B) and (C) and made payable to the Arizona State Board of Pharmacy by money order or certified or personal check.
4. An applicant for licensure by reciprocity shall:
 - a. Register for MPJE on a form furnished by the Board or NABP; and
 - b. Submit with the registration form:
 - i. The documents specified in the registration form; and
 - ii. The application fee specified by and made payable to NABP by money order, certified check, or bank draft.
5. The Board office shall deem an application for licensure by reciprocity form or MPJE registration invalid after 12 months from the date the Board office determines an application or registration form is complete. An applicant whose application or registration form is invalid and who wishes to continue licensure procedures, shall submit a new application or registration form and fee.

C. Passing grade; notification; re-examination.

1. To pass the required examination, an applicant shall obtain a score of at least 75 on the MPJE.

2. The Board office shall:

- a. Retrieve an applicant's MPJE score from the NABP online database no later than two weeks after the applicant's examination date; and
 - b. Mail an applicant's MPJE score to the applicant no later than seven days after the Board office receives the applicant's score from NABP.
3. An applicant who fails the MPJE may apply to retake the examination within the 12-month period specified in subsection (B)(5). An applicant applying to retake an examination shall submit to the Board office a completed MPJE registration form and pay the examination fee specified by and made payable to NABP by money order, certified check, or bank draft. An applicant who fails the MPJE three times shall petition the Board for permission before retaking the examination.

D. Licensure. The Board office shall issue a certificate of licensure to a successful applicant upon receipt of the licensure fee specified in R4-23-205(A)(1)(a). The Board office shall:

1. Provide a receipt for payment of the licensure fee to an applicant who delivers a payment in person; or
2. Mail a receipt for payment of the licensure fee to an applicant within one working day of receiving the payment by mail or other delivery service.

E. Time-frames for licensure by reciprocity. The Board office shall follow the time-frames established for licensure by examination in R4-23-202(F).**Historical Note**

Former Rules 2.4100, 2.4200, 2.4310, 2.4320, 2.4330, 2.4340, 2.4350, 2.4360, 2.4400, 2.4510, 2.4520, 2.4522, 2.4523, 2.4530, 2.4540, 2.4550, 2.4560, 2.4610, 2.4620, and 2.4700; Amended effective August 23, 1978 (Supp. 78-4). Amended subsections (H), (L), (O) through (Q) effective June 10, 1981 (Supp. 81-3). Former Section R4-23-203 repealed, new Section R4-23-203 adopted effective July 24, 1985 (Supp. 85-4). Amended effective March 13, 1991 (Supp. 91-1). Amended effective January 12, 1998 (Supp. 98-1). Amended effective January 12, 1998 (Supp. 98-1). Amended by final rulemaking at 8 A.A.R. 409 and 8 A.A.R. 646, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 10 A.A.R. 4356, effective December 4, 2004 (Supp. 04-4). Amended by final rulemaking at 14 A.A.R. 3605, effective November 8, 2008 (Supp. 08-3).

R4-23-204. Continuing Education Requirements**A. General.** In accordance with A.R.S. § 32-1925(G), the Board shall not renew a license unless the applicant has, during the two years preceding the application for renewal, participated in 30 contact hours (3.0 CEU's) of continuing education activity sponsored by an Approved Provider as defined in R4-23-110, of which at least three contact hours (0.3 CEU's) are approved courses in pharmacy law. Subject to A.R.S. § 32-1937, a pharmacist licensed for less than 24 months shall obtain continuing education units in an amount determined by multiplying 1.25 hours times the number of months between the date of initial licensure and the next license renewal date.**B. Acceptance of continuing education units (CEU's).** The Board shall:

1. Only accept CEU's for continuing education activities sponsored by an Approved Provider;
2. Only accept CEU's accrued during the two-year period immediately before licensure renewal;
3. Not allow CEU's accrued in a biennial renewal period in excess of the 3.0 CEU's required to be carried forward to the succeeding biennial renewal period;

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4. Allow a pharmacist who leads, instructs, or lectures to a group of health professionals on pharmacy-related topics in continuing education activities sponsored by an Approved Provider to receive CEU's for a presentation by following the same attendance procedures as any other attendee of the continuing education activity; and
 5. Not accept as CEU's the performance of normal teaching duties within a learning institution by a pharmacist whose primary responsibility is the education of health professionals.
- C.** Continuing education records and reporting CEU's. A pharmacist shall:
1. Maintain continuing education records that:
 - a. Verify the continuing education activities the pharmacist participated in during the preceding five years; and
 - b. Consist of a statement of credit or a certificate issued by an Approved Provider at the conclusion of a continuing education activity;
 2. At the time of licensure renewal, attest to the number of CEU's the pharmacist participated in during the renewal period on the biennial renewal form; and
 3. When requested by the Board office, submit proof of continuing education participation within 20 days of the request.
- D.** The Board may revoke, suspend, or place on probation the license of a pharmacist who fails to comply with continuing education participation, recording, or reporting requirements of this Section.
- E.** A pharmacist who is aggrieved by any decision of the Board or its administrative staff concerning continuing education units may request a hearing before the Board.

Historical Note

Adopted effective September 1, 1981 (Supp. 81-5).
 Amended effective March 13, 1991 (Supp. 91-1).
 Amended by final rulemaking at 8 A.A.R. 409 and 8 A.A.R. 646, effective January 10, 2002 (Supp. 02-1).

R4-23-205. Fees

- A.** Licensure fees:
1. Pharmacist:
 - a. Initial licensure [Prorated according to A.R.S. § 32-1925(B)]: \$180.
 - b. Licensure renewal: \$180.
 2. Pharmacy or graduate intern. Initial licensure: \$50.
 3. Pharmacy technician:
 - a. Initial licensure [prorated according to A.R.S. § 32-1925(B)]: \$72.
 - b. Licensure renewal: \$72.
 4. Pharmacy technician trainee: \$36.
- B.** Reciprocity fee: \$300.
- C.** Application fee: \$50.
- D.** Vendor permit fees (Resident and nonresident):
1. Pharmacy: \$480 biennially (Including hospital, and limited service).
 2. Drug wholesaler or manufacturer:
 - a. Manufacturer: \$1000 biennially.
 - b. Full-service drug wholesaler: \$1000 biennially.
 - c. Nonprescription drug wholesaler: \$500 biennially.
 3. Drug packager or repackager: \$1000 biennially.
 4. Nonprescription drug, retail:
 - a. Category I (30 or fewer items): \$120 biennially
 - b. Category II (more than 30 items): \$200 biennially
 5. Compressed medical gas distributor: \$200 biennially
 6. Compressed medical gas supplier: \$100 biennially
- E.** Other Fees:

1. Wall license.
 - a. Pharmacist: \$20.
 - b. Pharmacy or graduate intern: \$10.
 - c. Pharmacy technician: \$10.
 - d. Pharmacy technician trainee: \$10.
 2. Duplicate of any Board-issued license, registration, certificate, or permit: \$10.
 3. Duplicate current renewal license: \$10.
- F.** Fees are not refunded under any circumstances except for the Board's failure to comply with its established licensure or permit time-frames under R4-23-202 or R4-23-602.
- G.** Penalty fee. Renewal applications submitted after the expiration date are subject to penalty fees as provided in A.R.S. §§ 32-1925 and 32-1931.
1. Licensees: A fee equal to half the licensee's biennial licensure renewal fee under subsection (A) and not to exceed \$350.
 2. Permittees: A fee equal to half the permittee's biennial permit fee under subsection (D) and not to exceed \$350.

Historical Note

Adopted effective July 24, 1985 (Supp. 84-5). Amended subsection (A) paragraph (1) effective May 20, 1988 (Supp. 88-2). Amended effective August 12, 1988 (Supp. 88-3). Amended effective February 8, 1991 (Supp. 91-1). Amended effective April 1, 1995; filed with the Secretary of State January 31, 1995 (Supp. 95-1). Amended effective January 12, 1998 (Supp. 98-1). Amended by final rulemaking at 6 A.A.R. 4589, effective November 14, 2000 (Supp. 00-4). Amended by final rulemaking at 8 A.A.R. 409 and 8 A.A.R. 646, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 8 A.A.R. 416, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3). Amended by final rulemaking at 15 A.A.R. 173, effective March 7, 2009 (Supp. 09-1).

**ARTICLE 3. INTERN TRAINING AND PHARMACY
INTERN PRECEPTORS****R4-23-301. Intern Licensure**

- A.** Licensure as a pharmacy intern or graduate intern is for the purpose of complementing the individual's academic or experiential education in preparation for licensure as a pharmacist. An applicant may request a waiver of intern licensure requirements by submitting a written request and appearing in person at a Board meeting.
- B.** The prerequisites for licensure as a pharmacy intern are:
1. Current enrollment, in good standing, in a Board-approved college or school of pharmacy; or
 2. Graduation from a college or school of pharmacy that is not approved by the Board; and
 3. Proof that the applicant is certified by the Foreign Pharmacy Graduate Examination Committee (FPGEC); or
 4. By order of the Board if the Board determines the applicant needs intern training.
- C.** If a pharmacy intern licensee stops attending pharmacy school classes before completing the pharmacy school's requirements for graduation, the licensee shall immediately stop practicing as a pharmacy intern and surrender the pharmacy intern license to the Board or the Board's designee no later than 30 days after the date of the last attended class, unless the licensee requests and is granted permission by the Board to continue working as a pharmacy intern. A student re-entering a pharmacy program who wishes to continue internship training shall reapply for pharmacy intern licensure.

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- D.** The prerequisites for licensure as a graduate intern are:
1. Graduate from a Board-approved college or school of pharmacy, and
 2. Apply for licensure as a pharmacist by examination or reciprocity, or
 3. By order of the Board if the Board determines that the applicant needs intern training.
- E.** Experiential training. Intern training shall include the activities and services encompassed by the term "practice of pharmacy" as defined in A.R.S. § 32-1901.
- F.** Out-of-state experiential training. An intern shall receive credit for intern training received outside this state if the Board determines that the intern training requirements of the jurisdiction in which the training was received are equal to the minimum requirements for intern training in this state. An applicant seeking credit for intern training received outside this state shall furnish a certified copy of the records of intern training from:
1. The board of pharmacy or the intern licensing agency of the other jurisdiction where the training was received; or
 2. In a jurisdiction without an intern licensing agency, the director of the applicant's Board-approved college or school of pharmacy's experiential training program.
- G.** Management required to verify intern's qualifications. An owner, manager, or pharmacist-in-charge shall not permit a person to act as a pharmacy or graduate intern until the owner, manager, or pharmacist-in-charge verifies that the person is currently licensed by the Board as a pharmacy or graduate intern.
- H.** Intern application. An applicant for licensure as a pharmacy intern or graduate intern shall:
1. Ensure that the applicant's college or school of pharmacy provides documentation to the Board of the applicant's current enrollment or graduation; and
 2. File an application on a form furnished by the Board, that includes:
 - a. Applicant's name, address, mailing address, if different, telephone number, and social security number;
 - b. Name and address of college or school of pharmacy attending or attended, degree anticipated or received, and anticipated date or date of graduation;
 - c. Whether the applicant has ever been convicted of an offense involving moral turpitude, a felony offense, or any drug-related offense or has any currently pending felony or drug-related charges, and if so, indicate charge, conviction date, jurisdiction, and location;
 - d. Whether the applicant has ever had an intern license revoked, suspended, or denied in this state or any other jurisdiction, and if so, indicate where and when;
 - e. If the applicant graduated from an unapproved college or school of pharmacy, a notarized copy of the applicant's Foreign Pharmacy Graduate Examination Committee (FPGEC) certification document;
 - f. Date signed and applicant's verified signature; and
 - g. The initial licensure fee specified in R4-23-205.
- I.** Licensure. Within seven business days of receipt of a completed application, fees, and other information specified in subsection (H), the Board office shall determine whether an application is complete. If the application is complete, the Board office shall issue a license number and mail a current renewal receipt to an applicant. An applicant who is issued a license number may begin practice as a pharmacy intern or graduate intern. The initial licensure fee shall include the issuance of a wall certificate. The Board office shall mail the wall certificate to the licensee within 14 days of issuing the license number. If the application is incomplete, the Board office shall issue a notice of incompleteness. An applicant with an incomplete application shall comply with the requirements of R4-23-202(F)(2) and (3).
- J.** License renewal. A pharmacy intern whose license expires before the intern completes the education or training required for licensure as a pharmacist but less than six years after the issuance of the initial pharmacy intern license may renew the intern license for a period equal to the difference between the expiration date of the initial intern license and six years from the issue date of the initial intern license by payment of a prorated renewal fee based on the initial license fee specified in R4-23-205. If a pharmacy intern fails to graduate from a Board-approved college or school of pharmacy within six years from the date the Board issues the initial intern license, the intern is not eligible for relicensure as an intern unless the intern obtains Board approval as specified in A.R.S. § 32-1923(E). To remain in good standing, an intern who receives Board approval for relicensure shall pay a prorated renewal fee for the number of months of licensure approved by the Board based on the initial license fee specified in R4-23-205 before the license expiration date. If an intern receives Board approval for relicensure and does not pay the renewal fee specified in this subsection before the license expiration date, the intern license is suspended and the intern shall pay a penalty as provided in A.R.S. § 32-1925 to vacate the suspension.
- K.** Notification of training.
1. A pharmacy intern who is employed as an intern outside the experiential training program of a Board-approved college or school of pharmacy or a graduate intern shall notify the Board within ten days of starting or terminating training, or changing training site.
 2. The director of a Board-approved college or school of pharmacy's experiential training program shall provide the Board an intern training report as specified in R4-23-304(B)(3).

Historical Note

Former Rules 3.1000, 3.1100, 3.1200, 3.2000, 3.2100, and 3.2200; Amended effective August 23, 1978 (Supp. 78-4). Amended effective April 20, 1982 (Supp. 82-2). Amended subsections (A), (F) and (G) effective August 12, 1988 (Supp. 88-3). Amended effective November 1, 1993 (Supp. 93-4). Amended by final rulemaking at 8 A.A.R. 416, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 10 A.A.R. 4356, effective December 4, 2004 (Supp. 04-4). Amended by final rulemaking at 11 A.A.R. 3565, effective November 12, 2005 (Supp. 05-3). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3). Amended by final rulemaking at 14 A.A.R. 3670, effective November 8, 2008 (Supp. 08-3).

R4-23-302. Training Site and Pharmacy Intern Preceptors

- A.** To receive credit for intern training hours, a pharmacy or graduate intern shall train in a site that:
1. Holds a valid Arizona pharmacy permit and employs a pharmacy intern preceptor who supervises the intern; or
 2. Is an alternative training site. For purposes of this Section, the term alternative training site is a non-pharmacy training site established and monitored by a Board-approved college or school of pharmacy or other non-pharmacy site where pharmacy related activities are performed and where an intern gains experience as specified in R4-23-301(E).

- B.** The Board shall inform a pharmacy or alternative training site that an intern will not get credit for training received at the site if the Board determines that a pharmacy or alternative training site fails to provide experiential training as specified in R4-23-301(E) or violates A.R.S. Chapter 18 Title 32 or Chapter 27 Title 36 or the federal act.
- C.** Pharmacy intern preceptor. To be a pharmacy intern preceptor, a pharmacist shall:
1. Hold a current unrestricted pharmacist license;
 2. Have a minimum of one year of experience as an actively practicing pharmacist before acting as a pharmacy intern preceptor;
 3. If a pharmacist has been found guilty of violating any federal or state law relating to the practice of pharmacy, drug or device distribution or recordkeeping, or unprofessional conduct, enter into an agreement satisfactory to the Board that places restrictions on the pharmacist's license; and
 4. Hold a faculty position in the experiential training program of a Board-approved college or school of pharmacy; or
 5. Be approved by the Board as being otherwise qualified as a pharmacy intern preceptor.
- D.** Revocation of preceptorship privileges. The Board shall revoke a pharmacy intern preceptor's privilege to train pharmacy or graduate interns if the Board determines that a pharmacy intern preceptor fails to provide experiential training as specified in R4-23-301(E) or violates A.R.S. Title 32, Chapter 18 or Title 36, Chapter 27 or the federal act. R4-23-111 applies to revocation of preceptor privileges.
- E.** Pharmacist-to-intern ratio. A pharmacy intern preceptor may supervise the training of more than one pharmacy or graduate intern during a calendar quarter. The ratio of pharmacist to intern shall not exceed one pharmacist to two interns in a community pharmacy or limited-service pharmacy setting unless approved by the Board. In considering a request to exceed the ratio, the Board will consider pharmacy space limitations and whether exceeding the ratio poses a safety risk to the public health. Subject to R4-23-609 and the safety of public health, there is no pharmacist-to-intern ratio in a practice setting directed by a Board-approved college or school of pharmacy experiential training program.
- F.** Preceptor responsibilities. A pharmacy intern preceptor assumes the responsibilities of a teacher and mentor in addition to those of a pharmacist. A preceptor shall thoroughly review pharmacy policy and procedure with each intern. A preceptor is responsible for the pharmacy-related actions of an intern during the specific training period. A preceptor shall give an intern the opportunity for skill development and provide an intern with timely and realistic feedback regarding their progress.

Historical Note

Former Rules 3.3000, 3.3100, 3.3200, 3.3300, 3.3310, 3.3320, 3.3330, 3.3340, 3.3400, 3.4000, 3.4100, 3.4200, 3.4300, and 3.4400; Amended effective August 9, 1983 (Supp. 83-4). Amended by final rulemaking at 8 A.A.R. 416, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 14 A.A.R. 3605, effective November 8, 2008 (Supp. 08-3).

R4-23-303. Training Time

- A.** Training. The minimum hours of internship training required for licensure by examination shall be 1,500.
1. After enrolling in a Board-approved college or school of pharmacy as prescribed in R4-23-301(B) and receiving a Board-issued pharmacy intern license, a pharmacy intern

shall complete all required internship training as part of the pharmacy intern's Board-approved college or school of pharmacy experiential training program.

2. After receiving a Board-issued pharmacy intern license, an individual who is a graduate of a college or school of pharmacy that is not approved by the Board shall complete a minimum of 1,500 hours of internship training in a training site or sites as defined in R4-23-302(A).
 3. After receiving a Board-issued graduate intern license, a graduate intern shall complete the number of internship training hours required by the Board in a training site or sites as defined in R4-23-302(A).
- B.** Start of training and limitation of credit. To receive credit as internship training, the practical experience shall take place in a pharmacy or an alternative training site as specified in R4-23-302(A) and under the supervision of a pharmacy intern preceptor, except for a non-pharmacy site either as part of a Board-approved college or school of pharmacy experiential training program or as approved by the Board or its designee. The Board shall credit no more than 500 hours internship training as a pharmacy or graduate intern in an alternative training site specified in R4-23-302(A)(2).

Historical Note

Former Rules 3.5000 and 3.5200; Amended effective August 23, 1978 (Supp. 78-4). Amended effective August 9, 1983 (Supp. 83-4). Amended by final rulemaking at 8 A.A.R. 416, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 18 A.A.R. 2619, effective December 2, 2012 (Supp. 12-4).

R4-23-304. Reports

- A.** Change of employment or mailing address. A pharmacy intern or graduate intern shall notify the Board within 10 days of change of employment or mailing address.
- B.** Annual reports.
1. A pharmacy intern who is a graduate of a college or school of pharmacy that is not approved by the Board or is a graduate intern shall provide the Board annual intern training reports for the duration of training. The pharmacy intern shall file an annual intern training report on a report form provided by the Board by calendar year (January 1st through December 31st). An annual intern training report shall be received at the Board's office no later than 30 days after the end of the calendar year. The Board shall write the intern to acknowledge receipt of the reports and notify the intern of the remaining hours of training necessary for licensure. Any intern training hours reported to the Board office more than 30 days after the end of the calendar year in which the training hours were performed shall not be credited toward the total intern training hours required for licensure.
 2. After graduation and before sitting for the NAPLEX or MPJE, a pharmacy intern who is a graduate of a Board-approved college or school of pharmacy shall ensure that the director of the Board-approved college or school of pharmacy's experiential training program provides the Board an intern training report that includes:
 - a. The dates and number of training hours experienced, by training site and total; and
 - b. The date signed and experiential training program director's signature verifying that the pharmacy intern successfully completed the experiential training program.

Historical Note

Former Rules 3.6100, 3.6200, 3.6300, and 3.6400; Amended effective August 23, 1978 (Supp. 78-4).

Amended by final rulemaking at 8 A.A.R. 416, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 10 A.A.R. 4356, effective December 4, 2004 (Supp. 04-4). Amended by final rulemaking at 18 A.A.R. 2619, effective December 2, 2012 (Supp. 12-4).

R4-23-305. Miscellaneous Intern Training Provisions

To prevent a loss of intern hour credit and before beginning training, an intern may ask the Board if a training site meets the requirements specified in R4-23-301(E) and R4-23-302(A).

Historical Note

Former Rule 3.7000; Amended effective August 23, 1978 (Supp. 78-4). Amended by final rulemaking at 8 A.A.R. 416, effective January 10, 2002 (Supp. 02-1).

ARTICLE 4. PROFESSIONAL PRACTICES

R4-23-401. Time-frames for Board Approvals and Special Requests

- A.** To request a Board approval required by this Chapter or a special request to deviate from or waive compliance with a requirement of this Chapter, a person shall send a letter by regular mail, e-mail, or facsimile to the Board office, detailing the nature of the approval or special request, including the applicable Arizona Revised Statute or administrative code citation. This Section does not apply to a request from a person regarding the probation, suspension, or revocation of a license or permit.
- B.** The Board office shall complete an administrative completeness review within 15 days from the date of receipt of a written request and immediately open a request file for the applicant.
 1. The Board office shall issue a written notice of administrative completeness to the applicant if no deficiencies are found in the request.
 2. If the request is incomplete, the Board office shall provide the applicant with a written notice that includes a comprehensive list of the missing information. The 15-day time-frame for the Board office to finish the administrative completeness review is suspended from the date the notice of incompleteness is served until the applicant provides the Board office with all missing information.
 3. If the Board office does not provide the applicant with notice regarding administrative completeness, the request is deemed complete 15 days after receipt by the Board office.
- C.** An applicant with an incomplete request shall submit all of the missing information within 30 days of service of the notice of incompleteness.
 1. If an applicant cannot submit all missing information within 30 days of service of the notice of incompleteness, the applicant may send a written request for an extension to the Board office post-marked or delivered no later than 30 days from service of the notice of incompleteness.
 2. The written request for an extension shall document the reasons the applicant cannot meet the 30-day deadline.
 3. The Board office shall review the request for an extension of the 30-day deadline and grant the request if the Board office determines that an extension of the deadline will enable the applicant to assemble and submit the missing information. An extension shall be for no more than 30 days. The Board office shall notify the applicant in writing of its decision to grant or deny the request for an extension. An applicant who requires an additional extension shall submit an additional written request according to subsections (C)(1) and (C)(2).
- D.** If an applicant fails to submit a complete request within the time allowed, the Board office shall close the applicant's

request file. An applicant whose request file is closed and who later wishes to obtain an approval or special request shall apply again according to subsection (A).

- E.** From the date on which the administrative completeness review of a request is finished, the Board shall complete a substantive review of the applicant's request in no more than 120 days.
 1. The Board shall:
 - a. Approve the request,
 - b. Deny the request, or
 - c. If the Board determines deficiencies exist, request that the applicant produce additional documentation.
 2. If the Board approves or denies, the Board office shall issue a written approval or denial.
 3. If the Board finds deficiencies during the substantive review of a request, the Board office shall issue a written request to the applicant for additional documentation.
 4. The 120-day time-frame for a substantive review of a request for approval or special request is suspended from the date of a written request for additional documentation until the date of the next Board meeting after all documentation is received. The applicant shall submit the additional documentation according to subsection (C).
 5. If the applicant and the Board office mutually agree in writing, the 120-day substantive review time-frame may be extended once for no more than 30 days.
- F.** If the applicant fails to submit the additional information requested within the time allowed, the Board office shall close the applicant's request file. An applicant whose request file is closed and who later wishes to obtain an approval or special request shall apply again according to subsection (A).
- G.** For the purpose of A.R.S. § 41-1072 et seq., the Board establishes the following time-frames for a Board approval required by this Chapter or a special request to deviate from or waive compliance with a requirement of this Chapter:
 1. Administrative completeness review time-frame: 15 days;
 2. Substantive review time-frame: 120 days; and
 3. Overall time-frame: 135 days.

Historical Note

Former Rule 4.1000; Former Section R4-23-401 repealed, new Section R4-23-401 adopted effective August 9, 1983 (Supp. 83-4). Amended effective May 16, 1990 (Supp. 90-2). Repealed effective August 24, 1992 (Supp. 92-3). New Section made by final rulemaking at 9 A.A.R. 3184, effective August 30, 2003 (Supp. 03-3).

R4-23-402. Pharmacist, Graduate Intern, and Pharmacy Intern

- A.** A pharmacist or a graduate intern or pharmacy intern under the supervision of a pharmacist shall perform the following professional practices in dispensing a prescription medication from a prescription order:
 1. Receive, reduce to written form, and manually initial oral prescription orders;
 2. Obtain and record the name of an individual who communicates an oral prescription order;
 3. Obtain, or assume responsibility to obtain, from the patient, patient's agent, or medical practitioner and record, or assume responsibility to record, in the patient's profile, the following information:
 - a. Name, address, telephone number, date of birth (or age), and gender;
 - b. Individual history including known diseases and medical conditions, known drug allergies or drug reactions, and if available a comprehensive list of

- medications currently taken and medical devices currently used;
4. Record, or assume responsibility to record, in the patient's profile, a pharmacist's, graduate intern's, or pharmacy intern's comments relevant to the patient's drug therapy, including other information specific to the patient or drug;
 5. Verify the legality and pharmaceutical feasibility of dispensing a drug based upon:
 - a. A patient's allergies,
 - b. Incompatibilities with a patient's currently-taken medications,
 - c. A patient's use of unusual quantities of dangerous drugs or narcotics,
 - d. A medical practitioner's signature, and
 - e. The frequency of refills;
 6. Verify that a dosage is within proper limits;
 7. Interpret the prescription order, which includes exercising professional judgment in determining whether to dispense a particular prescription;
 8. Compound, mix, combine, or otherwise prepare and package the prescription medication needed to dispense individual prescription orders;
 9. Prepackage or supervise the prepackaging of drugs by a pharmacy technician or pharmacy technician trainee under R4-23-1104. For drugs prepackaged by a pharmacy technician or pharmacy technician trainee, a pharmacist shall:
 - a. Verify the drug to be prepackaged;
 - b. Verify that the label meets the official compendium's standards;
 - c. Check the completed prepackaging procedure and product; and
 - d. Manually initial the completed label; or
 - e. For automated packaging systems, manually initial the completed label or a written log or initial a computer-stored log;
 10. Check prescription order data entry to ensure that the data input:
 - a. Is for the correct patient by verifying the patient's name, address, telephone number, gender, and date of birth or age;
 - b. Is for the correct drug by verifying the drug name, strength, and dosage form;
 - c. Communicates the prescriber's directions precisely by verifying dose, dosage form, route of administration, dosing frequency, and quantity; and
 - d. Is for the correct medical practitioner by verifying the medical practitioner's name, address, and telephone number;
 11. Make a final accuracy check on the completed prescription medication and manually initial the finished label. Manual initialing of a finished label is not required if the pharmacy's computer system complies with the computer documentation requirements of R4-23-408(B)(4);
 12. Record, or assume responsibility to record, a prescription serial number and date dispensed on the original prescription order;
 13. Obtain, or assume responsibility to obtain, permission to refill a prescription order and record, or assume responsibility to record on the original prescription order:
 - a. Date dispensed,
 - b. Quantity dispensed, and
 - c. Name of medical practitioner or medical practitioner's agent who communicates permission to refill the prescription order;
 14. Reduce to written or printed form, or assume responsibility to reduce to written or printed form, a new prescription order received by:
 - a. Facsimile,
 - b. Computer modem, or
 - c. Other means of communication;
 15. Verify, or assume responsibility to verify, that a completed prescription medication is sold only to the correct patient, patient's care-giver, or authorized agent;
 16. Record on the original prescription order the name or initials of the pharmacist, graduate intern, or pharmacy intern who originally dispenses the prescription order; and
 17. Record on the original prescription order the name or initials of the pharmacist, graduate intern, or pharmacy intern who dispenses each refill.
- B.** Only a pharmacist, graduate intern, or pharmacy intern shall provide oral consultation about a prescription medication to a patient or patient's care-giver in an outpatient setting, including a patient discharged from a hospital. The oral consultation is required whenever the following occurs:
1. The prescription medication has not been previously dispensed to the patient in the same strength or dosage form or with the same directions;
 2. The pharmacist, through the exercise of professional judgment, determines that oral consultation is warranted; or
 3. The patient or patient's care-giver requests oral consultation.
- C.** Oral consultation shall include:
1. Reviewing the name and strength of a prescription medication or name of a prescription-only device and the labeled indication of use for the prescription medication or prescription-only device;
 2. Reviewing the prescription's directions for use;
 3. Reviewing the route of administration; and
 4. Providing oral information regarding special instructions and written information regarding side effects, procedure for missed doses, or storage requirements.
- D.** When, in the professional judgement of the pharmacist or graduate intern or pharmacy intern under the supervision of a pharmacist, or when circumstance precludes it, oral consultation may be omitted if the pharmacist, graduate intern, or pharmacy intern:
1. Personally provides written information to the patient or patient's care-giver that summarizes the information that would normally be orally communicated;
 2. Documents, or assumes responsibility to document, both the circumstance and reason for not providing oral consultation by a method approved by the Board or its designee; and
 3. Offers the patient or patient's care-giver the opportunity to communicate with a pharmacist, graduate intern, or pharmacy intern at a later time and provides a method for the patient or patient's care-giver to contact a pharmacist, graduate intern, or pharmacy intern at the pharmacy.
- E.** The pharmacist or graduate intern or pharmacy intern under the supervision of a pharmacist, through the exercise of professional judgment, may provide oral consultation that includes:
1. Common severe adverse effects, interactions, or therapeutic contraindications, and the action required if they occur;
 2. Techniques of self-monitoring drug therapy;
 3. The duration of the drug therapy; and
 4. Prescription refill information.

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- F. Nothing in subsection (B) requires a pharmacist, graduate intern, or pharmacy intern to provide oral consultation if a patient or patient's care-giver refuses the consultation.
- G. Using a method approved by the Board or its designee, a pharmacist, graduate intern, or pharmacy intern shall document, or assume responsibility to document, that oral consultation is or is not provided.
- H. Oral consultation documentation. When oral consultation is required as specified in subsection (B), a pharmacist, graduate intern, or pharmacy intern shall:
 1. Document, or assume responsibility to document, that oral consultation is provided; or
 2. When a patient refuses oral consultation or a person other than the patient or patient's care-giver picks up a prescription and oral consultation is not provided, document, or assume responsibility to document, that oral consultation is not provided; or
 3. When a pharmacist, graduate intern, or pharmacy intern determines to omit oral consultation under subsection (D) and oral consultation is not provided, document, or assume responsibility to document, both the circumstance and reason that oral consultation is not provided; and
 4. Document, or assume responsibility to document, the name, initials, or identification code of the pharmacist, graduate intern, or pharmacy intern who did or did not provide oral consultation.
- I. When a prescription is delivered to the patient or patient's care-giver outside the immediate area of a pharmacy and a pharmacist is not present, the prescription shall be accompanied by written or printed patient medication information that, in addition to the requirements in subsection (C), includes:
 1. Approved use for the prescription medication;
 2. Possible adverse reactions;
 3. Drug-drug, food-drug, or disease-drug interactions;
 4. Missed dose information; and
 5. Telephone number of the dispensing pharmacy or another method approved by the Board or its designee that allows a patient or patient's care-giver to consult with a pharmacist.
- J. A prescription medication or prescription-only device, delivered to a patient at a location where a licensed health care professional is responsible for administering the prescription medication to the patient, is exempt from the requirement of subsection (C).
- K. A pharmacist, graduate intern, or pharmacy intern shall wear a badge indicating name and title while on duty.
- L. Nothing in this Section prevents a hospital pharmacist from accepting a prescription order according to rules pertaining specifically to hospital pharmacies.

Historical Note

Former Rule 4.1100; Amended effective August 10, 1978 (Supp. 78-4). Amended effective August 9, 1983 (Supp. 83-4). Amended effective May 16, 1990 (Supp. 90-2). Amended effective July 7, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 4656, effective November 14, 2000 (Supp. 00-4). Amended by final rulemaking at 9 A.A.C. 5030, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 11 A.A.R. 2258, effective August 6, 2005 (Supp. 05-2). Amended by final rulemaking at 12 A.A.R. 274, effective March 11, 2006 (Supp. 06-1). Amended by final rulemaking at 12 A.A.R. 4691, effective February 3, 2007 (Supp. 06-4).

R4-23-403. Repealed**Historical Note**

Former Rule 4.1200; Amended effective August 10, 1978 (Supp. 78-4). Amended effective March 28, 1980 (Supp. 80-2). Amended effective August 9, 1983 (Supp. 83-4). Section repealed, new Section adopted effective May 16, 1990 (Supp. 90-2). Amended effective November 1, 1993 (Supp. 93-4). Amended by final rulemaking at 5 A.A.R. 4441, effective November 2, 1999 (Supp. 99-4). Section repealed by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1).

R4-23-404. Unethical Practices

- A. Rebates prohibited. A pharmacist or pharmacy permittee shall not offer, deliver, receive, or accept any unearned rebate, refund, commission, preference, patronage dividend, discount, or other unearned consideration, whether in the form of money or otherwise, as compensation or inducement to refer a patient, client, or customer to any person, except for a rebate or premium paid completely and directly to a patient. A pharmacist or pharmacy permittee shall not:
 1. Make payment to a medical practitioner in money or other consideration for a prescription order prescribed by the medical practitioner; or
 2. Make payment to a long-term care or assisted living facility or other health care institution in money, discount, rental, or other consideration in an amount above the prevailing rate for:
 - a. Prescription medication or devices dispensed or sold for a patient or resident of the facility or institution; or
 - b. Drug selection or drug utilization review services, drug therapy management services, or other pharmacy consultation services provided for a patient or resident of the facility or institution.
- B. Prescription order-blank advertising prohibited. A pharmacist or pharmacy permittee shall not:
 1. Directly or indirectly furnish to a medical practitioner a prescription order-blank that refers to a specific pharmacist or pharmacy in any manner; or
 2. Actively or passively participate in any arrangement or agreement where a prescription order-blank is prepared, written, or issued in a manner that refers to a specific pharmacist or pharmacy.
- C. Fraudulent claim for service. A pharmacist or pharmacy permittee shall not claim the performance of a service that the pharmacist or pharmacy permittee knows or should know was not performed, such as, claiming to dispense a prescription medication that is not dispensed.
- D. Fraudulent claim for a fee. A pharmacist or pharmacy permittee:
 1. Shall not claim a fee for a service that is not performed or earned;
 2. May divide a prescription order into two or more portions of prescription medication at the request of a patient, or for some other ethical reason, and charge a dispensing fee for the additional service; and
 3. Shall not divide a prescription order merely to obtain an additional fee.
- E. Prohibiting a prescription-only drug or device from being dispensed over the counter. A pharmacist shall ensure that:
 1. A prescription-only drug or device is dispensed only after receipt of a valid prescription order from a licensed medical practitioner;

2. The dispensed prescription-only drug or device is properly prepared, packaged, and labeled according to this Chapter; and
 3. The prescription order is filed according to this Chapter.
- F.** Drugs dispensed in the course of the conduct of a business of dispensing drugs through diagnosis by mail or the internet.
1. A pharmacist shall not dispense a drug from a prescription order if the pharmacist has knowledge, or reasonably should know under the circumstances, that the prescription order was issued on the basis of an internet-based questionnaire or an internet-based consultation without a medical practitioner-patient relationship as defined in R4-23-110.
 2. A pharmacist who dispenses a prescription-only drug, prescription-only device, or controlled substance in violation of this Section is engaging in unethical conduct in violation of A.R.S. § 32-1901.01.

Historical Note

Former Rules 4.2110, 4.2120, 4.2130, 4.2210, 4.2230, 4.2400, 4.2500, 4.2600, 4.4100, 4.4200, 4.4310, 4.4320, 4.4400, and 4.4500; Amended effective August 10, 1978 (Supp. 78-4); Amended subsection (I) effective August 9, 1983 (Supp. 83-4). Amended by deleting subsections (H) through (M) effective November 18, 1983 (Supp. 83-6). Amended by final rulemaking at 8 A.A.R. 1256, effective March 7, 2002 (Supp. 02-1). Amended by final rulemaking at 14 A.A.R. 3405, effective October 4, 2008 (Supp. 08-3).

R4-23-405. Change of Responsibility

A pharmacist designated as the pharmacist-in-charge for a pharmacy, manufacturer, or other establishment shall give immediate notice, as defined in R4-23-110, when:

1. The pharmacist's responsibility as a pharmacist-in-charge is terminated; or
2. The pharmacist knows of a pending termination of the pharmacist's responsibility as the pharmacist-in-charge.

Historical Note

Former Rules 4.5100 and 4.5200; Amended effective August 9, 1983 (Supp. 83-4). Amended effective February 8, 1991 (Supp. 91-1). Amended effective November 1, 1993 (Supp. 93-4). Amended by final rulemaking at 8 A.A.R. 1256, effective March 7, 2002 (Supp. 02-1).

R4-23-406. Repealed

Historical Note

Adopted as an emergency effective January 10, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Amended as an emergency effective April 2, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days. Adopted effective April 10, 1979 (Supp. 79-1). Former Section R4-23-406 repealed, new Section R4-23-406 adopted effective August 9, 1983 (Supp. 83-4). Amended effective April 1, 1995; filed with the Secretary of State January 31, 1995 (Supp. 95-1). Amended by final rulemaking at 8 A.A.R. 1256, effective March 7, 2002 (Supp. 02-1). Section repealed by final rulemaking at 10 A.A.R. 230, effective March 6, 2004 (Supp. 04-1).

R4-23-407. Prescription Requirements

A. Prescription orders. A pharmacist shall ensure that:

1. A prescription order dispensed by the pharmacist includes the following information:
 - a. Date of issuance;

- b. Name and address of the patient for whom or the owner of the animal for which the drug or device is dispensed;
- c. Drug name, strength, and dosage form or device name;
- d. Name of the drug's or device's manufacturer or distributor if the prescription order is written generically or a substitution is made;
- e. Prescribing medical practitioner's directions for use;
- f. Date of dispensing;
- g. Quantity prescribed and if different, quantity dispensed;
- h. For a prescription order for a controlled substance, the medical practitioner's address and DEA number;
- i. For a written prescription order, the medical practitioner's signature;
- j. For an electronically transmitted prescription order, the medical practitioner's digital or electronic signature;
- k. For an oral prescription order, the medical practitioner's name and telephone number; and
- l. Name or initials of the dispensing pharmacist;

2. A prescription order is kept by the pharmacist or pharmacy permittee as a record of the dispensing of a drug or device for seven years from the date the drug or device is dispensed, except for a drug or device personally administered by a medical practitioner to the medical practitioner's patient; and
3. The dispensing of a drug or device complies with the packaging requirements of the official compendium and state and federal law.

B. Prescription refills. A pharmacist shall ensure that the following information is recorded on the back of a prescription order when it is refilled:

1. Date refilled,
2. Quantity dispensed,
3. Name or approved abbreviation of the manufacturer or distributor if the prescription order is written generically or a substitution is made, and
4. The name or initials of the dispensing pharmacist.

C. A pharmacist may furnish a copy of a prescription order to the patient for whom it is prescribed or to the authorized representative of the patient if the copy is clearly marked "COPY FOR REFERENCE PURPOSES ONLY" or other similar statement. A copy of a prescription order is not a valid prescription order and a pharmacist shall not dispense a drug or device from the information on a copy.

D. Transfer of prescription order information. For a transfer of prescription order information to be valid, a pharmacy permittee or pharmacist-in-charge shall ensure that:

1. Both the original and the transferred prescription order are maintained for seven years after the last dispensing date;
2. The original prescription order information for a Schedule III, IV, or V controlled substance is transferred only as specified in 21 CFR 1306.25, published April 1, 2008, and no future amendments or editions, incorporated by reference, and on file with the Board, and available from the U.S. Government Printing Office, U.S. Superintendent of Documents, Washington, DC 20402-0001;
3. The original prescription order information for a non-controlled substance drug is transferred without limitation only up to the number of originally authorized refills;
4. For a transfer within Arizona:

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- a. The transfer of original prescription order information for a non-controlled substance drug meets the following conditions:
 - i. The transfer of information is communicated directly between:
 - (1) Two licensed pharmacists,
 - (2) A licensed pharmacist and a licensed pharmacy or graduate intern, or
 - (3) Two licensed pharmacy or graduate interns;
 - ii. The following information is recorded by the transferring pharmacist or pharmacy or graduate intern:
 - (1) The word "void" is written on the face of the invalidated original prescription unless it is an electronic or oral transfer and the transferred prescription order information is invalidated in the transferring pharmacy's computer system; and
 - (2) The name and identification code, number, or address and telephone number of the pharmacy to which the prescription is transferred, the name of the receiving pharmacist or pharmacy or graduate intern, the date of transfer, and the name of the transferring pharmacist or pharmacy or graduate intern is written on the back of the prescription or entered into the transferring pharmacy's computer system; and
 - iii. The following information is recorded by the receiving pharmacist or pharmacy or graduate intern on the transferred prescription order:
 - (1) The word "transfer;"
 - (2) Date of issuance of the original prescription order;
 - (3) Original number of refills authorized on the original prescription order;
 - (4) Date of original dispensing;
 - (5) Number of valid refills remaining and the date of the last refill;
 - (6) Name and identification code, number, or address, telephone number, and original prescription number of the pharmacy from which the prescription is transferred;
 - (7) Name of the transferring pharmacist or pharmacy or graduate intern; and
 - (8) Name of the receiving pharmacist or pharmacy or graduate intern;
- b. The transfer of original prescription order information for a Schedule III, IV, or controlled substance meets the following conditions:
 - i. The transfer of information is communicated directly between two licensed pharmacists;
 - ii. The following information is recorded by the transferring pharmacist:
 - (1) The word "void" is written on the face of the invalidated original prescription order unless it is an electronic or oral transfer and the transferred prescription order information is invalidated in the transferring pharmacy's computer system; and
 - (2) The name, address, and DEA number of the pharmacy to which the prescription is transferred, the name of the receiving pharmacist, the date of transfer, and the name of the transferring pharmacist is written on the back of the prescription order or entered into the transferring pharmacy's computer system; and
- iii. The following information is recorded by the receiving pharmacist on the transferred prescription order:
 - (1) The word "transfer;"
 - (2) Date of issuance of original prescription order;
 - (3) Original number of refills authorized on the original prescription order;
 - (4) Date of original dispensing;
 - (5) Number of valid refills remaining and the date of the last refill;
 - (6) Name, address, DEA number, and original prescription number of the pharmacy from which the prescription is transferred;
 - (7) Name of the transferring pharmacist; and
 - (8) Name of the receiving pharmacist;
5. For a transfer from out-of-state:
 - a. The transfer of original prescription order information for a non-controlled substance drug meets the conditions in subsections (D)(4)(a)(i) and (D)(4)(a)(iii); and
 - b. The transfer of original prescription order information for a Schedule III, IV, or V controlled substance meets the conditions in subsections (D)(4)(b)(i) and (D)(4)(b)(iii); and
6. For an electronic transfer, the electronic transfer of original prescription order information meets the following conditions:
 - a. The electronic transfer is between pharmacies owned by the same company using a common or shared database;
 - b. The electronic transfer of original prescription order information for a non-controlled substance drug is performed by a pharmacist or a pharmacy or graduate intern, pharmacy technician trainee, or pharmacy technician under the supervision of a pharmacist;
 - c. The electronic transfer of original prescription order information for a controlled substance is performed between two licensed pharmacists;
 - d. The electronic transfer of original prescription order information for a non-controlled substance drug meets the following conditions:
 - i. The transferring pharmacy's computer system:
 - (1) Invalidates the transferred original prescription order information;
 - (2) Records the identification code, number, or address of the pharmacy to which the prescription order information is transferred;
 - (3) Records the name or identification code of the receiving pharmacist, pharmacy or graduate intern, pharmacy technician trainee, or pharmacy technician; and
 - (4) Records the date of transfer; and
 - ii. The receiving pharmacy's computer system:
 - (1) Records that a prescription transfer occurred;
 - (2) Records the date of issuance of the original prescription order;
 - (3) Records the original number of refills authorized on the original prescription order;
 - (4) Records the date of original dispensing;

- (5) Records the number of valid refills remaining and the date of the last refill;
 - (6) Records the identification code, number, or address and original prescription number of the pharmacy from which the prescription is transferred;
 - (7) Records the name or identification code of the receiving pharmacist or pharmacy or graduate intern, pharmacy technician trainee, or pharmacy technician; and
 - (8) Records the date of transfer;
 - e. The electronic transfer of original prescription order information for a controlled substance meets the following conditions:
 - i. The transferring pharmacy's computer system:
 - (1) Invalidates the transferred original prescription order information;
 - (2) Records the identification code, number, or address, and DEA number of the pharmacy to which the prescription order information is transferred;
 - (3) Records the name or identification code of the receiving pharmacist;
 - (4) Records the date of transfer; and
 - (5) Records the name or identification code of the transferring pharmacist; and
 - ii. The electronic prescription order information received by the computer system of the receiving pharmacy includes the information required in subsection (D)(4)(b)(iii); and
 - f. In addition to electronic documentation of a transferred prescription order in the computer system, an original prescription order containing the requirements of this Section is filed in compliance with A.R.S. § 32-1964.
- E. Transmission of a prescription order from a medical practitioner to a pharmacy by facsimile machine.**
1. A medical practitioner or medical practitioner's agent may transmit a prescription order for a Schedule III, IV, or V controlled substance, prescription-only drug, or non-prescription drug to a pharmacy by facsimile under the following conditions:
 - a. The prescription order is faxed only to the pharmacy of the patient's choice;
 - b. The faxed prescription order:
 - i. Contains all the information required for a prescription order in A.R.S. §§ 32-1968 and 36-2525; and
 - ii. Is only faxed from the medical practitioner's practice location, except that a nurse in a hospital, long-term care facility, or inpatient hospice may send a facsimile of a prescription order for a patient of the facility; and
 - c. The faxed prescription order shall contain the following additional information:
 - i. The date the prescription order is faxed;
 - ii. The facsimile number of the prescribing medical practitioner or the facility from which the prescription order is faxed, and the telephone number of the facility; and
 - iii. The name of the person who transmits the facsimile, if other than the medical practitioner.
 2. A medical practitioner or medical practitioner's agent may fax a prescription order for a Schedule II controlled substance for information purposes only, unless the faxed prescription order meets the requirements of A.R.S. § 36-2525(F) and (G).
 3. A pharmacy may receive a faxed prescription order for a Schedule II controlled substance for information purposes only, except a faxed prescription order for a Schedule II controlled substance that meets the requirements of A.R.S. § 36-2525(F) and (G) may serve as the original written prescription order.
 4. To meet the seven-year record retention requirement of A.R.S. § 32-1964, a pharmacy shall receive a faxed prescription order on a plain paper facsimile machine, except a pharmacy that does not have a plain paper facsimile machine may make a Xerox copy of a faxed prescription order received on a non-plain paper facsimile machine.
 5. A medical practitioner or the medical practitioner's agent may fax refill authorizations to a pharmacy if the faxed authorization includes the medical practitioner's telephone number and facsimile number, the medical practitioner's signature or medical practitioner's agent's name, and date of authorization.
- F. Electronic transmission of a prescription order from a medical practitioner to a pharmacy.**
1. Unless otherwise prohibited by law, a medical practitioner or medical practitioner's agent may transmit a prescription order by electronic means, directly or through an intermediary, including an E-prescribing network, to the dispensing pharmacy as specified in A.R.S. § 32-1968.
 2. For electronic transmission of a Schedule II, III, IV, or V controlled substance prescription order, the medical practitioner and pharmacy shall ensure that the transmission complies with any security or other requirements of federal law.
 3. The medical practitioner and pharmacy shall ensure that all electronic transmissions comply with all the security requirements of state or federal law related to the privacy of protected health information.
 4. In addition to the information required to be included on a prescription order as specified in A.R.S. § 32-1968, an electronically transmitted prescription order shall include:
 - a. The date of transmission; and
 - b. If the individual transmitting the prescription is not the medical practitioner, the name of the medical practitioner's authorized agent who transmits the prescription order.
 5. A pharmacy receiving an electronically transmitted prescription order shall maintain the prescription order as specified in A.R.S. § 32-1964.
 6. A medical practitioner or medical practitioner's agent shall transmit an electronic prescription order only to the pharmacy of the patient's choice.

Historical Note

Adopted effective November 18, 1983 (Supp. 83-6).
 Amended by final rulemaking at 8 A.A.R. 1256, effective March 7, 2002 (Supp. 02-1). Amended by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 13 A.A.R. 440, effective April 7, 2007 (Supp. 07-1). Amended by final rulemaking at 14 A.A.R. 3605, effective November 8, 2008 (Supp. 08-3).

R4-23-408. Computer Records

- A.** Systems manual. A pharmacy permittee or pharmacist-in-charge shall:

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1. Develop, implement, and comply with policies and procedures for the following operational aspects of a computer system:
 - a. Examples of all output documentation provided by the computer system that contains original or refill prescription order or patient profile information;
 - b. Steps a pharmacy employee follows when the computer system is not operational due to scheduled or unscheduled system interruption;
 - c. Regular and routine backup file procedure and file maintenance, including secure storage of backup files;
 - d. Audit procedures, personnel code assignments, and personnel responsibilities; and
 - e. Quality assurance mechanism for data entry validation;
 2. Review biennially and, if necessary, revise the policies and procedures required under this Section;
 3. Document the review required under subsection (A)(2);
 4. Assemble the policies and procedures as a written manual or by another method approved by the Board or its designee; and
 5. Make the policies and procedures available within the pharmacy for reference by pharmacy personnel and inspection by the Board or its designee.
- B.** Computer system data storage and retrieval. A pharmacy permittee or pharmacist-in-charge shall ensure that the computer system is capable of:
1. Producing sight-readable information on all original and refill prescription orders and patient profiles;
 2. Providing online retrieval (via CRT display or hard-copy printout) of original prescription order information required in A.R.S. § 32-1968(C), R4-23-402(A), and R4-23-407(A);
 3. Providing online retrieval (via CRT display or hard-copy printout) of patient profile information required in R4-23-402(A);
 4. Providing documentation identifying the pharmacist responsible for dispensing each original or refill prescription order, except a pharmacy permittee with a computer system that is in use before the effective date of this Section that cannot provide documentation identifying the dispensing pharmacist may continue to use the computer system by providing manual documentation identifying the dispensing pharmacist;
 5. Producing a printout of all prescription order information, including a single-drug usage report that contains:
 - a. The name of the prescribing medical practitioner;
 - b. The name and address of the patient;
 - c. The quantity dispensed on each original or refill prescription order;
 - d. The date of dispensing for each original or refill prescription order;
 - e. The name or identification code of the dispensing pharmacist; and
 - f. The serial number of each prescription order; and
 6. Providing a printout of requested prescription order information to an individual pharmacy within 72 hours of the request if prescription order information is maintained in a centralized computer record system.
- C.** A pharmacy permittee or pharmacist-in-charge of a pharmacy that uses a pharmacy computer system:
1. Shall notify the D.E.A. and the Board in writing that original and refill prescription information and patient profiles are stored in a pharmacy computer system;
2. Shall comply with this Section if the pharmacy computer system's refill records are used as an alternative to the manual refill records required in R4-23-407(B);
 3. Is exempt from the manual refill recordkeeping requirements of R4-23-407(B), if the pharmacy computer system complies with the requirements of this Section; and
 4. Shall ensure that documentation of the accuracy of original and refill information entered into a computer system is provided by each pharmacist using the computer system and kept on file in the pharmacy for seven years from the date of the last refill. Documentation includes one of the following:
 - a. A hard-copy printout of each day's original and refill data that:
 - i. States original and refill data for prescriptions dispensed by each pharmacist is reviewed for accuracy;
 - ii. Includes the printed name of each dispensing pharmacist; and
 - iii. Is signed and initialed by each dispensing pharmacist; or
 - b. A log book or separate file of daily statements that:
 - i. States original and refill data for prescriptions dispensed by each pharmacist is reviewed for accuracy;
 - ii. Includes the printed name of each dispensing pharmacist; and
 - iii. Is signed and initialed by each dispensing pharmacist.
- D.** If a pharmacy computer system does not comply with the requirements of subsections (A), (B), and (F), the pharmacy permittee or pharmacist-in-charge shall bring the computer system into compliance within three months of a notice of noncompliance or violation letter. If the computer system is still noncompliant with subsection (A), (B), or (F) after three months, the pharmacy permittee or pharmacist-in-charge shall immediately comply with the manual recordkeeping requirements of R4-23-402 and R4-23-407.
- E.** If a pharmacy's personnel perform manual recordkeeping under subsection (D), the pharmacy's personnel shall continue manual recordkeeping until the pharmacist-in-charge sends proof, verified by a Board compliance officer, that the computer system complies with subsections (A), (B), and (F).
- F.** Security. To maintain the confidentiality of patient records, a pharmacy permittee or pharmacist-in-charge shall ensure that:
1. The computer system has security and systems safeguards designed to prevent and detect unauthorized access, modification, or manipulation of prescription order information and patient profiles; and
 2. After a prescription order is dispensed, any alteration of prescription order information is documented, including the identification of the pharmacist responsible for the alteration.
- G.** A computer system that does not comply with all the requirements of subsections (A), (B), and (F) may be used in a pharmacy if:
1. The computer system was in use in the pharmacy before July 11, 2001, and
 2. The pharmacy complies with the manual recordkeeping requirements of R4-23-402 and R4-23-407.
- H.** Prescription records and retention.
1. Instead of filing the original hard-copy prescription as required in A.R.S. § 32-1964, a pharmacy permittee or pharmacist-in-charge may use an electronic imaging recordkeeping system, if:

- a. The system is capable of capturing, storing, and reproducing the exact image of a prescription, including the reverse side of the prescription if necessary;
 - b. Any notes of clarification of and alterations to a prescription are directly associated with the electronic image of the prescription;
 - c. The prescription image and any associated notes of clarification to or alterations to a prescription are retained for a period not less than seven years from the date the prescription is last dispensed;
 - d. The original hard-copy prescription is maintained for no less than 30 days after the date dispensed;
 - e. Policies and procedures for the use of an electronic imaging recordkeeping system are developed, implemented, reviewed, and revised in the same manner described in subsection (A) and complied with; and
 - f. The prescription is not for a schedule II controlled substance.
2. If a pharmacy's computer system fields are automatically populated by an electronically transmitted prescription order, the automated record constitutes the original prescription and a hard-copy or electronic image is not required if the computer system is capable of maintaining, printing, and providing all the prescription information required in A.R.S. §§ 32-1968 and 36-2525 and R4-23-407(A) within 72 hours of a request by the Board, the Board's compliance officers, other authorized regulatory board agents, or authorized officers of the law.

Historical Note

Adopted effective November 18, 1983 (Supp. 83-6).
 Amended by final rulemaking at 7 A.A.R. 646, effective January 11, 2001 (Supp. 01-1). Amended by final rulemaking at 9 A.A.C. 5030, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 11 A.A.R. 4270, effective December 6, 2005 (Supp. 05-4).
 Amended by final rulemaking at 12 A.A.R. 274, effective March 11, 2006 (Supp. 06-1). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3). Amended by final rulemaking at 13 A.A.R. 440, effective April 7, 2007 (Supp. 07-1).

R4-23-409. Returning Drugs and Devices

- A. After a person for whom a drug is prescribed or the person's agent takes the drug from the premises where sold, distributed, or dispensed, a pharmacist or pharmacy permittee shall not accept the drug for return or exchange for the purpose of resale unless the pharmacist determines that:
 1. The drug is in its original, manufacturer's, unopened container; and
 2. The drug or its container has not been subjected to contamination or deterioration.
- B. The provisions of subsection (A) of this Section do not apply to a drug dispensed to:
 1. A hospital inpatient as defined in R4-23-651; or
 2. A resident of a long-term care facility where a licensed health care professional administers the drug, and the pharmacist ensures and documents that the drug:
 - a. Has been stored in compliance with the requirements of the official compendium; and
 - b. Is not obviously contaminated or deteriorated.
- C. After a person for whom a device is prescribed or the person's agent takes the device from the premises where sold, distributed, or dispensed, a pharmacist or pharmacy permittee shall

not accept the device for return or exchange for the purpose of resale or reuse unless the pharmacist determines that:

1. The device is inspected and is free of defects;
2. The device is rendered incapable of transferring disease; and
3. The device, if resold or reused, is not claimed to be new or unused.

Historical Note

Adopted effective November 18, 1983 (Supp. 83-6).
 Amended by final rulemaking at 8 A.A.R. 1256, effective March 7, 2002 (Supp. 02-1).

R4-23-410. Current Good Compounding Practices

- A. This Section establishes the current good compounding practices to be used by a pharmacist licensed by the Board, in a pharmacy permitted by the Board, and in compliance with applicable federal and state law governing the practice of pharmacy.
- B. A pharmacy permittee shall ensure compliance with the provisions in this subsection.
 1. All substances for compounding that are received, stored, or used by the pharmacy permittee:
 - a. Meet official compendium requirements;
 - b. Are of high quality, such as Chemically Pure (CP), Analytical Reagent (AR), certified American Chemical Society (ACS), or Food Chemical Codex (FCC) grade; or
 - c. Are obtained from a source that, in the professional judgment of the pharmacist, is acceptable and reliable.
 2. Before compounding a pharmaceutical product in excess of the quantity dispensed in anticipation of receiving valid prescriptions for the pharmaceutical product, a pharmacist, employed by the pharmacy permittee, shall establish a history of compounding valid prescriptions for the pharmaceutical product.
 3. Neither the pharmacy permittee nor a pharmacist employed by the pharmacy permittee provides a compounded pharmaceutical product to a pharmacy, medical practitioner, or other person for dispensing or distributing except that a compounded pharmaceutical product may be provided to a medical practitioner to administer to a patient of the medical practitioner if each container is accompanied by the written list required in subsection (I)(5) and has a label that includes the following:
 - a. The pharmacy's name, address, and telephone number;
 - b. The pharmaceutical product's name and the information required in subsection (I)(4);
 - c. A lot or control number;
 - d. A beyond-use-date based upon the pharmacist's professional judgment, but not more than the maximum guidelines recommended in the Pharmacy Compounding Practices chapter of the official compendium unless there is published or unpublished stability test data that shows a longer period is appropriate;
 - e. The statement "Not For Dispensing;" and
 - f. The statement "For Office or Hospital Administration Only."
 4. A pharmacy or pharmacist may advertise or otherwise promote the fact that the pharmacy or pharmacist provides prescription compounding services.
- C. A pharmacy permittee shall ensure compliance with the organization, training, and personnel issues in this subsection.

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1. Before dispensing a compounded pharmaceutical product, a pharmacist:
 - a. Inspects and approves or rejects, or assumes responsibility for inspecting and approving or rejecting, components, pharmaceutical product containers and closures, in-process materials, and labeling;
 - b. Prepares or assumes responsibility for preparing all compounding records;
 - c. Reviews all compounding records to ensure that no errors occur in the compounding process;
 - d. Ensures the proper use, cleanliness, and maintenance of all compounding equipment; and
 - e. Documents by hand-written initials or signature in the compounding record the completion of the requirements of subsections (C)(1)(a), (b), (c), and (d).
 2. A pharmacist engaged in compounding:
 - a. Complies with the current good compounding practices and applicable state pharmacy laws;
 - b. Maintains compounding proficiency through current awareness, training, and continuing education; and
 - c. Ensures that personnel engaged in compounding wear:
 - i. Clean clothing appropriate to the work performed; and
 - ii. Protective apparel, such as coats, aprons, gowns, gloves or masks to protect the personnel from chemical exposure and prevent pharmaceutical product contamination.
- D.** A pharmacy permittee shall ensure the security, safety, and quality of a compounded pharmaceutical product by conforming with the following standards:
1. Implement procedures to exclude from direct contact with components, pharmaceutical product containers and closures, in-process materials, labeling, and pharmaceutical products, any person with an apparent illness or open lesion that may adversely affect the safety or quality of a compounded pharmaceutical product, until the illness or lesion, as determined by competent medical personnel, does not jeopardize the safety or quality of a compounded pharmaceutical product; and
 2. Require all personnel to inform a pharmacist of any health condition that may adversely affect a compounded pharmaceutical product.
- E.** A pharmacy permittee shall provide compounding facilities that conform with the standards in this subsection.
1. In addition to the minimum area requirements of R4-23-609, R4-23-655, or R4-23-673, the compounding area:
 - a. Complies with the requirements in R4-23-611; and
 - b. Has sufficient space to permit efficient pharmacy practice, free movement of personnel, and visual surveillance by a pharmacist.
 2. If sterile pharmaceutical product or radiopharmaceutical product compounding is performed, the compounding area complies with the requirements of R4-23-670, R4-23-681, and R4-23-682.
 3. A clean, dry, and temperature-controlled area and, if required, a refrigerated area, in which to store properly labeled containers of bulk drugs, chemicals, and materials used in compounding, that complies with state statutes and rules.
- F.** To protect pharmaceutical product safety, identity, strength, quality, and purity, a pharmacy permittee shall ensure that equipment and utensils used in pharmaceutical product compounding are:
1. Of appropriate design, adequate size, and suitably located for proper operation, cleaning, and maintenance;
 2. Made of material that is not reactive, additive, or absorptive when exposed to components, in-process materials, or pharmaceutical products;
 3. Cleaned and protected from contamination before use;
 4. Inspected and determined suitable for use before initiation of compounding operations; and
 5. Routinely inspected, calibrated, or checked to make proper performance certain.
- G.** A pharmacy permittee shall ensure that the pharmacist-in-charge establishes, implements, and complies with procedures to prevent cross-contamination when pharmaceutical products that require special precautions to prevent cross-contamination, such as penicillin, are used in a compounding procedure. The procedures shall include either the dedication of equipment or the meticulous cleaning of contaminated equipment before its use in compounding other pharmaceutical products.
- H.** A pharmacy permittee shall ensure that the pharmacist-in-charge establishes, implements, and complies with control procedures for components and pharmaceutical product containers and closures, either written or electronically stored with printable documentation, that conform with the standards in this subsection.
1. Components and pharmaceutical product containers and closures are:
 - a. Stored off the floor,
 - b. Handled and stored to prevent contamination, and
 - c. Rotated so the oldest approved stock is used first.
 2. Container closure systems comply with official compendium standards.
 3. Pharmaceutical product containers and closures are clean and made of material that is not reactive, additive, or absorptive.
- I.** A pharmacy permittee shall ensure that the pharmacist-in-charge establishes, implements, and complies with pharmaceutical product compounding controls that conform with the standards in this subsection.
1. Pharmaceutical product compounding procedures are available in either written form or electronically stored with printable documentation:
 - a. To ensure that a finished pharmaceutical product has the identity, strength, quality, and purity it is purported or represented to possess, the procedures include, for each pharmaceutical product compounded, a description of:
 - i. The components, their manufacturer, lot number, expiration date, and amounts, the order of component addition, if applicable, and the compounding process;
 - ii. The equipment and utensils used; and
 - iii. The pharmaceutical product container and closure system proper for the sterility and stability of the pharmaceutical product as it is intended to be used.
 - b. To test the pharmaceutical product being compounded, the procedures monitor the output and validate the performance of compounding processes that may cause variability in the final pharmaceutical product, including assessing:
 - i. Dosage form weight variation;
 - ii. Adequacy of mixing to ensure uniformity and homogeneity; and
 - iii. Clarity, completeness, and pH of solutions, if applicable.

2. Components for pharmaceutical product compounding are accurately weighed, measured, or subdivided. To ensure that each weight, measure, or subdivision is correct as stated in the compounding procedures, a pharmacist:
 - a. Checks and rechecks, or assumes responsibility for checking and re-checking, the operations at each stage of the compounding process; and
 - b. Documents by hand-written initials or signature the completion and accuracy of the compounding process.
 3. Compounding equipment and utensils are properly cleaned and maintained.
 4. In addition to the labeling requirements of A.R.S. § 32-1968(D), the label contains:
 - a. A statement, symbol, designation, or abbreviation that the pharmaceutical product is a compounded pharmaceutical product, and
 - b. A beyond-use-date as specified in subsection (B)(3)(d).
 5. A written list of the compounded pharmaceutical product's active ingredients is given to the patient at the time of dispensing.
 6. When a component is removed from its original container and transferred to another container, the new container label contains, in full text or an abbreviated code system, the following:
 - a. The component name,
 - b. The manufacturer's or supplier's name,
 - c. The lot or control number,
 - d. The weight or measure,
 - e. The beyond-use-date as specified in subsection (B)(3)(d), and
 - f. The transfer date.
 - J.** A pharmacy permittee shall ensure that the pharmacist-in-charge stores any quantity of compounded pharmaceutical product produced in excess of the quantity dispensed in accordance with subsection (B):
 1. In an appropriate container with a label that contains:
 - a. A complete list of components or the pharmaceutical product's name;
 - b. The preparation date;
 - c. The assigned lot or control number; and
 - d. A beyond-use-date as specified in subsection (B)(3)(d); and
 2. Under conditions, dictated by the pharmaceutical product's composition and stability characteristics, that ensure its strength, quality, and purity.
 - K.** A pharmacy permittee shall ensure that the pharmacist-in-charge establishes, implements, and complies with record-keeping procedures that comply with this subsection:
 1. Pharmaceutical product compounding procedures and other records required by this Section are maintained by the pharmacy for not less than seven years, and
 2. Pharmaceutical product compounding procedures and other records required by this Section are readily available for inspection by the Board or its designee.
- R4-23-411. Pharmacist-administered or Pharmacy or Graduate Intern-administered Immunizations**
- A.** Certification to administer immunizations, vaccines, and, in an emergency, epinephrine and diphenhydramine to an eligible adult patient or eligible minor patient. As used in this Section, "eligible adult patient" means an eligible patient 18 years of age or older and "eligible minor patient" means an eligible patient at least 6 years of age but under 18 years of age. A pharmacist or a pharmacy or graduate intern, in the presence of and under the immediate personal supervision of a certified pharmacist, may administer, without a prescription, immunizations or vaccines and, in an emergency, epinephrine and diphenhydramine to an eligible adult patient or eligible minor patient, if:
 1. The pharmacist or pharmacy or graduate intern meets the qualifications and standards specified by A.R.S. § 32-1974 and this Section.
 2. The Board certifies the pharmacist or pharmacy or graduate intern as specified in subsection (D).
 3. For an eligible adult patient, the immunization or vaccine is listed in the United States Centers for Disease Control and Prevention's Recommended Adult Immunization Schedule; or the immunization or vaccine is recommended in the United States Centers for Disease Control and Prevention's Health Information for International Travel.
 4. For an eligible adult patient, the immunization or vaccine is not on the Arizona Department of Health Services list specified in A.A.C. R9-6-1301 as required under A.R.S. § 32-1974 and subsection (I).
 5. For an eligible minor patient, the immunization or vaccine is for influenza.
 6. For an eligible minor patient, any immunizations or vaccines other than influenza are administered in response to a public health emergency declared by the Governor under A.R.S. § 36-787.
 - B.** A pharmacist or a pharmacy or graduate intern, in the presence of and under the immediate personal supervision of a certified pharmacist, may administer, with a prescription, any immunizations or vaccines and, in an emergency, epinephrine and diphenhydramine to an eligible adult patient or eligible minor patient, if:
 1. The pharmacist or pharmacy or graduate intern meets the qualifications and standards specified by A.R.S. § 32-1974 and this Section.
 2. The Board certifies the pharmacist or pharmacy or graduate intern as specified in subsection (D).
 - C.** A pharmacist or pharmacy or graduate intern who is certified to administer immunizations or vaccines and, in an emergency, epinephrine and diphenhydramine to an eligible adult patient or eligible minor patient shall:
 1. Not delegate the authority to any other pharmacist, pharmacy or graduate intern, or employee; and
 2. Maintain their current certificate for inspection by the Board or its designee or review by the public.
 - D.** Qualifications for certification to administer immunizations or vaccines and, in an emergency, epinephrine and diphenhydramine to an eligible adult patient or eligible minor patient. After receipt of a completed application form, the Board shall issue a certificate authorizing the administration of immunizations or vaccines and, in an emergency, epinephrine and diphenhydramine to an eligible adult patient or eligible minor patient to a pharmacist or pharmacy or graduate intern who meets the following qualifications:
 1. Has a current license to practice pharmacy in this state,

Historical Note

Adopted effective August 5, 1997 (Supp. 97-3).
Amended by final rulemaking at 10 A.A.R. 3391, effective October 2, 2004 (Supp. 04-3). Amended by final rulemaking at 12 A.A.R. 3981, effective December 4, 2006 (Supp. 06-4).

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2. Successfully completes a training program specified in subsection (E), and
 3. Has a current certificate in basic cardiopulmonary resuscitation.
- E.** Immunizations training program requirements. A training program for pharmacists or pharmacy or graduate interns to administer immunizations or vaccines and, in an emergency, epinephrine and diphenhydramine to an eligible adult patient or eligible minor patient shall include the following courses of study:
1. Basic immunology and the human immune response;
 2. Mechanics of immunity, adverse effects, dose, and administration schedule of available vaccines;
 3. Response to an emergency situation as a result of the administration of an immunization, including administering epinephrine and diphenhydramine to counteract the adverse effects of an immunization given based on a patient-specific prescription order received before administering the immunization;
 4. Administration of intramuscular injections;
 5. Other immunization administration methods; and
 6. Recordkeeping and reporting requirements specified in subsection (F).
- F.** Recordkeeping and reporting requirements.
1. A pharmacist or pharmacy or graduate intern granted certification under this Section to administer immunizations or vaccines and, in an emergency, epinephrine and diphenhydramine to an eligible patient shall provide to the pharmacy the following information and documentation regarding each immunization or vaccine administered:
 - a. The name, address, and date of birth of the patient;
 - b. The date of administration and site of injection;
 - c. The name, dose, manufacturer's lot number, and expiration date of the vaccine, epinephrine, or diphenhydramine;
 - d. The name and address of the patient's primary care provider or physician, as identified by the patient;
 - e. The name of the pharmacist or pharmacy or graduate intern administering the immunization;
 - f. A record of the pharmacist's or pharmacy or graduate intern's consultation with the patient determining that the patient is an eligible patient as defined in R4-23-110;
 - g. The date and time that the written report specified in subsection (F)(2) was sent to the patient's primary care provider or physician;
 - h. Consultation or other professional information provided to the patient by the pharmacist or pharmacy or graduate intern;
 - i. The name and date of the vaccine information sheet provided to the patient; and
 - j. For immunizations or vaccines given to an eligible minor patient, a consent form signed by the minor's parent or guardian.
 2. The pharmacist or pharmacy or graduate intern shall provide a written report to the patient's primary care provider or physician containing the documentation required in subsection (F)(1) within 48 hours after the immunization. The pharmacy shall make the required records specified in subsection (F)(1) and a record of compliance with this subsection available in the pharmacy for inspection by the Board or its designee.
 3. A pharmacy's pharmacist-in-charge shall maintain the records required in subsection (F)(1) in the pharmacy for a minimum of seven years from the immunization's administration date.
- G.** Confidentiality of records. A pharmacist, pharmacy or graduate intern, pharmacy permittee, or pharmacist-in-charge shall comply with applicable state and federal privacy statutes and rules when releasing patient health information.
- H.** Renewal of a certificate for pharmacist-administered immunizations. A certificate authorizing a pharmacist to administer immunizations or vaccines and, in an emergency, epinephrine and diphenhydramine to an eligible adult patient or eligible minor patient shall be renewed every five years by submitting a renewal request within the 30 days before the certificate's expiration date. A pharmacist desiring to renew the certificate shall provide to the Board proof of the following:
1. Current certification in basic cardiopulmonary resuscitation, and
 2. Completion of a minimum of five contact hours (0.5 CEU) of continuing education related to immunizations during the five-year renewal period. A pharmacist may use the continuing education hours required in this subsection as part of the total continuing education hours required for pharmacist license renewal.
- I.** Pharmacist-administered or pharmacy or graduate intern-administered adult immunizations that require a prescription order. A pharmacist or pharmacy or graduate intern certified by the Board to administer adult immunizations or vaccines shall not administer any immunization or vaccine listed in A.A.C. R9-6-1301 without a prescription order. In addition to filing a prescription order as required in A.R.S. § 32-1964, a pharmacist or pharmacy or graduate intern who administers an immunization or vaccine listed in A.A.C. R9-6-1301 shall comply with the recordkeeping requirements of subsection (F)(1).

Historical Note

New Section made by final rulemaking at 10 A.A.R.

3967, effective November 13, 2004 (Supp. 04-3).

Amended by final rulemaking at 12 A.A.R. 279, effective March 11, 2006 (Supp. 06-1). Amended by final rulemaking at 14 A.A.R. 3674, effective November 8, 2008 (Supp. 08-3). Amended by final rulemaking at 15 A.A.R. 1930, effective November 3, 2009 (Supp. 09-4).

Amended by final rulemaking at 17 A.A.R. 2596, effective February 4, 2012 (Supp. 11-4).

R4-23-412. Emergency Refill Prescription Dispensing

- A.** When a state of emergency is declared under A.R.S. § 32-1910(A) or (B) and the state of emergency results in individuals being unable to refill existing prescriptions, a pharmacist may work in the affected county, city, or town and may dispense a one-time emergency refill prescription of up to a 30-day supply of a prescribed medication to an affected individual if both of the following apply:
1. In the pharmacist's professional opinion the medication is essential to the maintenance of life or to the continuation of therapy, and
 2. The pharmacist makes a good faith effort to reduce the information to a written prescription marked "emergency prescription" and files and maintains the prescription as required by law.
- B.** If the state of emergency declared under A.R.S. § 32-1910(A) or (B) continues for at least 21-days after the pharmacist dispenses an emergency prescription under subsection (A), the pharmacist may dispense one additional emergency refill prescription of up to a 30-day supply of the prescribed medication if the pharmacist complies with subsection (A)(2).

- C. A pharmacist's authority to dispense emergency prescriptions under this Section ends when the declared state of emergency is terminated.

Historical Note

New Section made by final rulemaking at 14 A.A.R. 4400, effective January 3, 2009 (Supp. 08-4).

R4-23-413. Temporary Recognition of Nonresident Licensure

- A. When a state of emergency is declared under A.R.S. § 32-1910(A) or (B):
1. A pharmacist who is not licensed in this state, but who is currently licensed in another state, may dispense prescription medications in those affected counties, cities, or towns in this state during the time that a declared state of emergency exists under A.R.S. § 32-1910(A) or (B) if both of the following apply:
 - a. The pharmacist provides proof of current licensure in another state, and
 - b. The pharmacist is engaged in a relief effort during a state of emergency.
 2. Acting under the direct supervision of a pharmacist, a pharmacy technician or pharmacy intern not licensed in this state, but currently licensed or registered in another state, may assist a pharmacist in dispensing prescription medications in affected counties, cities, or towns in this state during the time that a declared state of emergency exists under A.R.S. § 32-1910(A) or (B) if both of the following apply:
 - a. The pharmacy technician or pharmacy intern provides proof of current licensure or registration in another state, and
 - b. The pharmacy technician or pharmacy intern is engaged in a relief effort during a state of emergency.
- B. The recognition of nonresident licensure or registration shall end with the termination of the declared state of emergency.

Historical Note

New Section made by final rulemaking at 14 A.A.R. 4400, effective January 3, 2009 (Supp. 08-4).

R4-23-414. Reserved

R4-23-415. Impaired Licensees – Treatment and Rehabilitation

- A. The Board may contract with qualified organizations to operate a program for the treatment and rehabilitation of licensees impaired as the result of alcohol or other drug abuse, pursuant to A.R.S. § 32-1932.01.
- B. Participants in the program are either "confidential" or "known." Confidential participants are self-referred and may remain unidentified to the Board, subject to maintaining compliance with their program contract. Known participants are under Board order to complete a minimum tenure in the program. After a known participant completes the minimum tenure, the Board may terminate the Board order and reinstate the participant's license to practice pharmacy.
- C. The program contract with a qualified organization shall include as a minimum the following:
1. Duties and responsibilities of each party.
 2. Duration, not to exceed two years, of contract and terms of compensation.
 3. Quarterly reports from the program administrator to the Board indicating:
 - a. Identity of participants;
 - i. By name, if a known participant; or
 - ii. By case number, if a confidential participant;
 - b. Status of each participant, including:
 - i. Clinical findings;

- ii. Diagnosis and treatment recommendations;
- iii. Program activities; and
- iv. General recovery and rehabilitation program information.

4. The program administrator shall report immediately to the Board the name of any impaired licensee who poses a danger to self or others.
 5. The program administrator shall report to the Board, as soon as possible, the name of any impaired licensee:
 - a. Who refuses to submit to treatment,
 - b. Whose impairment is not substantially alleviated through treatment, or
 - c. Who violates the terms of their contract.
 6. The program administrator shall periodically provide informational programs to the profession, including approved continuing education programs on the topic of drug and chemical impairment, treatment, and rehabilitation.
- D. Under A.R.S. § 32-1903(F), the Board may publish the names of participants under current Board orders.
- E. The Board or its executive director may request the treatment records for any participant. The program administrator shall provide treatment records within 10 working days of receiving a written request from the Board or its executive director for such records. Upon request of the program administrator or the Board or its executive director, a program participant shall authorize a drug and alcohol treatment facility or program or a private practitioner or treatment program to release the participant's records to the program administrator or the Board or its executive director.
- F. On the recommendation of the program administrator or a Board member and by mutual consent, the program administrator, Board member, Board staff, and program participant may meet informally to discuss program compliance.

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 467, effective January 4, 2000 (Supp. 00-1). Amended by final rulemaking at 14 A.A.R. 3611, effective November 8, 2008 (Supp. 08-3).

R4-23-416. Reserved through

R4-23-420. Reserved

R4-23-421. Repealed

Historical Note

New Section made by final rulemaking at 8 A.A.R. 4052, effective November 9, 2002 (Supp. 02-3). Section repealed by final rulemaking at 17 A.A.R. 2600, effective February 4, 2012 (Supp. 11-4).

R4-23-422. Repealed

Historical Note

New Section made by final rulemaking at 8 A.A.R. 4052, effective November 9, 2002 (Supp. 02-3). Section repealed by final rulemaking at 17 A.A.R. 2600, effective February 4, 2012 (Supp. 11-4).

R4-23-423. Repealed

Historical Note

New Section made by final rulemaking at 8 A.A.R. 4052, effective November 9, 2002 (Supp. 02-3). Section repealed by final rulemaking at 17 A.A.R. 2600, effective February 4, 2012 (Supp. 11-4).

R4-23-424. Repealed**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 4052, effective November 9, 2002 (Supp. 02-3). Section repealed by final rulemaking at 17 A.A.R. 2600, effective February 4, 2012 (Supp. 11-4).

R4-23-425. Repealed**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 4052, effective November 9, 2002 (Supp. 02-3). Section repealed by final rulemaking at 17 A.A.R. 2600, effective February 4, 2012 (Supp. 11-4).

R4-23-426. Repealed**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 4052, effective November 9, 2002 (Supp. 02-3). Section repealed by final rulemaking at 17 A.A.R. 2600, effective February 4, 2012 (Supp. 11-4).

R4-23-427. Repealed**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 4052, effective November 9, 2002 (Supp. 02-3). Section repealed by final rulemaking at 17 A.A.R. 2600, effective February 4, 2012 (Supp. 11-4).

R4-23-428. Repealed**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 4052, effective November 9, 2002 (Supp. 02-3). Section repealed by final rulemaking at 17 A.A.R. 2600, effective February 4, 2012 (Supp. 11-4).

R4-23-429. Repealed**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 4052, effective November 9, 2002 (Supp. 02-3). Section repealed by final rulemaking at 17 A.A.R. 2600, effective February 4, 2012 (Supp. 11-4).

ARTICLE 5. CONTROLLED SUBSTANCES PRESCRIPTION MONITORING PROGRAM

New Article 5, consisting of Sections R4-23-501 through R4-23-505, made by final rulemaking at 14 A.A.R. 3410, effective October 4, 2008 (Supp. 08-3).

Article 5, consisting of Sections R4-23-501 and R4-23-502, recodified to Article 8 at 9 A.A.R. 4011, effective August 18, 2003 (Supp. 03-3).

R4-23-501. Controlled Substances Prescription Monitoring Program Registration

- A.** Under A.R.S. § 36-2606, a medical practitioner who is issued a license under A.R.S. Title 32, Chapter 7, 11, 13, 14, 15, 16, 17, 21, 25, or 29 and possesses a current DEA registration under the Federal Controlled Substances Act shall have a current CSPMP registration issued by the Board.
- B.** Application. To obtain a CSPMP registration, a person shall submit a completed application on a form furnished by the Board that includes:
 1. Applicant's name, address, mailing address, if different, e-mail address, telephone number, facsimile number, license number issued under A.R.S. Title 32, Chapter 7, 11, 13, 14, 15, 16, 17, 21, 25, or 29, and DEA registration number;

2. Whether the applicant's license and DEA registration listed in subsection (B)(1) are current and in good standing, and if not, the status of the license and registration; and
3. Date signed and applicant's verified signature.

- C.** Registration. Within seven business days of receipt of a completed application specified in subsection (B), the Board office shall determine whether an application is complete. If the application is complete, the Board office shall issue a registration number and mail a current renewal receipt to the applicant. If the application is incomplete, the Board office shall issue a notice of incompleteness. An applicant with an incomplete application shall comply with the requirements of R4-23-202(F)(2) and (3).
- D.** Registration renewal. As specified in A.R.S. § 36-2606(C), the Board shall automatically suspend the registration of any registrant that fails to renew the registration on or before May 1 of the year in which the renewal is due. The Board shall vacate a suspension if the registrant submits a renewal application. A suspended registrant is prohibited from accessing information in the prescription monitoring program database.
- E.** Pharmacy registration and renewal. Each pharmacy with a current Board-issued pharmacy permit and a current DEA registration is automatically registered in the CSPMP. Existing pharmacy permittees who possess a current DEA registration will receive a registration receipt before the implementation date of the CSPMP. For pharmacy permits issued on or after the CSPMP implementation date, the Board will issue a registration receipt when issuing the pharmacy's permit. Each pharmacy shall renew the CSPMP registration on or before May 1 of the year in which the renewal is due. The Board shall automatically suspend the registration of any registrant that fails to renew the registration on or before the date on which the renewal is due. The Board shall vacate a suspension if the registrant submits a renewal application. A suspended registrant is prohibited from accessing information in the prescription monitoring program database.
- F.** CSPMP database access. A medical practitioner or pharmacy that chooses to use the CSPMP database shall request a user name and password in writing from the CSPMP Director. Upon receipt of the request, the CSPMP Director or designee shall issue a user name and password provided the medical practitioner or pharmacy is in compliance with the registration requirements of this Section.

Historical Note

Former Rule 5.2110; Amended effective August 9, 1983 (Supp. 83-4). Amended by final rulemaking at 8 A.A.R. 4898, effective January 5, 2003 (Supp. 02-4). Recodified to R4-23-801 at 9 A.A.R. 4011, effective August 18, 2003 (Supp. 03-3). New Section made by final rulemaking at 14 A.A.R. 3410, effective October 4, 2008 (Supp. 08-3).

R4-23-502. Requirements for Data Format and Transmission

- A.** Each dispenser shall submit to the Board or its designee by electronic means information regarding each prescription dispensed for a controlled substance listed in Schedules II, III, and IV of A.R.S. Title 36, Chapter 27, the Arizona Uniform Controlled Substances Act. The information reported shall conform to the August 31, 2005 Version 003, Release 000 ASAP Rules-based Standard Implementation Guide for Prescription Monitoring Programs published by the American Society for Automation in Pharmacy as specified in A.R.S. § 36-2608(B). The information submitted for each prescription shall include:

1. The name, address, telephone number, prescription number, and DEA registration number of the dispenser;
 2. The name, address, gender, date of birth, and telephone number of the person or, if for an animal, the owner of the animal for whom the prescription is written;
 3. The name, address, telephone number, and DEA registration number of the prescribing medical practitioner;
 4. The quantity and National Drug Code (NDC) number of the Schedule II, III, or IV controlled substance dispensed;
 5. The date the prescription was dispensed;
 6. The number of refills, if any, authorized by the medical practitioner;
 7. The date the prescription was issued;
 8. The method of payment identified as cash or third party; and
 9. Whether the prescription is new or a refill.
- B.** A dispenser shall submit the required information electronically unless the Board approves a waiver as specified in subsection (D).
- C.** A dispenser's electronic data transfer equipment including hardware, software, and internet connections shall meet the privacy and security standards of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and A.R.S. § 12-2292, in addition to common internet industry standards for privacy and security. A dispenser shall ensure that each electronic transmission meets the following data protection requirements:
1. Data shall be at least 128-bit encryption in transmission and at rest; and
 2. Data shall be transmitted via secure e-mail, telephone modem, diskette, CD-ROM, tape, secure File Transfer Protocol (FTP), Virtual Private Network (VPN), or other Board-approved media.
- D.** A dispenser who does not have an automated recordkeeping system capable of producing an electronic report in the Board established format may request a waiver from electronic reporting by submitting a written request to the Board. The Board shall grant the request if the dispenser agrees in writing to report the data by submitting a completed universal claim form supplied by the Board or its designee.
- E.** Unless otherwise approved by the Board, a dispenser shall report by the close of business on each Friday the required information for the previous week, Sunday through Saturday. If a Friday falls on a state holiday, the dispenser shall report the information on the following business day. The Board may approve a less frequent reporting period if a dispenser makes a showing that a less frequent reporting period will not reduce the effectiveness of the system or jeopardize the public health.

Historical Note

Former Rule 5.2510. Amended by final rulemaking at 8 A.A.R. 4898, effective January 5, 2003 (Supp. 02-4). Recodified to R4-23-802 at 9 A.A.R. 4011, effective August 18, 2003 (Supp. 03-3). New Section made by final rulemaking at 14 A.A.R. 3410, effective October 4, 2008 (Supp. 08-3).

R4-23-503. Access to Controlled Substances Prescription Monitoring Program Data

- A.** Except as provided in A.R.S. § 36-2604(B) and (C) and this Section, prescription information submitted to the Board or its designee is confidential and is not subject to public inspection.
- B.** The Board or its designee shall review the prescription information collected under A.R.S. Title 36, Chapter 28 and R4-23-502. If the Board or its designee has reason to believe an act of unprofessional or illegal conduct has occurred, the Board or its designee shall notify the appropriate professional licensing

board or law enforcement or criminal justice agency and provide the prescription information required for an investigation.

- C.** The Board or its designee is authorized to release data collected by the program to the following:
1. A person who is authorized to prescribe or dispense a controlled substance to assist that person to provide medical or pharmaceutical care to a patient or to evaluate a patient;
 2. An individual who requests the individual's own controlled substance prescription information under A.R.S. § 12-2293;
 3. A professional licensing board established under A.R.S. Title 32, Chapter 7, 11, 13, 14, 15, 16, 17, 18, 21, 25, or 26. Except as required under subsection (B), the Board or its designee shall provide this information only if the requesting board states in writing that the information is necessary for an open investigation or complaint;
 4. A local, state, or federal law enforcement or criminal justice agency. Except as required under subsection (B), the Board or its designee shall provide this information only if the requesting agency states in writing that the information is necessary for an open investigation or complaint;
 5. The Arizona Health Care Cost Containment System Administration regarding individuals who are receiving services under A.R.S. Title 36, Chapter 29. Except as required under subsection (B), the Board or its designee shall provide this information only if the Administration states in writing that the information is necessary for an open investigation or complaint;
 6. A person serving a lawful order of a court of competent jurisdiction; and
 7. The Board staff for purposes of administration and enforcement of A.R.S. Title 36, Chapter 28 and this Article.
- D.** The Board or its designee may provide data to public or private entities for statistical, research, or educational purposes after removing information that could be used to identify individual patients or persons who received prescriptions from dispensers.

Historical Note

Former Rules 5.3500, 5.3520, 5.3540, 5.3550, 5.3560, 5.3570, 5.3580, 5.3590, 5.4110, and 5.6110; Repealed effective August 2, 1982 (Supp. 82-4). New Section made by final rulemaking at 14 A.A.R. 3410, effective October 4, 2008 (Supp. 08-3).

R4-23-504. Computerized Central Database Tracking System Task Force

- A.** The Board shall appoint a task force to help it administer the computerized central database tracking system as specified in A.R.S. § 36-2603.
- B.** The Task Force shall meet at least once each year and at the call of the chairperson to establish the procedures and conditions relating to the release of prescription information specified in A.R.S. § 36-2604 and R4-23-503.
- C.** The Task Force shall determine:
1. The information to be screened;
 2. The frequency and thresholds for screening; and
 3. The parameters for using the information to notify medical practitioners, patients, and pharmacies to educate and provide for patient management and treatment options.
- D.** The Board shall review and approve the procedures and conditions established by the Task Force as needed but at least once every calendar year.

Historical Note

Former Rule 5.7010; Amended effective August 10, 1978

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(Supp. 78-4). Repealed effective August 2, 1982 (Supp. 82-4). New Section made by final rulemaking at 14 A.A.R. 3410, effective October 4, 2008 (Supp. 08-3).

R4-23-505. Reports

- A.** Before releasing prescription monitoring program data, the Board or its designee shall receive a written request for controlled substance prescription information.
- B.** A person authorized to access CSPMP data under R4-23-503(C)(1) through (6) shall submit a written request that:
1. Specifies the information requested for the report;
 2. For a medical practitioner, provides a statement that the report's purpose is to provide medical or pharmaceutical care to a patient or to evaluate a patient;
 3. For an individual obtaining the individual's own controlled substance prescription information, provides a form of non-expired government-issued identification;
 4. For a professional licensing board, states that the information is necessary for an open investigation or complaint;
 5. For a local, state, or federal law enforcement or criminal justice agency, states that the information is necessary for an open investigation or complaint;
 6. For the AHCCCS Administration, states that the information is necessary for an open investigation or complaint; and
 7. For a person serving a lawful order of a court of competent jurisdiction, provides a copy of the court order.
- C.** The Board or its designee may provide reports through U.S. mail, other common carrier, facsimile, or secured electronic media or may allow reports to be picked up in-person at the Board office.

Historical Note

Former Rules 5.7100, 5.8100, 5.8500, 5.9100, and 5.9500; Amended effective August 10, 1978 (Supp. 78-4). Repealed effective August 2, 1982 (Supp. 82-4). New Section made by final rulemaking at 14 A.A.R. 3410, effective October 4, 2008 (Supp. 08-3).

R4-23-506. Repealed**Historical Note**

Adopted effective December 3, 1974 (Supp. 75-1). Repealed effective August 24, 1992 (Supp. 92-3).

ARTICLE 6. PERMITS AND DISTRIBUTION OF DRUGS**R4-23-601. General Provisions**

- A.** Permit required to sell a narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical. A person shall have a current Board permit to:
1. Sell a narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical in Arizona; or
 2. Sell a narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical from outside Arizona and ship the narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical into Arizona.
- B.** A medical practitioner is exempt from subsection (A) to administer a narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical for the emergency needs of a patient.
- C.** Permit fee. Permits are issued biennially on an odd- and even-year expiration based on the assigned permit number. The fee,

specified in R4-23-205, is not refundable under any circumstances except the Board's failure to comply with the permit time-frames established in R4-23-602.

D. Record of receipt and disposal of narcotics or other controlled substances, prescription-only drugs or devices, nonprescription drugs, precursor chemicals, or regulated chemicals.

1. Every person manufacturing a narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical, including repackaging or relabeling, shall prepare and retain for not less than three years the manufacturing, repackaging, or relabeling date for each narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical.
2. Every person receiving, selling, delivering, or disposing of a narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical shall record and retain for not less than three years the following information:
 - a. The name, strength, dosage form, and quantity of each narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical received, sold, delivered, or disposed;
 - b. The name, address, and license or permit number, if applicable, of the person from whom each narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical is received;
 - c. The name, address, and license or permit number, if applicable, of the person to whom each narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical is sold or delivered, or of the person who disposes of each narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical; and
 - d. The receipt, sale, deliver, or disposal date of each narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical.
3. The record required in this subsection shall be available for inspection by the Board or its compliance officer during regular business hours.
4. If the record required in this subsection is stored in a centralized recordkeeping system and not immediately available for inspection, a permittee, manager, or pharmacist-in-charge shall provide the record within four working days of the Board's or its compliance officer's request.

- E.** Narcotics or other controlled substances, prescription-only drugs or devices, nonprescription drugs, precursor chemicals, or regulated chemicals damaged by water, fire, or from human or animal consumption or use. No person shall sell or offer to sell any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical damaged by water, fire, or from human or animal consumption or use.

Historical Note

Former Rules 6.1100, 6.1200, 6.1300, 6.1400, and 6.1500. Amended effective August 10, 1978 (Supp. 78-4). Amended subsection (C) effective August 9, 1983 (Supp. 83-4). Amended subsection (C) effective August 12, 1988 (Supp. 88-3). Amended by final rulemaking at 6 A.A.R. 4656, effective November 14, 2000 (Supp. 00-4).

Amended by final rulemaking at 12 A.A.R. 1912, effective July 1, 2006 (Supp. 06-2). Amended by final rulemaking at 14 A.A.R. 3670, effective November 8, 2008 (Supp. 08-3).

R4-23-602. Permit Application Process and Time-frames

- A.** A person applying for a permit shall submit to the Board Office an application packet consisting of:
 1. A completed application form for the desired permit signed by the applicant;
 2. A cashier's, certified, business, or personal check, or money order for the applicable biennial permit fee; and
 3. Other information or documents required by R4-23-603, R4-23-604, R4-23-605, R4-23-606, R4-23-607, or R4-23-671.
- B.** The Board Office shall deem an application packet received on the date that the Board Office stamps on the packet immediately upon receipt.
- C.** The Board Office shall finish an administrative completeness review within 20 days from the date of receipt of an application packet.
 1. The Board Office shall issue a written notice of administrative completeness to the applicant if no deficiencies are found in the application packet.
 2. If the application packet is incomplete, the Board Office shall provide the applicant with a written notice that includes a comprehensive list of the missing information. The 20-day time-frame for the Board Office to finish the administrative completeness review is suspended from the date the notice of incompleteness is served until the applicant provides the Board Office with all missing information.
 3. If the Board Office does not provide the applicant with notice regarding administrative completeness, the application packet shall be deemed complete 20 days after receipt by the Board Office.
- D.** An applicant with an incomplete application packet shall submit to the Board Office all of the missing information within 60 days of service of the notice of incompleteness.
 1. If an applicant cannot submit all missing information within 60 days of service of the notice of incompleteness, the applicant may obtain an extension by submitting a written request to the Board Office postmarked or delivered within 60 days of service of the notice of incompleteness.
 2. The written request for an extension shall document the reasons the applicant is unable to meet the 60-day deadline.
 3. The Board Office shall review the request for an extension of the 60-day deadline and grant the request if the Board Office determines that an extension of the 60-day deadline will enable the applicant to assemble and submit the missing information. An extension of the 60-day deadline shall be for no more than 60 days. An applicant that requires an additional extension shall submit an additional written request in accordance with this subsection. The Board Office shall notify the applicant in writing of its decision to grant or deny the request for an extension.
- E.** If an applicant fails to submit a complete application packet within the time allowed, the Board Office shall close the applicant's file. An applicant whose file has been closed and who later wishes to obtain a permit shall apply again in accordance with subsection (A).
- F.** For a nonprescription drug permit applicant, the Board Office shall issue a permit on the day that the Board Office determines an administratively complete application packet is received.

- G.** Except as described in subsection (F), from the date on which the administrative completeness review of an application packet is finished, the Board Office shall complete a substantive review of the applicant's qualifications in no more than 120 days.
 1. If an applicant is found to be ineligible, the Board Office shall issue a written notice of denial to the applicant;
 2. If an applicant is found to be eligible, the Board Office shall recommend to the Board that the applicant be issued a permit. Upon receipt of the Board Office's recommendation, the Board shall either issue a permit to the applicant or if the Board determines the applicant does not meet eligibility requirements, return the matter to the Board Office.
 3. If the Board Office finds deficiencies during the substantive review of the application packet, the Board Office shall issue a written request to the applicant for additional documentation.
 4. The 120-day time-frame for a substantive review for the issuance or denial of a permit is suspended from the date of the written request for additional documentation until the date that all documentation is received.
 5. When the applicant and the Board Office mutually agree in writing, the 120-day substantive review time-frame may be extended once for no more than 35 days.
- H.** For the purpose of A.R.S. § 41-1072 et seq., the Board establishes the following time-frames for permits.
 1. Administrative completeness review time-frame: 20 days.
 2. Substantive review time-frame:
 - a. Nonprescription drug permit: none;
 - b. Except as described in subsection (H)(2)(a): 120 days.
 3. Overall time-frame:
 - a. Nonprescription drug permit: 20 days;
 - b. Except as described in subsection (H)(3)(a): 140 days.

Historical Note

Former Rules 6.2100, 6.2200, 6.2300, 6.2400, 6.2500, 6.2600, 6.2610, 6.2620, 6.2630, 6.2640, and 6.2650.
 Amended effective August 10, 1978 (Supp. 78-4).
 Amended effective August 9, 1983 (Supp. 83-4).
 Repealed effective August 12, 1988 (Supp. 88-3). New Section adopted effective August 5, 1997 (Supp. 97-3).
 Amended by final rulemaking at 6 A.A.R. 4589, effective November 14, 2000 (Supp. 00-4).

R4-23-603. Nonprescription Drugs, Retail

- A.** Permit. A person, including the following, shall not sell or distribute a nonprescription drug without a current Board-issued permit:
 1. A grocer;
 2. Other non-pharmacy retail outlet; or
 3. Mobile or non-fixed location retailer, such as a swap-meet vendor.
- B.** A medical practitioner licensed under A.R.S. Title 32 is exempt from the requirements of subsection (A).
- C.** Application. To obtain a permit to sell a nonprescription drug, a person shall submit a completed application, on a form furnished by the Board, that includes:
 1. Whether applying for Category I or Category II permit;
 2. Business name, address, mailing address, if different, telephone number, and facsimile number;
 3. Owner's name, if corporation or partnership, officers or partners, including address and title;
 4. Date business started or planned opening date;

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5. Documentation of compliance with local zoning laws;
 6. Type of business, such as convenience, drug, grocery, or health food store, swap-meet vendor, or vending machine;
 7. If application is submitted because of ownership change, former owner's name and business name, if different;
 8. Date signed, applicant's verified signature; and
 9. Fee specified in R4-23-205.
- D. Drug sales:** A nonprescription drug permittee:
1. Shall sell a drug only in the original container packaged and labeled by the manufacturer; and
 2. Shall not package, repackage, label, or relabel any drug.
- E. Inspection.** A nonprescription drug permittee shall consent to inspection during business hours by a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901(4).
- F. Quality control.** A nonprescription drug permittee shall:
1. Ensure that all drugs stocked, sold, or offered for sale are:
 - a. Kept clean;
 - b. Protected from contamination, excessive heat, cold, sunlight, and other deteriorating factors; and
 - c. Comply with federal law; and
 2. Develop and implement a program to ensure that:
 - a. Any expiration-dated drug is reviewed regularly;
 - b. Any drug, that exceeds its expiration date, is deteriorated or damaged, or does not comply with federal law, is moved to a quarantine area and not sold or distributed; and
 - c. Any quarantined drug is destroyed or returned to its source of supply.
- G. Nonprescription drug vending machine outlet.** In addition to the requirements of R4-23-601, R4-23-602, and subsections (A) through (F), a person selling or distributing a nonprescription drug in a vending machine shall comply with the following requirements:
1. Each individual vending machine is considered an outlet and shall have a Board-issued nonprescription drug permit;
 2. Each nonprescription-drug-permitted vending machine shall display in public view an identification seal, furnished by the Board, containing the permit number, vending machine's serial number, owner's name, telephone contact number, and permit expiration date;
 3. Each nonprescription-drug-permitted vending machine is assigned a specific location that is within a weather-tight structure, protected from direct sunlight, and maintained at a temperature not less than 59° F and not greater than 86° F;
 4. Each nonprescription drug sold in a vending machine is packaged and labeled in the manufacturer's original FDA-approved container;
 5. A nonprescription-drug-permitted vending machine is subject to inspection by a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901(4) as follows:
 - a. The owner, manager, or other staff of the nonprescription drug permittee shall provide access to the contents of the vending machine within 24 hours of a request from a Board compliance officer or other authorized officer of the law; or
 - b. The Board compliance staff shall have independent access to the vending machine;
 6. Before relocating or retiring a nonprescription-drug-permitted vending machine, the owner or manager shall notify the Board in writing. The notice shall include:
 - a. Permit number;
 - b. Vending machine's serial number;
 - c. Action planned (relocate or retire); and
 - d. If retiring a vending machine, the disposition of the nonprescription drug contents of the vending machine;
 7. The sale or distribution of a precursor chemical or regulated chemical in a vending machine is prohibited unless the nonprescription drug permittee provides written proof to the Board of compliance with the requirements of A.R.S. §§ 13-3401, 13-3404, and 13-3404.01; and
 8. Under no circumstance may expired drugs be sold or distributed for human or animal consumption.

Historical Note

Adopted effective August 10, 1978 (Supp. 78-4).

Amended subsection (D) paragraph (1) and added subsection (G) effective April 20, 1982 (Supp. 82-2).

Amended effective August 12, 1988 (Supp. 88-3).

Amended effective February 8, 1991 (Supp. 91-1).

Amended effective August 5, 1997 (Supp. 97-3).

Amended by final rulemaking at 6 A.A.R. 4589, effective November 14, 2000 (Supp. 00-4).

R4-23-604. Resident Drug Manufacturer

- A. Permit.** A person shall not manufacture, package, repackage, label, or relabel any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical without a current Board-issued drug manufacturer permit.
- B. Application.** To obtain a permit to operate a drug manufacturing firm in Arizona, a person shall submit a completed application, on a form furnished by the Board, that includes:
1. Business name, address, mailing address, if different, telephone number, and facsimile number;
 2. Owner's name, if corporation or partnership, officers or partners, including address and title, and any other trade or business names used;
 3. Whether the owner, corporation, or partnership has conducted a similar business in any other jurisdiction and if so, indicate under what name and location;
 4. Whether the owner, any officer, or active partner has ever been convicted of an offense involving moral turpitude, a felony offense, or any drug-related offense or has any currently pending felony or drug-related charges, and if so, indicate charge, conviction date, jurisdiction, and location;
 5. Whether the owner, any officer, or active partner has ever been denied a drug manufacturer permit in this state or any other jurisdiction, and if so, indicate where and when;
 6. A copy of the drug list required by the FDA;
 7. Plans or construction drawings showing facility size and security for the proposed business;
 8. Applicant's and manager's name, address, emergency telephone number, and resumé indicating educational or experiential qualifications related to drug manufacturer operation;
 9. Pharmacist-in-charge's name, address, emergency telephone number, Arizona pharmacist license number, and expiration date;
 10. The applicant's current FDA drug manufacturer or repackager registration number and expiration date;
 11. Documentation of compliance with local zoning laws;
 12. For an application submitted because of ownership change, the former owner's name and business name, if different;

13. Date signed, applicant's, corporate officer's, partner's, manager's, or pharmacist-in-charge's verified signature and title, and
 14. Fee specified in R4-23-205.
- C.** Before issuing a drug manufacturer permit, the Board shall:
1. Receive and approve a completed permit application;
 2. Interview the applicant and manager, if different from the applicant, and the pharmacist-in-charge at a Board meeting; and
 3. Receive a satisfactory compliance inspection report on the facility from a Board compliance officer.
- D.** Notification. A resident drug manufacturer permittee shall notify the Board of changes involving the drug list, ownership, address, telephone number, name of business, manager, or pharmacist-in-charge, including manager's or pharmacist-in-charge's telephone number. The resident drug manufacturer permittee shall submit a written notice via mail, fax, or e-mail to the Executive Director within 24 hours of the change, except any change of ownership requires that the resident drug manufacturer permittee comply with subsection (E).
- E.** Change of ownership. Before a change of ownership occurs that involves changes of stock ownership of more than 30% of the voting stock of a corporation or an existing and continuing corporation that is not actively traded on any securities market or over-the-counter market, the prospective owner shall submit the application packet described under subsection R4-23-604(B).
- F.** Before an existing resident drug manufacturer permittee relocates, the drug manufacturer permittee shall submit the application packet described in subsection R4-23-604(B), excluding the fee. The facility at the new location shall pass a final inspection by a Board compliance officer before operations begin.
- G.** A resident drug manufacturer permittee shall submit the application packet described under subsection R4-23-604(B) for any change of officers in a corporation, excluding the fee and final inspection.
- H.** Manufacturing and distribution.
1. A drug manufacturer permittee shall manufacture and distribute a drug only:
 - a. To a pharmacy, drug manufacturer, and full-service or nonprescription drug wholesaler currently permitted by the Board;
 - b. To a medical practitioner currently licensed as a medical practitioner as defined in A.R.S. § 32-1901; or
 - c. To a properly permitted, registered, licensed, or certified person or firm of another jurisdiction; and
 - d. Under the supervision of an Arizona Board-licensed pharmacist as required in A.R.S. § 32-1961. Manufacturing processes that require the supervision of a pharmacist include weighing, mixing, compounding, tableting, packaging, and labeling.
 2. Before manufacturing and distributing a drug that is not listed on a drug manufacturer's permit application, the drug manufacturer permittee shall send to the Board office a written request to amend the permit application, including documentation of FDA approval to manufacture the drug not listed on the original permit application. If a request to amend a permit application includes the documentation required in this subsection, the Board or its designee shall approve the request to amend within 30 days of receipt.
- I.** A drug manufacturer permit is subject to denial, suspension, probation, or revocation under A.R.S. § 32-1932.
- J.** A drug manufacturer permittee shall:
1. Designate an Arizona Board-licensed pharmacist as the pharmacist-in-charge. The pharmacist-in-charge shall:
 - a. Communicate Board directives to the management, other pharmacists, interns, and other personnel of the drug manufacturer; and
 - b. Ensure compliance with all federal and state drug laws and rules by the drug manufacturer; and
 2. Ensure that an Arizona Board-licensed pharmacist is present at the facility whenever a drug is manufactured, packaged, repackaged, labeled, or relabeled.
- K.** Current Good Manufacturing Practice. A drug manufacturer permittee shall comply with the current good manufacturing practice requirements of 21 CFR 210 through 211, published April 1, 2000, and no future amendments or editions, incorporated by reference and on file with the Board and the Office of the Secretary of State.
- L.** Records. A drug manufacturer permittee shall:
1. Establish and implement written procedures for maintaining records pertaining to production, process control, labeling, packaging, quality control, distribution, complaints, and any information required by federal or state law;
 2. Retain the records required by this Article and 21 CFR 210 through 211 as incorporated in subsection (H) for at least two years after distribution of a drug or one year after the expiration date of a drug, whichever is longer; and
 3. Make the records required by this Article and 21 CFR 210 through 211 as incorporated in subsection (H) available within 48 hours for review by a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901(4).
- M.** Inspections. A drug manufacturer permittee shall make the drug manufacturer's facility available for inspection by the Board or its compliance officer under A.R.S. § 32-1904.
- N.** Nonresident drug manufacturer. A nonresident drug manufacturer shall comply with the requirements of R4-23-607.
- O.** Manufacturing radiopharmaceuticals. Before manufacturing a radiopharmaceutical, a drug manufacturer permittee shall:
1. Comply with the regulatory requirements of the Arizona Radiation Regulatory Agency, the U.S. Nuclear Regulatory Commission, the FDA, and this Section;
 2. Be or employ an Arizona Board-licensed authorized nuclear pharmacist as specified in R4-23-681(A);
 3. Comply with the requirements specified in R4-23-682(F)(1), (2), (3), and (5);
 4. Hold a current Arizona Radiation Regulatory Agency Radioactive Materials License. If a drug manufacturer permittee who manufactures radiopharmaceuticals fails to maintain a current Arizona Radiation Regulatory Agency Radioactive Materials License, the permittee's drug manufacturer permit shall be immediately suspended pending a hearing by the Board;
 5. Designate an authorized nuclear pharmacist as the pharmacist-in-charge. The pharmacist-in-charge shall:
 - a. Communicate Board directives to the management, other pharmacists, interns, and other personnel of the drug manufacturer; and
 - b. Ensure compliance with all federal and state drug laws and rules by the drug manufacturer;
 6. Ensure that an authorized nuclear pharmacist:
 - a. Directly supervises all personnel who perform tasks in the manufacture and distribution of radiopharmaceuticals; and

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- b. Is present at the facility whenever a radiopharmaceutical is manufactured, packaged, repackaged, labeled, relabeled, or distributed.

Historical Note

Former Rules 6.4001, 6.4002, 6.4003, 6.4004, 6.4005, 6.4006, 6.4007, 6.4008, 6.4009, 6.4100, 6.4110, 6.4111, 6.4115, 6.4116, 6.4120, 6.4122, 6.4190, 6.4191, 6.4200, 6.4250, 6.4300, 6.4350, 6.4355, 6.4360, 6.4400, 6.4401, 6.4403, 6.4410, 6.4430, 6.4450, 6.4500, 6.4510, 6.4530, 6.4533, 6.4600, 6.4610, 6.4640, 6.4660, 6.4700, 6.4710, and 6.4750. Adopted effective December 3, 1974 (Supp. 75-1). Amended effective August 10, 1978 (Supp. 78-4). Amended subsection (B) paragraph (2) effective April 20, 1982 (Supp. 82-2). Amended subsections (B), (G), (K) and (L) effective August 12, 1988 (Supp. 88-3). Amended effective August 24, 1992 (Supp. 92-3). Amended effective November 1, 1993 (Supp. 93-4). Amended by final rulemaking at 7 A.A.R. 3815, effective August 9, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 1105, effective April 30, 2005 (Supp. 05-1).

R4-23-605. Resident Drug Wholesaler Permit

- A.** Permit. A person shall not operate a business or firm for the wholesale distribution of any drug, device, precursor chemical, or regulated chemical without a current Board-issued full-service or nonprescription drug wholesale permit.

B. Application.

1. To obtain a permit to operate a full-service or nonprescription drug wholesale firm in Arizona, a person shall submit a completed application on a form furnished by the Board that includes:
 - a. Whether the application is for a full-service or nonprescription drug wholesale permit;
 - b. Business name, address, mailing address, if different, telephone number, and facsimile number;
 - c. Owner's name, if corporation or partnership, officers or partners, including address and title, and any other trade or business names used;
 - d. Whether the owner, corporation, or partnership has conducted a similar business in any other jurisdiction and if so, indicate under what name and location;
 - e. Whether the owner, any officer or active partner has ever been convicted of an offense involving moral turpitude, a felony offense, or any drug-related offense or has any currently pending felony or drug-related charges, and if so, indicate charge, conviction date, jurisdiction, and location;
 - f. Whether the owner or any officer or active partner has ever been denied a drug wholesale permit in this state or any other jurisdiction, and if so, indicate where and when;
 - g. For a full-service drug wholesale firm:
 - i. The designated representative's name, address, and emergency telephone number;
 - ii. Documentation that the designated representative meets the requirements of A.R.S. § 32-1982(B) and the following as specified in A.R.S. § 32-1982(C):
 - (1) A full set of fingerprints from the designated representative; and
 - (2) The state and federal criminal history record check fee specified by and made payable to the Arizona State Department of Public Safety by money order, certified

- check, or bank draft; and
- iii. A \$100,000 bond as specified in A.R.S. § 32-1982(D) submitted on a form supplied by the Board;

- h. The type of drugs, whether nonprescription, prescription-only, controlled substances, human, or veterinary, the applicant will distribute;
- i. Plans or construction drawings showing facility size and security for the proposed business;
- j. Documentation of compliance with local zoning laws;
- k. For a nonprescription drug wholesale firm, the manager's or designated representative's name, address, emergency telephone number, and resumé indicating educational or experiential qualifications related to drug wholesale operation;
- l. For an application submitted because of ownership change, the former owner's name and business name, if different;
- m. Date signed, and applicant's, corporate officer's, partner's, manager's, or designated representative's verified signature and title; and
- n. Fee specified in R4-23-205.

2. Before issuing a full-service or nonprescription drug wholesale permit, the Board shall:

- a. Receive and approve a completed permit application;
- b. Interview the applicant and the designated representative, if different from the applicant, at a Board meeting;
- c. Receive a satisfactory compliance inspection report on the facility from a Board compliance officer; and
- d. For a full-service drug wholesale permit, issue a fingerprint clearance to a qualified designated representative, as specified in subsection (L). If the fingerprint clearance of a designated representative for a full-service drug wholesale permit applicant is denied, the full-service drug wholesale permit applicant shall appoint another designated representative and submit the documentation, fingerprints, and fee required in subsection (B)(1)(g)(ii).

- C.** Notification. A resident full-service or nonprescription drug wholesale permittee shall notify the Board of changes involving the type of drugs sold or distributed, ownership, address, telephone number, name of business, or manager or designated representative, including the manager's or designated representative's telephone number.

1. The resident full-service or nonprescription drug wholesale permittee shall submit a written notice via mail, fax, or e-mail to the Executive Director within 10 days of the change, except any change of ownership requires that the resident full-service or nonprescription drug wholesale permittee comply with subsection (D).
2. For a change of designated representative, a resident full-service drug wholesale permittee shall submit the documentation, fingerprints, and fee required in subsection (B)(1)(g)(ii). If the fingerprint clearance of a designated representative for a full-service drug wholesale permit applicant is denied, the full-service drug wholesale permit applicant shall appoint another designated representative and submit the documentation, fingerprints, and fee required in subsection (B)(1)(g)(ii).

- D.** Change of ownership. Before a change of ownership occurs that involves changes of stock ownership of more than 30% of the voting stock of a corporation or an existing and continuing corporation that is not actively traded on any securities market

or over-the-counter market, the prospective owner shall submit the application packet described under subsection (B).

- E. Before an existing resident full-service or nonprescription drug wholesaler permittee relocates, the resident full-service or nonprescription drug wholesale permittee shall submit the application packet described under subsection (B), excluding the fee. The facility at the new location shall pass a final inspection by a Board compliance officer before operations begin.
- F. A resident full-service or nonprescription drug wholesale permittee shall submit the application packet described under subsection (B) for any change of officers in a corporation, excluding the fee and final inspection.
- G. Distribution restrictions. In addition to the requirements of this subsection, a resident full-service wholesale permittee shall comply with the distribution restrictions specified in A.R.S. § 32-1983.

1. Records.

a. A full-service drug wholesale permittee shall:

- i. Maintain records to ensure full accountability of any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical including dates of receipt and sales, names, addresses, and DEA registration numbers, if required, of suppliers or sources of merchandise, and customer names, addresses, and DEA registration numbers, if required;
- ii. File the records required in subsection (G)(1)(a)(i) in a readily retrievable manner for a minimum of three years;
- iii. Make the records required in subsection (G)(1)(a)(i) available upon request during regular business hours for inspection by a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901(5). Records kept at a central location apart from the business location and not electronically retrievable shall be made available within two business days; and
- iv. In addition to the records requirements of subsection (G)(1)(a)(i), provide a pedigree as specified in A.R.S. § 32-1984(E) for all prescription-only drugs that leave the normal distribution channel as defined in A.R.S. § 32-1981.

b. A nonprescription drug wholesale permittee shall:

- i. Maintain records to ensure full accountability of any nonprescription drug, precursor chemical, or regulated chemical including dates of receipt and sales, names, addresses, and DEA registration numbers, if required, of suppliers or sources of merchandise, and customer names, addresses, and DEA registration numbers, if required;
- ii. File the records required in subsection (G)(1)(b)(i) in a readily retrievable manner for a minimum of three years; and
- iii. Make the records required in subsection (G)(1)(b)(i) available upon request during regular business hours for inspection by a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901(5). Records kept at a central location apart from the business location and not electronically

retrievable shall be made available within two business days.

2. Drug sales.

a. A full-service drug wholesale permittee shall:

- i. Not sell, distribute, give away, or dispose of, any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical, except in the original container packaged and labeled by the manufacturer or repackager;
- ii. Not package, repack, label, or relabel any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical;
- iii. Not sell, distribute, give away, or dispose of, any narcotic or other controlled substance, or prescription-only drug or device, to anyone except a pharmacy, drug manufacturer, or full-service drug wholesaler currently permitted by the Board or a medical practitioner currently licensed under A.R.S. Title 32;
- iv. Not sell, distribute, give away, or dispose of, any nonprescription drug, precursor chemical, or regulated chemical, to anyone except a pharmacy, drug manufacturer, full-service or nonprescription drug wholesaler, or nonprescription drug retailer currently permitted by the Board or a medical practitioner currently licensed under A.R.S. Title 32;
- v. Provide pedigree records upon request, if immediately available, or in no less than two business days from the date of a request of a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901(5);
- vi. Maintain a copy of the current permit or license of each person or firm who buys, receives, or disposes of any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical; and
- vii. Provide permit and license records upon request, if immediately available, or in no less than two business days from the date of the request of a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901(5).

b. A nonprescription drug wholesale permittee shall:

- i. Not sell, distribute, give away, or dispose of any nonprescription drug, precursor chemical, or regulated chemical, except in the original container packaged and labeled by the manufacturer or repackager;
- ii. Not package, repack, label, or relabel any nonprescription drug, precursor chemical, or regulated chemical;
- iii. Not sell or distribute any nonprescription drug, precursor chemical, or regulated chemical, to anyone except a pharmacy, drug manufacturer, full-service or nonprescription drug wholesaler, or nonprescription drug retailer currently permitted by the Board or a medical practitioner currently licensed under A.R.S. Title 32;
- iv. Maintain a record of the current permit or license of each person or firm who buys, receives, or disposes of any nonprescription

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- drug, precursor chemical, or regulated chemical; and
- v. Provide permit and license records upon request, if immediately available, or in no less than two business days from the date of the request of a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901(5).
- c. Nothing in this subsection shall be construed to prevent the return of a narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical to the original source of supply.
3. Out-of-state drug sales.
 - a. A full-service drug wholesale permittee shall:
 - i. Not sell, distribute, give away, or dispose of any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical, except in the original container packaged and labeled by the manufacturer or repackager;
 - ii. Not package, repack, label, or relabel any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical;
 - iii. Not sell, distribute, give away, or dispose of any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical, to anyone except a person or firm that is properly permitted, registered, licensed, or certified in another jurisdiction;
 - iv. Provide pedigree records upon request, if immediately available, or in no less than two business days from the date of the request of a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901(5);
 - v. Maintain a copy of the current permit, registration, license, or certificate of each person or firm who buys, receives, or disposes of any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical; and
 - vi. Provide permit, registration, license, and certificate records upon request, if immediately available, or in no less than two business days from the date of the request of a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901(5); and
 - b. A nonprescription drug wholesale permittee shall:
 - i. Not sell, distribute, give away, or dispose of any nonprescription drug, precursor chemical, or regulated chemical, except in the original container packaged and labeled by the manufacturer or repackager;
 - ii. Not package, repack, label, or relabel any nonprescription drug, precursor chemical, or regulated chemical;
 - iii. Not sell or distribute any nonprescription drug, precursor chemical, or regulated chemical, to anyone except a person or firm that is properly permitted, registered, licensed, or certified in another jurisdiction;
 - iv. Maintain a record of the current permit, registration, license, or certificate of each person or firm who buys, receives, or disposes of any nonprescription drug, precursor chemical, or regulated chemical; and
 - v. Provide permit, registration, license, or certificate records upon request, if immediately available, or in no less than two business days from the date of the request of a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901(5).
4. Cash-and-carry sales.
 - a. A full-service drug wholesale permittee shall complete a cash-and-carry sale or distribution of any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical, only after:
 - i. Verifying the validity of the order;
 - ii. Verifying the identity of the pick-up person for each transaction by confirming that the person or firm represented placed the cash-and-carry order; and
 - iii. For a prescription-only drug order, verifying that the cash-and-carry sale or distribution is used only to meet the immediate needs of a particular patient of the person or firm who placed the cash-and-carry order; and
 - b. A nonprescription drug wholesale permittee shall complete a cash-and-carry sale or distribution of any nonprescription drug, precursor chemical, or regulated chemical, only after:
 - i. Verifying the validity of the order; and
 - ii. Verifying the identity of the pick-up person for each transaction by confirming that the person or firm represented placed the cash-and-carry order.
- H. Prescription-only drug returns or exchanges. A full-service drug wholesale permittee shall ensure that any prescription-only drug returned or exchanged by a pharmacy or chain pharmacy warehouse under A.R.S. § 32-1983(A) meets the following criteria:
 1. The prescription-only drug is not adulterated or counterfeited, except an adulterated or counterfeited prescription-only drug that is the subject of an FDA or manufacturer recall may be returned for destruction or subsequent return to the manufacturer;
 2. The quantity of prescription-only drug returned or exchanged does not exceed the quantity of prescription-only drug that the full-service drug wholesale permittee or a full-service drug wholesale permittee under common ownership sold to the pharmacy or chain pharmacy warehouse; and
 3. The pharmacy or chain pharmacy warehouse provides documentation that:
 - a. Lists the name, strength, manufacturer, lot number, and expiration date of the prescription-only drug being returned or exchanged; and
 - b. States that the prescription-only drug was maintained in compliance with storage conditions prescribed on the drug label or manufacturer's package insert.
- I. Returned, outdated, damaged, deteriorated, adulterated, misbranded, counterfeited, and contraband drugs.
 1. Except as specified in subsection (H)(1) for a prescription-only drug, a full-service drug wholesale permittee shall ensure that the return of any narcotic or other controlled substance, prescription-only drug or device, non-

prescription drug, precursor chemical, or regulated chemical meets the following criteria.

- a. Any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical that is outdated, damaged, deteriorated, adulterated, misbranded, counterfeited, or contraband or suspected of being adulterated, misbranded, counterfeited, or contraband, or otherwise deemed unfit for human or animal consumption shall be quarantined and physically separated from other narcotics or other controlled substances, prescription-only drugs or devices, nonprescription drugs, precursor chemicals, or regulated chemicals until the narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical is destroyed or returned to the manufacturer or wholesale distributor from which it was acquired as authorized by the Board and the FDA.
- b. Any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical whose immediate or sealed outer or secondary containers or product labeling are misbranded, counterfeited, or contraband or suspected of being misbranded, counterfeited, or contraband shall be quarantined and physically separated from other narcotics or other controlled substances, prescription-only drugs or devices, nonprescription drugs, precursor chemicals, or regulated chemicals until the narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical is destroyed or returned to the manufacturer or wholesale distributor from which it was acquired as authorized by the Board and the FDA. When the immediate or sealed outer or secondary containers or product labeling are determined to be misbranded, counterfeited, or contraband or suspected of being misbranded, counterfeited, or contraband, the full-service drug wholesale permittee shall provide notice of the misbranding, counterfeiting, or contrabandage or suspected misbranding, counterfeiting, or contrabandage within three business days of the determination to the Board, FDA, and manufacturer or wholesale distributor from which the narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical was acquired.
- c. Any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical that has been opened or used, but is not adulterated, misbranded, counterfeited, or contraband or suspected of being misbranded, counterfeited, or contraband, shall be identified as opened or used, or both, and quarantined and physically separated from other narcotics or other controlled substances, prescription-only drugs or devices, nonprescription drugs, precursor chemicals, or regulated chemicals until the narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical is destroyed or returned to the manufacturer or wholesale distributor from which it

was acquired as authorized by the Board and the FDA.

- d. If the conditions under which a narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical has been returned cast doubt on the narcotic's or other controlled substance's, prescription-only drug's or device's, nonprescription drug's, precursor chemical's, or regulated chemical's safety, identity, strength, quality, or purity, the narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical shall be quarantined and physically separated from other narcotics or other controlled substances, prescription-only drugs or devices, nonprescription drugs, precursor chemicals, or regulated chemicals until the narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical is destroyed or returned to the manufacturer or wholesale distributor from which it was acquired as authorized by the Board and the FDA, except as provided in subsection (I)(1)(d)(i).
 - i. If examination, testing, or other investigation proves that the narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical meets appropriate standards of safety, identity, strength, quality, and purity, it does not have to be destroyed or returned to the manufacturer or wholesale distributor.
 - ii. In determining whether the conditions under which a narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical has been returned cast doubt on the narcotic's or other controlled substance's, prescription-only drug's or device's, nonprescription drug's, precursor chemical's, or regulated chemical's safety, identity, strength, quality, or purity, the full-service drug wholesale permittee shall consider, among other things, the conditions under which the narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical has been held, stored, or shipped before or during its return and the condition of the narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical and the condition of its container, carton, or product labeling as a result of storage or shipping.
 - e. For any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical identified under subsections (I)(1)(a) or (b), the full-service drug wholesale permittee shall ensure that the identified item or items and other evidence of criminal activity, and accompanying documentation is retained and not destroyed until its disposition is authorized by the Board and the FDA.
2. A nonprescription drug wholesale permittee shall ensure that the return of any nonprescription drug, precursor chemical, or regulated chemical meets the following criteria.

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- a. Any nonprescription drug, precursor chemical, or regulated chemical that is outdated, damaged, deteriorated, adulterated, misbranded, counterfeited, or contraband or suspected of being adulterated, misbranded, counterfeited, or contraband, or otherwise deemed unfit for human or animal consumption shall be quarantined and physically separated from other nonprescription drugs, precursor chemicals, or regulated chemicals until the nonprescription drug, precursor chemical, or regulated chemical is destroyed or returned to the manufacturer or wholesale distributor from which it was acquired as authorized by the Board and the FDA.
 - b. Any nonprescription drug, precursor chemical, or regulated chemical whose immediate or sealed outer or secondary containers or product labeling are misbranded, counterfeited, or contraband or suspected of being misbranded, counterfeited, or contraband shall be quarantined and physically separated from other nonprescription drugs, precursor chemicals, or regulated chemicals until the nonprescription drug, precursor chemical, or regulated chemical is destroyed or returned to the manufacturer or wholesale distributor from which it was acquired as authorized by the Board and the FDA. When the immediate or sealed outer or secondary containers or product labeling are determined to be misbranded, counterfeited, or contraband or suspected of being misbranded, counterfeited, or contraband, the nonprescription drug wholesale permittee shall provide notice of the misbranding, counterfeiting, or contrabandage or suspected misbranding, counterfeiting, or contrabandage within three business days of the determination to the Board, FDA, and manufacturer or wholesale distributor from which the nonprescription drug, precursor chemical, or regulated chemical was acquired.
 - c. Any nonprescription drug, precursor chemical, or regulated chemical that has been opened or used, but is not adulterated, misbranded, counterfeited, or contraband or suspected of being misbranded, counterfeited, or contraband, shall be identified as opened or used, or both, and quarantined and physically separated from other nonprescription drugs, precursor chemicals, or regulated chemicals until the nonprescription drug, precursor chemical, or regulated chemical is destroyed or returned to the manufacturer or wholesale distributor from which it was acquired as authorized by the Board and the FDA.
 - d. If the conditions under which a nonprescription drug, precursor chemical, or regulated chemical has been returned cast doubt on the nonprescription drug's, precursor chemical's, or regulated chemical's safety, identity, strength, quality, or purity, the nonprescription drug, precursor chemical, or regulated chemical shall be quarantined and physically separated from other nonprescription drugs, precursor chemicals, or regulated chemicals until the nonprescription drug, precursor chemical, or regulated chemical is destroyed or returned to the manufacturer or wholesale distributor from which it was acquired as authorized by the Board and the FDA, except as provided in subsection (1)(2)(d)(i).
 - i. If examination, testing, or other investigation proves that the nonprescription drug, precursor chemical, or regulated chemical meets appropriate standards of safety, identity, strength, quality, and purity, it does not need to be destroyed or returned to the manufacturer or wholesale distributor.
 - ii. In determining whether the conditions under which a nonprescription drug, precursor chemical, or regulated chemical has been returned cast doubt on the nonprescription drug's, precursor chemical's, or regulated chemical's safety, identity, strength, quality, or purity, the nonprescription drug wholesale permittee shall consider, among other things, the conditions under which the nonprescription drug, precursor chemical, or regulated chemical has been held, stored, or shipped before or during its return and the condition of the nonprescription drug, precursor chemical, or regulated chemical and the condition of its container, carton, or product labeling as a result of storage or shipping.
 - e. For any nonprescription drug, precursor chemical, or regulated chemical identified under subsections (1)(2)(a) or (b), the nonprescription drug wholesale permittee shall ensure that the identified item or items and other evidence of criminal activity, and accompanying documentation is retained and not destroyed until its disposition is authorized by the Board and the FDA.
3. A full-service drug wholesale permittee and nonprescription drug wholesale permittee shall comply with the recordkeeping requirements of subsection (G) for all outdated, damaged, deteriorated, adulterated, misbranded, counterfeited and contraband narcotics or other controlled substances, prescription-only drugs or devices, nonprescription drugs, precursor chemicals, or regulated chemicals.
- J. Facility.** A full-service or nonprescription drug wholesale permittee shall:
1. Ensure that the facility occupied by the full-service or nonprescription drug wholesale permittee is of adequate size and construction, well-lighted inside and outside, adequately ventilated, and kept clean, uncluttered, and sanitary;
 2. Ensure that the permittee's warehouse facility:
 - a. Is secure from unauthorized entry; and
 - b. Has an operational security system designed to provide protection against theft;
 3. In a full-service drug wholesale facility, ensure that only authorized personnel may enter areas where any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical is kept;
 4. In a nonprescription drug wholesale facility, ensure that only authorized personnel may enter areas where any nonprescription drug, precursor chemical, or regulated chemical is kept;
 5. In a full-service drug wholesale facility, ensure that any thermolabile narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical is stored in an area where room temperature is maintained in compliance with storage conditions prescribed on the product label;
 6. In a nonprescription drug wholesale facility, ensure that any thermolabile nonprescription drug, precursor chemical, or regulated chemical is stored in an area where room

temperature is maintained in compliance with storage conditions prescribed on the product label;

7. Make the facility available for inspection by a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901(5) during regular business hours;
8. In a full-service drug wholesale facility, provide a quarantine area for storage of any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical that is outdated, damaged, deteriorated, adulterated, misbranded, counterfeited, or contraband or suspected of being adulterated, misbranded, counterfeited, or contraband, otherwise deemed unfit for human or animal consumption, or that is in an open container; and
9. In a nonprescription drug wholesale facility, provide a quarantine area for storage of any nonprescription drug, precursor chemical, or regulated chemical that is outdated, damaged, deteriorated, adulterated, misbranded, counterfeited, or contraband or suspected of being adulterated, misbranded, counterfeited, or contraband, otherwise deemed unfit for human or animal consumption, or that is in an open container.

K. Quality controls.

1. A full-service drug wholesale permittee shall:
 - a. Ensure that any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical that meets the criteria specified in subsection (I)(1) is not sold, distributed, or delivered to any person for human or animal consumption;
 - b. Ensure that a narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical is not manufactured, packaged, repackaged, labeled, or relabeled by any of its employees;
 - c. Ensure that any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical stocked, sold, offered for sale, or delivered is:
 - i. Kept clean,
 - ii. Protected from contamination and other deteriorating environmental factors, and
 - iii. Stored in a manner that complies with applicable federal and state law and official compendium storage requirements;
 - d. Maintain manual or automatic temperature and humidity recording devices or logs to document conditions in areas where any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical is stored; and
 - e. Develop and implement a program to ensure that:
 - i. Any expiration-dated narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical is reviewed regularly;
 - ii. Any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical that has less than 120 days remaining on the expiration date, or is deteriorated, damaged, or does not comply with federal law, is moved to a quarantine area and not sold or distributed; and

- iii. Any quarantined narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical is destroyed or returned to the manufacturer or wholesale distributor from which it was acquired.

2. A nonprescription drug wholesale permittee shall:

- a. Ensure that any nonprescription drug, precursor chemical, or regulated chemical that meets the criteria specified in subsection (I)(2) is not sold, distributed, or delivered to any person for human or animal consumption;
- b. Ensure that a nonprescription drug, precursor chemical, or regulated chemical is not manufactured, packaged, repackaged, labeled, or relabeled by any of its employees;
- c. Ensure that any nonprescription drug, precursor chemical, or regulated chemical stocked, sold, offered for sale, or delivered is:
 - i. Kept clean,
 - ii. Protected from contamination and other deteriorating environmental factors, and
 - iii. Stored in a manner that complies with applicable federal and state law and official compendium storage requirements;
- d. Maintain manual or automatic temperature and humidity recording devices or logs to document conditions in areas where any nonprescription drug, precursor chemical, or regulated chemical is stored; and
- e. Develop and implement a program to ensure that:
 - i. Any expiration-dated nonprescription drug, precursor chemical, or regulated chemical is reviewed regularly;
 - ii. Any nonprescription drug, precursor chemical, or regulated chemical that has less than 120 days remaining on the expiration date, or is deteriorated, damaged, or does not comply with federal law, is moved to a quarantine area and not sold or distributed; and
 - iii. Any quarantined nonprescription drug, precursor chemical, or regulated chemical is destroyed or returned to the manufacturer or wholesale distributor from which it was acquired.

L. Fingerprint clearance.

1. After receiving the state and federal criminal history record of a designated representative, the Board shall compare the record with the list of criminal offenses that preclude a designated representative from receiving a fingerprint clearance. If the designated representative's criminal history record does not contain any of the offenses listed in subsection (L)(2), the Board shall issue the designated representative a fingerprint clearance.
2. The Board shall not issue a fingerprint clearance to a designated representative who is awaiting trial for or who has been convicted of committing or attempting or conspiring to commit one or more of the following offenses in this state or the same or similar offenses in another state or jurisdiction:
 - a. Unlawfully administering intoxicating liquors, controlled substances, dangerous drugs, or prescription-only drugs;
 - b. Sale of peyote;
 - c. Possession, use, or sale of marijuana, dangerous drugs, prescription-only drugs, or controlled substances;

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- d. Manufacture or distribution of an imitation controlled substance;
 - e. Manufacture or distribution of an imitation prescription-only drug;
 - f. Possession or possession with intent to use an imitation controlled substance;
 - g. Possession or possession with intent to use an imitation prescription-only drug; or
 - h. A felony offense involving sale, distribution, or transportation of, offer to sell, transport, or distribute, or conspiracy to sell, transport, or distribute marijuana, dangerous drugs, prescription-only drugs, or controlled substances.
3. If after conducting a state and federal criminal history record check the Board determines that it is not authorized to issue a fingerprint clearance, the Board shall notify the full-service drug wholesale applicant or permittee that employs the designated representative that the Board is not authorized to issue a fingerprint clearance. This notice shall include the criminal history information on which the denial was based. This criminal history information is subject to dissemination restrictions under A.R.S. § 41-1750 and federal law.
 4. The issuance of a fingerprint clearance does not entitle a person to employment.

Historical Note

Former Rules 6.5110, 6.5120, 6.5130, 6.5140, 6.5210, 6.5220, 6.5230, 6.5240, 6.5310, 6.5320, 6.5410, and 6.5420. Amended effective August 10, 1978 (Supp. 78-4). Amended effective April 20, 1982 (Supp. 82-2). Amended subsection (A) effective August 12, 1988 (Supp. 88-3). Amended effective February 8, 1991 (Supp. 91-1). Amended effective August 24, 1992 (Supp. 92-3). Amended by final rulemaking at 6 A.A.R. 4589, effective November 14, 2000 (Supp. 00-4). Amended by final rulemaking at 10 A.A.R. 232, effective March 6, 2004 (Supp. 04-1). Amended by final rulemaking at 11 A.A.R. 1105, effective April 30, 2005 (Supp. 05-1). Amended by final rulemaking at 11 A.A.R. 4270, effective December 6, 2005 (Supp. 05-4). Amended by final rulemaking at 13 A.A.R. 3477, effective December 1, 2007 (Supp. 07-4).

R4-23-606. Pharmacy Permit, Community, Hospital, and Limited Service

A. Permit. A person shall not operate a pharmacy in Arizona without a current Board-issued pharmacy permit.

B. Application.

1. To obtain a permit to operate a new pharmacy or change ownership, relocate, or remodel an existing pharmacy in Arizona, a person shall submit a completed application, on a form furnished by the Board, that includes:
 - a. The type of pharmacy;
 - b. Business name, address, mailing address, if different, telephone number, and facsimile number;
 - c. Owner's name, if corporation or partnership, officers or partners, including address and title, and any other trade or business names used;
 - d. Whether the owner, corporation, or partnership has conducted a similar business in any other jurisdiction and if so, indicate under what name and location;
 - e. Whether the owner, any officer, or active partner has ever been convicted of an offense involving moral turpitude, a felony offense, or any drug-related offense or has any currently pending felony or drug-related charges, and if so, indicate charge, conviction date, jurisdiction, and location;
 - f. Whether the owner, any officer, or active partner has ever been denied a pharmacy permit in this state or any other jurisdiction, and if so, indicate where and when;
 - g. Whether the owner, any officer, or partner is a medical practitioner;
 - h. Name and telephone number of individual to contact before opening;
 - i. If applying for a hospital pharmacy permit, the hospital's Department of Health Services license number, number of beds, and manager's or administrator's name;
 - j. Planned opening, change of ownership, relocation, or remodel date;
 - k. Plans or construction drawings showing pharmacy size and security for the proposed business;
 - l. Documentation of compliance with local zoning laws;
 - m. Lease agreement and a disclosure statement indicating whether a medical practitioner receives income from the lease;
 - n. Pharmacist-in-charge's name;
 - o. For an application submitted because of ownership change, the former pharmacy's name, address, owner's name, and permit number;
 - p. Date signed, applicant's, corporate officer's, partner's, manager's, administrator's, or pharmacist-in-charge's verified signature and title; and
 - q. Fee specified in R4-23-205.
2. Before issuing a pharmacy permit, the Board shall:
 - a. Receive and approve a completed permit application; and
 - b. Receive a satisfactory compliance inspection report on the facility from a Board compliance officer.
 3. Before issuing a pharmacy permit, the Board may interview the applicant and the pharmacist-in-charge, if different from the applicant, at a Board meeting based on the need for additional information.
- C.** Notification. A pharmacy permittee shall notify the Board of changes involving the type of pharmacy operated, pharmacy area, ownership, address, telephone number, name of business, pharmacist-in-charge, or staff pharmacist.
- D.** If any nonprescription drugs are sold outside the pharmacy area when the pharmacy area is closed, the pharmacy permittee shall ensure that the business has a current, Board-issued nonprescription drug permit as required in Sections R4-23-602 and R4-23-603.
- E.** Change of ownership. Before any change of ownership occurs, a prospective owner shall submit the application packet described under subsection R4-23-606(B), except for changes of stock ownership of less than 30% of the voting stock of a corporation or an existing and continuing corporation that is actively traded on any securities market or over-the-counter market.
- F.** Before the relocation or remodel of an existing pharmacy, the pharmacy permittee shall submit the application packet described under subsection R4-23-606(B), except a fee is not required. The new or remodeled facility shall pass a final inspection by a Board compliance officer before operations begin.
- G.** A pharmacy permittee shall submit the application packet described under subsection R4-23-606(B) for any change of officers in a corporation, except a fee and final inspection are not required.

Historical Note

Former Rules 6.6010, 6.6020, 6.6030, 6.6040, 6.6050, 6.6060, 6.6071, 6.6072, 6.6073, 6.6074, 6.6075, and 6.6076. Amended effective August 10, 1978 (Supp. 78-4). Amended subsections (G) and (H) effective April 20, 1982 (Supp. 82-2). Amended subsection (L) effective July 2, 1982 (Supp. 82-4). Amended subsections (G) and (H) effective August 12, 1988 (Supp. 88-3). Amended effective November 1, 1993 (Supp. 93-4). Section heading amended effective April 5, 1996 (Supp. 96-2). Amended by final rulemaking at 7 A.A.R. 3825, effective August 9, 2001 (Supp. 01-3).

R4-23-607. Nonresident Permits

A. Permit. A person who is not a resident of Arizona shall not sell or distribute any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical into Arizona without:

1. Processing a current Board-issued nonresident pharmacy permit, nonresident manufacturer permit, nonresident full-service or nonprescription drug wholesale permit, or nonresident nonprescription drug permit;
2. Possessing a current equivalent license or permit issued by the licensing authority in the jurisdiction where the person or firm resides;
3. For a nonresident pharmacy, employing a pharmacist who is designated as the pharmacist-in-charge and who possesses a current Arizona Board-issued pharmacist license; and
4. For a nonresident pharmacy permit issued before April 7, 2007, complying with subsection (A)(3) and submitting to the Board the pharmacist-in-charge's name, current Arizona Board-issued pharmacist license number, and telephone number by November 1, 2007.

B. Application. To obtain a nonresident pharmacy, nonresident manufacturer, nonresident full-service or nonprescription drug wholesale, or nonprescription drug permit, a person shall submit a completed application, on a form furnished by the Board, that includes:

1. Business name, address, mailing address, if different, telephone number, and facsimile number;
2. Owner's name, if corporation or partnership, officers or partners, including address and title, and any other trade or business names used;
3. Whether the owner, corporation, or partnership has conducted a similar business in any other jurisdiction and if so, indicate under what name and location;
4. Whether the owner, any officer, or active partner has ever been convicted of an offense involving moral turpitude, a felony offense, or any drug-related offense or has any currently pending felony or drug-related charges, and if so, indicate charge, conviction date, jurisdiction, and location;
5. A copy of the applicant's current equivalent license or permit, issued by the licensing authority in the jurisdiction where the person or firm resides and required by subsection (A)(2);
6. For an application submitted because of ownership change, the former owner's name and business name, if different;
7. Date signed, and applicant's, corporate officer's, partner's, manager's, administrator's, pharmacist-in-charge's, or designated representative's verified signature and title; and
8. Fee specified in R4-23-205.

C. In addition to the requirements of subsection (B), the following information is required on the application:

1. Nonresident pharmacy.
 - a. The type of pharmacy;
 - b. Whether the owner, any officer, or active partner has ever been denied a pharmacy permit in this state or any other jurisdiction, and if so, indicate where and when;
 - c. If applying for a hospital pharmacy permit, the number of beds, manager's or administrator's name, and a copy of the hospital's current equivalent license or permit issued by the licensing authority in the jurisdiction where the person or firm resides;
 - d. Pharmacist-in-charge's name, current Arizona Board-issued pharmacist license number, and telephone number; and
 - e. For an application submitted because of ownership change, the former pharmacy's name, address, and permit number; and
 2. Nonresident manufacturer.
 - a. Whether the owner, any officer, or active partner has ever been denied a drug manufacturer permit in this state or any other jurisdiction, and if so, indicate where and when;
 - b. A copy of the drug list required by the FDA;
 - c. Manager's or responsible person's name, address, and emergency telephone number; and
 - d. The firm's current FDA drug manufacturer or repackager registration number and expiration date; and
 3. Nonresident full-service drug wholesaler.
 - a. The designated representative's name, address, and emergency telephone number;
 - b. Documentation that the designated representative meets the requirements of A.R.S. § 32-1982(B) and the following as specified in A.R.S. § 32-1982(C):
 - i. A full set of fingerprints from the designated representative; and
 - ii. The state and federal criminal history record check fee specified by and made payable to the Arizona State Department of Public Safety by money order, certified check, or bank draft; and
 - c. A \$100,000 bond as specified in A.R.S. § 32-1982(D) submitted on a form supplied by the Board; and
 4. Nonresident full-service or nonprescription drug wholesaler.
 - a. The type of drug wholesale permit;
 - b. Whether the owner, any officer, or active partner has ever been denied a drug wholesale permit in this state or any other jurisdiction, and if so, indicate where and when;
 - c. The types of drugs, nonprescription, prescription-only, controlled substances, human, or veterinary, the applicant will distribute;
 - d. Manager's or designated representative's name, address, emergency telephone number, and resumé indicating educational or experiential qualifications related to drug wholesale operation; and
 5. Nonresident nonprescription drug retailer.
 - a. Whether applying for Category I or Category II permit;
 - b. Date business started or planned opening date; and
 - c. Type of business, such as convenience, drug, grocery, or health food store, swap-meet vendor, or vending machine.
- D.** Before issuing a nonresident full-service drug wholesale permit, the Board shall:

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1. Receive and approve a completed permit application; and
 2. Issue a fingerprint clearance to a qualified designated representative, as specified in R4-23-605(L). If a nonresident full-service drug wholesaler permit applicant's designated representative's fingerprint clearance is denied, the nonresident full-service drug wholesaler permit applicant shall appoint another designated representative and submit the documentation, fingerprints, and fee required in subsection (C)(3)(b).
- E.** Notification. A permittee shall submit any notification of change required in this subsection as a written notice via mail, fax, or e-mail to the Executive Director within 10 days of the change, except any change of ownership requires that the nonresident permittee comply with subsection (F).
1. Nonresident pharmacy. A nonresident pharmacy permittee shall notify the Board of changes involving the type of pharmacy operated, ownership, address, telephone number, name of business, or pharmacist-in-charge.
 2. Nonresident manufacturer. A nonresident manufacturer permittee shall notify the Board of changes involving listed drugs, ownership, address, telephone number, name of business, or manager, including manager's telephone number.
 3. Nonresident drug wholesaler. A nonresident full-service or nonprescription drug wholesaler permittee shall notify the Board of changes involving the types of drugs sold or distributed, ownership, address, telephone number, name of business, or manager or designated representative, including the manager's or designated representative's telephone number. For a change of designated representative, a nonresident full-service drug wholesaler permittee shall submit the documentation, fingerprints, and fee required in subsection (C)(3)(b). If a nonresident full-service drug wholesaler permit applicant's designated representative's fingerprint clearance is denied, the nonresident full-service drug wholesaler permittee shall appoint another designated representative and submit the documentation, fingerprints, and fee required in subsection (C)(3)(b).
 4. Nonresident nonprescription drug retailer. A nonresident nonprescription drug permittee shall notify the Board of changes involving permit category, ownership, address, telephone number, name of business, or manager, including manager's telephone number.
- F.** Change of ownership. Before a change of ownership occurs that involves changes of stock ownership of more than 30% of the voting stock of a corporation or an existing and continuing corporation that is not actively traded on any securities market or over-the-counter market, the prospective owner shall submit the appropriate application packet described under subsections (B) and (C).
- G.** Drug sales.
1. Nonresident pharmacy. A nonresident pharmacy permittee shall:
 - a. Not sell, distribute, give away, or dispose of any narcotic or other controlled substance or prescription-only drug or device, to anyone in Arizona except:
 - i. A pharmacy, drug manufacturer, or full-service drug wholesaler currently permitted by the Board;
 - ii. A medical practitioner currently licensed under A.R.S. Title 32; or
 - iii. An Arizona resident upon receipt of a valid prescription order for the resident;
 - b. Not sell, distribute, give away, or dispose of any nonprescription drug, precursor chemical, or regulated chemical, to anyone in Arizona except:
 - i. A pharmacy, drug manufacturer, full-service or nonprescription drug wholesaler, or nonprescription drug retailer currently permitted by the Board;
 - ii. A medical practitioner currently licensed under A.R.S. Title 32; or
 - iii. An Arizona resident either upon receipt of a valid prescription order for the resident or in the original container packaged and labeled by the manufacturer;
 - c. Except for a drug sale that results from the receipt and dispensing of a valid prescription order for an Arizona resident, maintain a copy of the current permit or license of each person or firm in Arizona who buys, receives, or disposes of any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical; and
 - d. Provide permit and license records upon request, if immediately available, or in no less than two business days from the date of the request of a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901(5).
 2. Nonresident manufacturer. A nonresident manufacturer permittee shall:
 - a. Not sell, distribute, give away, or dispose of any narcotic or other controlled substance or prescription-only drug or device, to anyone in Arizona except, a pharmacy, drug manufacturer, or full-service drug wholesaler currently permitted by the Board or a medical practitioner currently licensed under A.R.S. Title 32;
 - b. Not sell, distribute, give away, or dispose of any nonprescription drug, precursor chemical, or regulated chemical, to anyone in Arizona except, a pharmacy, drug manufacturer, full-service or nonprescription drug wholesaler, or nonprescription drug retailer currently permitted by the Board or a medical practitioner currently licensed under A.R.S. Title 32;
 - c. Maintain a copy of the current permit or license of each person or firm in Arizona who buys, receives, or disposes of any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical; and
 - d. Provide permit and license records upon request, if immediately available, or in no less than two business days from the date of the request of a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901(5).
 3. Nonresident full-service drug wholesaler. In addition to complying with the distributions restrictions specified in A.R.S. § 32-1983, a nonresident full-service drug wholesaler permittee shall:
 - a. Not sell, distribute, give away, or dispose of, any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical to anyone in Arizona, except in the original container, packaged and labeled by the manufacturer or repackager;
 - b. Not package, repack, label, or relabel any narcotic or other controlled substance, prescription-

- only drug or device, nonprescription drug, precursor chemical, or regulated chemical for shipment or delivery to anyone in Arizona;
- c. Provide pedigree records upon request, if immediately available, or in no less than two business days from the date of the request of a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901(5);
 - d. Not sell, distribute, give away, or dispose of any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical to anyone in Arizona except a pharmacy, drug manufacturer, or full-service drug wholesaler currently permitted by the Board or a medical practitioner currently licensed under A.R.S. Title 32;
 - e. Not sell, distribute, give away, or dispose of, any nonprescription drug, precursor chemical, or regulated chemical, to anyone in Arizona except, a pharmacy, drug manufacturer, full-service or nonprescription drug wholesaler, or nonprescription drug retailer currently permitted by the Board or a medical practitioner currently licensed under A.R.S. Title 32;
 - f. Maintain a copy of the current permit or license of each person or firm in Arizona who buys, receives, or disposes of any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical; and
 - g. Provide permit and license records upon request, if immediately available, or in no less than two business days from the date of the request of a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901(5).
4. Nonresident nonprescription drug wholesaler. A nonresident nonprescription drug wholesale permittee shall:
 - a. Not sell, distribute, give away, or dispose of any nonprescription drug, precursor chemical, or regulated chemical to anyone in Arizona, except in the original container, packaged and labeled by the manufacturer or repackager;
 - b. Not package, repackage, label, or relabel any nonprescription drug, precursor chemical, or regulated chemical for shipment or delivery to anyone in Arizona;
 - c. Not sell, distribute, give away, or dispose of, any nonprescription drug, precursor chemical, or regulated chemical, to anyone in Arizona except, a pharmacy, drug manufacturer, full-service or nonprescription drug wholesaler, or nonprescription drug retailer currently permitted by the Board or a medical practitioner currently licensed under A.R.S. Title 32;
 - d. Maintain a copy of the current permit or license of each person or firm in Arizona who buys, receives, or disposes of any nonprescription drug, precursor chemical, or regulated chemical; and
 - e. Provide permit and license records upon request, if immediately available, or in no less than two business days from the date of the request of a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901(5).
 5. Nonresident nonprescription drug retailer. A nonresident nonprescription drug permittee shall not:
 - a. Sell, distribute, give away, or dispose of a nonprescription drug, precursor chemical, or regulated chemical to anyone in Arizona except in the original container packaged and labeled by the manufacturer;
 - b. Package, repackage, label, or relabel any drug, precursor chemical, or regulated chemical for shipment or delivery to anyone in Arizona; or
 - c. Sell, distribute, give away, or dispose of any drug, precursor chemical, or regulated chemical to anyone in Arizona that exceeds its expiration date, is contaminated or deteriorated from excessive heat, cold, sunlight, moisture, or other factors, or does not comply with federal law.
 - H. When selling or distributing any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical into Arizona, a nonresident pharmacy, nonresident manufacturer, nonresident full-service or nonprescription drug wholesale, or nonprescription drug permittee shall comply with federal law, the permittee's resident state drug law, and this Section.

Historical Note

Former Rules 6.6110, 6.6120, and 6.6130; Amended effective August 10, 1978 (Supp. 78-4). Repealed effective July 24, 1985 (Supp. 85-4). New Section adopted by final rulemaking at 6 A.A.R. 4589, effective November 14, 2000 (Supp. 00-4). Amended by final rulemaking at 7 A.A.R. 3825, effective August 9, 2001 (Supp. 01-3). Amended by final rulemaking at 10 A.A.R. 232, effective March 6, 2004 (Supp. 04-1). Amended by final rulemaking at 13 A.A.R. 520, effective April 7, 2007 (Supp. 07-1). Amended by final rulemaking at 13 A.A.R. 3477, effective December 1, 2007 (Supp. 07-4).

R4-23-608. Change of Personnel and Responsibility

- A. A community, hospital, or limited-service pharmacy permittee shall give the Board:
 1. Notice by mail, facsimile, or electronic mail within ten days of employing or terminating a pharmacist; and
 2. Immediate notice of designating or terminating a pharmacist-in-charge.
- B. Responsibility of ownership and management. The owner and management of a pharmacy shall:
 1. Ensure that pharmacists, interns, and other pharmacy employees comply with state and federal laws and administrative rules; and
 2. Not overrule a pharmacist in matters of pharmacy ethics and interpreting laws pertaining to the practice of pharmacy or the distribution of drugs and devices.
- C. The Board may suspend or revoke a pharmacy permit if the owner or management of a pharmacy violates subsection (B).

Historical Note

Former Rules 6.6140 and 6.6150; Amended subsection (A) effective August 9, 1983 (Supp. 83-4). Amended effective November 1, 1993 (Supp. 93-4). Amended by final rulemaking at 7 A.A.R. 4253, effective September 11, 2001 (Supp. 01-3).

R4-23-609. Pharmacy Area of Community Pharmacy

- A. Minimum area of community pharmacy. The minimum area of a community pharmacy, the actual area primarily devoted to stocking drugs restricted to pharmacists, and to the compounding and dispensing of prescription medication, exclusive of office area or other support function area, shall not be less than 300 square feet. A maximum of three pharmacy personnel may practice or work simultaneously in the minimum area. The pharmacy permittee shall provide an additional 60 square

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feet of floor area for each additional pharmacist, graduate intern, pharmacy intern, pharmacy technician, pharmacy technician trainee, or support personnel who may practice or work simultaneously. All of the allotted square footage area, including adequate shelving, shall lend itself to efficient pharmaceutical practice and permit free movement and visual surveillance of personnel by the pharmacist.

- B.** Compounding and dispensing counter. On or after January 6, 2004, a pharmacy permit applicant or remodel or relocation applicant shall provide a compounding and dispensing counter that provides a minimum of three square feet of pharmacy counter working area of not less than 16 inches in depth and 24 inches in length for the practice of one pharmacist, graduate intern, pharmacy intern, pharmacy technician, or pharmacy technician trainee. For each additional pharmacist, graduate intern, pharmacy intern, pharmacy technician, or pharmacy technician trainee practicing simultaneously, there shall be an additional three square feet of pharmacy counter working area of not less than 16 inches in depth and 24 inches in length. The Board shall determine a pharmacy's total required compounding and dispensing counter area by multiplying the maximum number of personnel allowed in the pharmacy area using the requirements specified in subsection (A) by three square feet per person. A pharmacy permittee or pharmacist-in-charge may operate the pharmacy with a total pharmacy counter working area specified in subsection (A) that is equal to the actual maximum number of pharmacists, graduate interns, pharmacy interns, pharmacy technicians, and pharmacy technician trainees, working simultaneously in the pharmacy area times three square feet per person.
- C.** Working area for compounding and dispensing counter. The aisle floor area used by the pharmacist, graduate intern, pharmacy intern, pharmacy technician, or pharmacy technician trainee at the compounding and dispensing counter shall extend the full length of the counter and be clear and continuous for a minimum of 36 inches from any counter, fixture, or structure.
- D.** Area for patient counseling. On or after April 1, 1995, a pharmacy permit applicant or remodel or relocation applicant shall provide a separate and distinct patient counseling area that provides patient privacy. This subsection does not apply to a pharmacy exempt from the requirements of R4-23-402(B).
- E.** Narcotic cabinet or safe. To prevent diversion, narcotics and other controlled substances may be:
 - 1. Kept in a separate locked cabinet or safe, or
 - 2. Dispersed throughout the pharmacy's prescription-only drug stock.
- F.** Building security standard of community pharmacy area. The pharmacy area shall be enclosed by a permanent barrier or partition from floor or counter to structural ceiling or roof, with entry doors that can be securely locked. The barrier shall be designed so that only a pharmacist can access the area where prescription-only drugs, narcotics, and other controlled substances are stored, compounded and dispensed. The permanent barrier may be constructed of other than a solid material. If constructed of a material other than a solid, the openings or interstices of the material shall not be large enough to permit removal of items in the pharmacy area through the barrier. Any material used in the construction of the permanent barrier must be of sufficient strength and thickness that it cannot be readily or easily removed, penetrated, or bent. The pharmacy permittee shall submit plans and specifications of the permanent barrier to the Board for approval.
- G.** Drug storage and security.
 - 1. The pharmacy permittee shall ensure that drugs and devices are stored in a dry, well-lit, ventilated, and clean

and orderly area. The pharmacy permittee shall maintain the drug storage area at temperatures that ensure the integrity of the drugs before dispensing as stated in the official compendium defined in A.R.S. § 32-1901(52) or the manufacturer's or distributor's labeling.

- 2. If the pharmacy permittee needs additional storage area for drugs that are restricted to sale by a pharmacist, the pharmacy permittee shall ensure that the area is contained by a permanent barrier from floor or counter to structural ceiling or roof. The pharmacy permittee shall lock all doors and gates to the drug storage area. Only a pharmacist with a key is permitted to enter the storage area, except in an extreme emergency.
- H.** A pharmacy permittee or pharmacist-in-charge shall ensure that the pharmacy working counter area is protected from unauthorized access while the pharmacy is open for business by a barrier not less than 66 inches in height or another method approved by the Board or its designee.

Historical Note

Former Rules 6.6210, 6.6220, 6.6230, 6.6240, 6.6250, 6.6310, 6.6320, and 6.6330; Amended effective August 10, 1978 (Supp. 78-4). Amended effective August 9, 1983 (Supp. 83-4). Amended effective November 1, 1993 (Supp. 93-4). Amended effective April 1, 1995; filed with the Secretary of State January 31, 1995 (Supp. 95-1). Amended by final rulemaking at 9 A.A.C. 5030, effective January 3, 2004 (Supp. 03-4).

R4-23-610. Community Pharmacy Personnel and Security Procedures

- A.** Every pharmacy shall have a pharmacist designated as the "pharmacist-in-charge."
 - 1. The pharmacist-in-charge shall ensure the communication and compliance of Board directives to the management, other pharmacists, interns, and technicians of the pharmacy.
 - 2. The pharmacist-in-charge shall:
 - a. Ensure that all pharmacy policies and procedures required under 4 A.A.C. 23 are prepared, implemented, and complied with;
 - b. Review biennially and, if necessary, revise all pharmacy policies and procedures required under 4 A.A.C. 23;
 - c. Document the review required under subsection (A)(2)(b);
 - d. Ensure that all pharmacy policies and procedures required under 4 A.A.C. 23 are assembled as a written or electronic manual; and
 - e. Make all pharmacy policies and procedures required under 4 A.A.C. 23 available in the pharmacy for employee reference and inspection by the Board or its staff.
- B.** Personnel permitted in the pharmacy area of a community pharmacy include pharmacists, graduate interns, pharmacy interns, compliance officers, drug inspectors, peace officers acting in their official capacity, other persons authorized by law, pharmacy technicians, pharmacy technician trainees, support personnel, and other designated personnel. Pharmacy interns, graduate interns, pharmacy technicians, pharmacy technician trainees, support personnel, and other designated personnel shall be permitted in the pharmacy area only when a pharmacist is on duty, except in an extreme emergency as defined in R4-23-110.
 - 1. The pharmacist-in-charge shall comply with the minimum area requirements as described in R4-23-609 for a

- community pharmacy and for compounding and dispensing counter area.
2. A pharmacist employed by a pharmacy shall ensure that the pharmacy is physically secure while the pharmacist is on duty.
- C.** In a community pharmacy, a pharmacist shall ensure that the pharmacy area, and any additional storage area for drugs that is restricted to access only by a pharmacist is locked when a pharmacist is not present, except in an extreme emergency.
- D.** A pharmacist is the only person permitted by the Board to unlock the pharmacy area or any additional storage area for drugs restricted to access only by a pharmacist, except in an extreme emergency.
- E.** A pharmacy permittee or pharmacist-in-charge shall ensure that any prescription-only drugs and controlled substances received in an area outside the pharmacy area are immediately transferred unopened to the pharmacy area. The pharmacist-in-charge shall ensure that any prescription-only drug and controlled substance shipments are opened and marked by pharmacy personnel in the pharmacy area under the supervision of a pharmacist, graduate intern, or pharmacy intern.
- F.** A pharmacy permittee or pharmacist-in-charge may provide a small opening or slot through which a written prescription order or prescription medication container to be refilled may be left in the prescription area when the pharmacist is not present.
- G.** A pharmacist shall ensure that prescription medication is not left outside the prescription area or picked up by the patient when the pharmacist is not present by either:
1. Delivering the prescription medication to the patient, or
 2. Securing the prescription medication inside the locked pharmacy, except when using an automated storage and distribution system that complies with the requirements of R4-23-614.

Historical Note

Former Rules 6.6410, 6.6420, 6.6430, 6.6440, 6.6450, 6.6460, 6.6470, 6.6480, and 6.6490; Amended subsection (F), deleted subsection (I) effective August 9, 1983 (Supp. 83-4). Amended effective May 16, 1990 (Supp. 90-2). Amended effective November 1, 1993 (Supp. 93-4). Amended effective April 1, 1995; filed with the Secretary of State January 31, 1995 (Supp. 95-1). Amended by final rulemaking at 5 A.A.R. 4441, effective November 2, 1999 (Supp. 99-4). Amended by final rulemaking at 10 A.A.R. 4453, effective December 4, 2004 (Supp. 04-4). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3). Amended by final rulemaking at 13 A.A.R. 2631, effective September 8, 2007 (Supp. 07-3).

R4-23-611. Pharmacy Facilities

- A.** Facilities. A pharmacy permittee or pharmacist-in-charge shall ensure that:
1. A pharmacy's facilities are constructed according to state and local laws and ordinances;
 2. A pharmacy facility's:
 - a. Walls, ceilings, windows, floors, shelves, and equipment are clean and in good repair and order; and
 - b. Counters, shelves, aisles, and open spaces are not cluttered;
 3. Adequate trash receptacles are provided and emptied periodically during the day;
 4. A pharmacy facility of any pharmacy permit issued or pharmacy remodeled after October 1, 2001 provides toilet facilities either:
 - a. Within the pharmacy area, or
 - b. No further than a walking distance of 50 feet from the pharmacy area;

5. The toilet facilities are maintained in a sanitary condition and in good repair;
 6. All professional personnel and staff of the pharmacy keep themselves and their apparel clean while in the pharmacy area;
 7. No animals, except licensed assistant animals and guard animals, are allowed in the pharmacy;
 8. The pharmacy facility is kept free of insects and rodents; and
 9. There is a sink with hot and cold running water, other than a sink in a toilet facility, within the pharmacy area for use in preparing drug products.
- B.** Supply of drugs and chemicals. A pharmacy permittee or pharmacist-in-charge shall ensure that:
1. A pharmacy maintains a stock of drugs and chemicals that:
 - a. Are sufficient to meet the normal demands of the trading area or patient base the pharmacy serves; and
 - b. Meet all standards of strength and purity as established by the official compendiums;
 2. All stock, materials, drugs, and chemicals held for ultimate sale or supply to the consumer are not contaminated;
 3. Policies and procedures are developed, implemented, and complied with to prevent the sale or use of a drug or chemical:
 - a. That exceeds its expiration date;
 - b. That is deteriorated or damaged by reason of age, heat, light, cold, moisture, crystallization, chemical reaction, rupture of coating, disintegration, solidification, separation, discoloration, change of odor, precipitation, or other change as determined by organoleptic examination or by other means;
 - c. That is improperly labeled;
 - d. Whose container is defective; or
 - e. That does not comply with federal law; and
 4. The policies and procedures described in subsection (B)(3):
 - a. Are made available in the pharmacy for employee reference and inspection by the Board or its designee; and
 - b. Provide the following:
 - i. Any expiration-dated drug or chemical is reviewed regularly;
 - ii. Any drug or chemical that exceeds its expiration date, is deteriorated or damaged, improperly labeled, has a defective container, or does not comply with federal law, is moved to a quarantine area and not sold or distributed; and
 - iii. Any quarantined drug or chemical is properly destroyed or returned to its source of supply.

Historical Note

Former Rules 6.6510, 6.6520, 6.6530, 6.6540, 6.6550, 6.6560, 6.6570, 6.6580, 6.6600, 6.6610, 6.6620, 6.6630, 6.6640, 6.6650, and 6.6660; Amended subsection (B) effective August 9, 1983 (Supp. 83-4). Amended effective April 1, 1995; filed with the Secretary of State January 31, 1995 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 4253, effective September 11, 2001 (Supp. 01-3). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3).

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R4-23-612. Equipment

A pharmacy permittee or pharmacist-in-charge shall ensure that a pharmacy has the necessary equipment to allow a pharmacist to practice the profession of pharmacy, including the following:

1. Adequate refrigeration equipment dedicated to the storage of drugs and biologicals;
2. A C-V controlled substance register, if C-V controlled substances are sold without an order of a medical practitioner;
3. Graduates in assorted sizes;
4. One mortar and pestle;
5. Spatulas of assorted sizes including one nonmetallic;
6. Prescription balance, Class A with weights or an electronic balance of equal or greater accuracy;
7. One ointment tile or equivalent;
8. A current hard-copy or access to a current electronic copy of the Arizona Pharmacy Act and administrative rules and Arizona Controlled Substance Act;
9. A professional reference library consisting of a minimum of one current reference or text, in hard-copy or electronic media, addressing the following subject areas:
 - a. Pharmacology or toxicology,
 - b. Therapeutics,
 - c. Drug compatibility, and
 - d. Drug product equivalency;
10. An assortment of labels, including prescription labels, transfer labels for controlled substances, and cautionary and warning labels;
11. A red C stamp as defined in R4-23-110, if C-III, C-IV, and C-V controlled substance invoices are not filed separately from other invoices;
12. Current antidote and drug interaction information; and
13. Regional poison control phone number prominently displayed in the pharmacy area.

Historical Note

Former Rule 6.6670; Former Section R4-23-612 repealed, new Section R4-23-612 adopted effective August 10, 1978 (Supp. 78-4). Amended effective August 9, 1983 (Supp. 83-4). Amended effective April 5, 1996 (Supp. 96-2).

Amended by final rulemaking at 7 A.A.R. 4253, effective September 11, 2001 (Supp. 01-3).

R4-23-613. Procedure for Discontinuing a Pharmacy

A. A pharmacy permittee or pharmacist-in-charge shall provide written notice to the Board and the Drug Enforcement Administration (D.E.A.) at least 14 days before discontinuing operation of the pharmacy. The notice shall contain the following information:

1. Name, address, pharmacy permit number, and D.E.A. registration number of the pharmacy discontinuing business;
2. Name, address, pharmacy permit number (if applicable), and D.E.A. registration number (if applicable) of the licensee, permittee, or registrant to whom any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical will be sold or transferred;
3. Name and address of the location where the discontinuing pharmacy's records of purchase and disbursement of any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical will be kept and the person responsible for the records. These records shall be kept for a minimum of three years from the date the pharmacy is discontinued;

4. Name and address of the location where the discontinuing pharmacy's prescription files and patient profiles will be kept and the person responsible for the files and profiles. These records shall be kept for a minimum of seven years from the date the last original or refill prescription was dispensed; and
5. The proposed date of discontinuing business operations.

B. The pharmacy permittee shall ensure that all pharmacy signs and symbols are removed from both the inside and outside of the premises.

C. The pharmacy permittee or pharmacist-in-charge shall ensure that all state permits and certificates of registration are returned to the Board office and that D.E.A. registration certificates and unused D.E.A. Schedule II order forms are returned to the D.E.A. Regional Office in Phoenix.

D. The pharmacist-in-charge of the pharmacy discontinuing business shall ensure that:

1. Only a pharmacist has access to the prescription-only drugs and controlled substances until they are transferred to the licensee, permittee, or registrant listed in subsection (A)(2);
2. All narcotics or other controlled substances, prescription-only drugs or devices, nonprescription drugs, precursor chemicals, or regulated chemicals are removed from the premises on or before the date the pharmacy is discontinued; and
3. All controlled substances are transferred as follows:
 - a. Take an inventory of all controlled substances that are transferred using the procedures in R4-23-1003;
 - b. Include a copy of the inventory with the controlled substances that are transferred;
 - c. Keep the original of the inventory with the discontinued pharmacy's records of narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical purchase and disbursement for a minimum of three years from the date the pharmacy is discontinued;
 - d. Use a D.E.A. form 222 to transfer any Schedule II controlled substances; and
 - e. Transfer controlled substances that need destruction in the same manner as all other controlled substances.

E. Upon receipt of outdated or damaged controlled substances from a discontinued pharmacy, the licensee, permittee, or registrant described in subsection (A)(2) shall contact a D.E.A. registered reverse distributor for proper destruction of outdated or damaged controlled substances. If there are controlled substances a reverse distributor will not accept, the licensee, permittee, or registrant shall then contact the Board office and request an inspection for the purpose of drug destruction.

F. During the three-year record retention period specified in subsection (A)(3), the person described in subsection (A)(3) shall provide to the Board upon its request a discontinued pharmacy's records of the purchase and disbursement of narcotics or other controlled substances, prescription-only drugs or devices, nonprescription drugs, precursor chemicals, or regulated chemicals.

G. During the seven-year record retention period specified in subsection (A)(4), the person described in subsection (A)(4) shall provide to the Board upon its request a discontinued pharmacy's records of prescription files and patient profiles.

Historical Note

New Section made by final rulemaking at 7 A.A.R. 3825, effective August 9, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 1105, effective April 30, 2005

(Supp. 05-1). Amended by final rulemaking at 12 A.A.R. 1912, effective July 1, 2006 (Supp. 06-2). Amended by final rulemaking at 14 A.A.R. 3670, effective November 8, 2008 (Supp. 08-3).

R4-23-614. Automated Storage and Distribution System

- A.** Before using an automated storage and distribution system, a pharmacy permittee or pharmacist-in-charge shall:
 1. Ensure that the automated storage and distribution system and the policies and procedures comply with subsection (B); and
 2. Notify the Board in writing of the intent to use an automated storage and distribution system, including the type or name of the system.
- B.** A pharmacy permittee or pharmacist-in-charge shall establish policies and procedures for appropriate performance and use of the automated storage and distribution system that:
 1. Ensure that the automated storage and distribution system is in good working order while maintaining appropriate recordkeeping and security safeguards;
 2. Ensure that an automated storage and distribution system used by the pharmacy that allows access to drugs or devices by a patient:
 - a. Only contains prescriptions that:
 - i. Do not require oral consultation as specified in R4-23-402(B); and
 - ii. Are properly labeled and verified by a pharmacist before placement into the automated storage and distribution system and subsequent release to patients;
 - b. Allows a patient to choose whether or not to use the system;
 - c. Is located either in a wall of a properly permitted pharmacy or within 20 feet of a properly permitted pharmacy if the automated storage and distribution system is secured against the wall or floor in such a manner that prevents the automated storage and distribution system's unauthorized removal;
 - d. Provides a method to identify the patient and only release that patient's prescriptions;
 - e. Is secure from access and removal of drugs or devices by unauthorized individuals;
 - f. Provides a method for a patient to obtain a consultation with a pharmacist if requested by the patient; and
 - g. Does not allow the system to dispense refilled prescriptions if a pharmacist determines that the patient requires oral counseling as specified in R4-23-402(B);
 3. Ensure that an automated storage and distribution system used by the pharmacy that allows access to drugs or devices only by authorized licensed personnel for the purposes of administration based on a valid prescription order or medication order:
 - a. Provides for adequate security to prevent unauthorized individuals from accessing or obtaining drugs or devices; and
 - b. Provides for the filling, stocking, or restocking of all drugs or devices in the system only by a Board licensee or other authorized licensed personnel; and
 4. Implement an ongoing quality assurance program that monitors compliance with the established policies and procedures of the automated storage and distribution system and federal and state law.
- C.** A pharmacy permittee or pharmacist-in-charge shall:

1. Ensure that the policies and procedures required under subsection (B) are prepared, implemented, and complied with;
 2. Review biennially and, if necessary, revise the policies and procedures required under subsection (B);
 3. Document the review required under subsection (C)(2);
 4. Assemble the policies and procedures as a written or electronic manual; and
 5. Make the policies and procedures available for employee reference and inspection by the Board or its staff within the pharmacy and at any location outside the pharmacy where the automated storage and distribution system is used.
- D.** The Board may prohibit a pharmacy permittee or pharmacist-in-charge from using an automated storage and distribution system if the pharmacy permittee or the pharmacy permittee's employees do not comply with the requirements of subsections (A), (B), or (C).

Historical Note

New Section made by final rulemaking at 13 A.A.R. 616, effective April 7, 2007 (Supp. 07-1).

R4-23-615. Mechanical Storage and Counting Device for a Drug in Solid, Oral Dosage Form

- A.** A pharmacy permittee or pharmacist-in-charge shall ensure that a mechanical storage and counting device for a drug in a solid, oral dosage form that is used by a pharmacist or a pharmacy intern, graduate intern, pharmacy technician, or pharmacy technician trainee under the supervision of a pharmacist complies with the following method to identify the contents of the device:
 1. The drug name and strength are affixed to the front of each cell or cassette of the device;
 2. A paper or electronic log is kept for each cell or cassette that contains:
 - a. An identification of the cell or cassette by the drug name and strength or the number of the cell or cassette;
 - b. The drug's manufacturer or National Drug Code (NDC) number;
 - c. The expiration date and lot number from the manufacturer's stock bottle that is used to fill the cell or cassette. If multiple lot numbers of the same drug are added to a cell or cassette, each lot number and expiration date shall be documented, and the earliest expiration date shall become the expiration date of the mixed lot of drug in the cell or cassette;
 - d. The date the cell or cassette is filled;
 - e. Documentation of the identity of the licensee who placed the drug into the cell or cassette; and
 - f. If the licensee who filled the cell or cassette is not a pharmacist, documentation of the identity of the pharmacist who supervised the non-pharmacist licensee who filled the cell or cassette; and
 3. The paper or electronic log is available in the pharmacy for inspection by the Board or its designee for not less than two years.
- B.** A pharmacy permittee or pharmacist-in-charge shall ensure that any drug previously counted by a mechanical storage and counting device for a drug in a solid, oral dosage form that has not left the pharmacy is not returned to the drug's cell, cassette, or stock bottle, unless the drug return method is approved by the Board or its designee as specified in subsection (G). This subsection does not prevent a pharmacy permittee or pharmacist-in-charge from using a manual or mechanical counting device to count and dispense a previously

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counted drug that has not left the pharmacy if the previously counted drug is dispensed before its beyond-use-date.

- C. A pharmacy permittee or pharmacist-in-charge shall ensure the accuracy of any mechanical storage and counting device for a drug in a solid, oral dosage form that is used by a pharmacist or a pharmacy intern, graduate intern, pharmacy technician, or pharmacy technician trainee under the supervision of a pharmacist by documenting completion of the following:
 1. Training in the maintenance, calibration, and use of the mechanical storage and counting device for each employee who uses the mechanical storage and counting device;
 2. Maintenance and calibration of the mechanical storage and counting device as recommended by the device's manufacturer; and
 3. Routine quality assurance and accuracy validation testing for each mechanical storage and counting device.
- D. A pharmacy permittee or pharmacist-in-charge shall ensure that the documentation required in subsection (C) is available for inspection by the Board or its designee.
- E. A pharmacy permittee or pharmacist-in-charge shall:
 1. Ensure that policies and procedures for the performance and use of a mechanical storage and counting device for a drug in a solid, oral dosage form are prepared, implemented, and complied with;
 2. Review biennially and, if necessary, revise the policies and procedures required under subsection (E)(1);
 3. Document the review required under subsection (E)(2);
 4. Assemble the policies and procedures as a written or electronic manual; and
 5. Make the policies and procedures available within the pharmacy for employee reference and inspection by the Board or its staff.
- F. The Board may prohibit a pharmacy permittee or pharmacist-in-charge from using a mechanical storage and counting device for a drug in a solid, oral dosage form if the pharmacy permittee or the pharmacy permittee's employees do not comply with the requirements of subsections (A), (B), (C), (D), or (E).
- G. Returning a drug previously counted by a mechanical storage and counting device for a drug in a solid, oral dosage form that has not left the pharmacy to the drug's cell or cassette.
 1. Before returning a drug previously counted by a mechanical storage and counting device that has not left the pharmacy to the drug's cell or cassette, a pharmacy permittee or pharmacist-in-charge shall:
 - a. Apply for approval from the Board or its designee for the drug return method to be used in returning the drug;
 - b. Develop a drug return method that uses technology, such as bar coding, to prevent drug return errors;
 - c. Provide documentation depicting the drug return method;
 - d. Demonstrate the drug return method for a Board Compliance Officer; and
 - e. Receive approval from the Board or its designee for the drug return method to be used in returning the drug.
 2. Before approving a request to waive the drug return prohibition in subsection (B), the Board or its designee shall:
 - a. Receive a request in writing from the pharmacy permittee or pharmacist-in-charge;
 - b. Review the documentation of the drug return method; and
 - c. Receive a satisfactory inspection report from a Board Compliance Officer that the drug return

method uses technology to prevent drug return errors.

Historical Note

New Section made by final rulemaking at 13 A.A.R. 616, effective April 7, 2007 (Supp. 07-1). Amended by final rulemaking at 14 A.A.R. 3677, effective November 8, 2008 (Supp. 08-3).

R4-23-616. Mechanical Counting Device for a Drug in Solid, Oral Dosage Form

- A. A pharmacy permittee or pharmacist-in-charge shall ensure the accuracy of any mechanical counting device for a drug in a solid, oral dosage form that is used by a pharmacist or a pharmacy intern, graduate intern, pharmacy technician, or pharmacy technician trainee under the supervision of a pharmacist by documenting completion of the following:
 1. Training in the maintenance, calibration, and use of the mechanical counting device for each employee who uses the mechanical counting device;
 2. Maintenance and calibration of the mechanical counting device as recommended by the device's manufacturer; and
 3. Routine quality assurance and accuracy validation testing for each mechanical counting device.
- B. A pharmacy permittee or pharmacist-in-charge shall ensure that the documentation required in subsection (A) is available for inspection by the Board or its designee.
- C. A pharmacy permittee or pharmacist-in-charge shall:
 1. Ensure that policies and procedures for the performance and use of a mechanical counting device for a drug in a solid, oral dosage form are prepared, implemented, and complied with;
 2. Review biennially and, if necessary, revise the policies and procedures required under subsection (C)(1);
 3. Document the review required under subsection (C)(2);
 4. Assemble the policies and procedures as a written or electronic manual; and
 5. Make the policies and procedures available within the pharmacy for employee reference and inspection by the Board or its staff.
- D. The Board may prohibit a pharmacy permittee or pharmacist-in-charge from using a mechanical counting device for a drug in a solid, oral dosage form if the pharmacy permittee or the pharmacy permittee's employees do not comply with the requirements of subsections (A), (B), or (C).

Historical Note

New Section made by final rulemaking at 13 A.A.R. 616, effective April 7, 2007 (Supp. 07-1).

R4-23-617. Temporary Pharmacy Facilities or Mobile Pharmacies

- A. Pharmacies located in declared disaster areas, nonresident pharmacies, and pharmacies licensed or permitted in another state but not licensed or permitted in this state, if necessary to provide pharmacy services during a declared state of emergency, may arrange to temporarily locate to a temporary pharmacy facility or mobile pharmacy or relocate to a temporary pharmacy facility or mobile pharmacy if the pharmacist-in-charge of the temporary pharmacy facility or mobile pharmacy ensures that:
 1. The pharmacy is under the control and management of the pharmacist-in-charge or a supervising pharmacist designated by the pharmacist-in-charge;
 2. The pharmacy is located within or adjacent to the declared disaster area;
 3. The Board is notified of the pharmacy's location;

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4. The pharmacy is properly secured to prevent theft and diversion of drugs;
 5. The pharmacy's records are maintained in accordance with Arizona statutes and rules; and
 6. The pharmacy stops providing pharmacy services when the declared state of emergency ends, unless it possesses a current resident pharmacy permit issued by the Board under A.R.S. §§ 32-1929, 32-1930, and 32-1931.
- B.** The Board shall have the authority to approve or deny temporary pharmacy facilities, mobile pharmacies, and shall make arrangements for appropriate monitoring and inspection of the temporary pharmacy facilities and mobile pharmacies on a case-by-case basis.
- C.** A temporary pharmacy facility wishing to permanently operate at its temporary site shall apply for and have received a permit issued under A.R.S. §§ 32-1929, 32-1930, and 32-1931 by following the application process under R4-23-606.
- D.** A mobile pharmacy, placed in operation during a declared state of emergency, shall not operate permanently.

Historical Note

New Section made by final rulemaking at 14 A.A.R. 4400, effective January 3, 2009 (Supp. 08-4).

R4-23-618. Reserved**R4-23-619. Reserved****R4-23-620. Continuous Quality Assurance Program**

- A.** Each pharmacy permittee shall implement or participate in a continuous quality assurance (CQA) program. A pharmacy permittee meets the requirements of this Section if it holds a current general, special or rural general hospital license from the Arizona Department of Health Services and is any of the following:
1. Certified by the Centers for Medicare and Medicaid Services to participate in the Medicare or Medicaid programs;
 2. Accredited by the Joint Commission on the Accreditation of Healthcare Organizations; or
 3. Accredited by the American Osteopathic Association.
- B.** A pharmacy permittee or the pharmacist-in-charge shall ensure that:
1. The pharmacy develops, implements, and utilizes a CQ program consistent with the requirements of this Section and A.R.S. § 32-1973;
 2. The medication error data generated by the CQA program is utilized and reviewed on a regular basis, as required by subsection (D); and
 3. Training records, policies and procedures, and other program records or documents, other than medication error data, are maintained for a minimum of two years in the pharmacy or in a readily retrievable manner.
- C.** A pharmacy permittee or pharmacist-in-charge shall:
1. Ensure that policies and procedures for the operation and management of the pharmacy's CQA program are prepared, implemented, and complied with;
 2. Review biennially and, if necessary, revise the policies and procedures required under subsection (C)(1);
 3. Document the review required under subsection (C)(2);
 4. Assemble the policies and procedures as a written or electronic manual; and
 5. Make the policies and procedures available within the pharmacy for employee reference and inspection by the Board or its staff.
- D.** The policies and procedures shall address a planned process to:

1. Train all pharmacy personnel in relevant phases of the CQA program;
 2. Identify and document medication errors;
 3. Record, measure, and analyze data collected to:
 - a. Assess the causes and any contributing factors relating to medication errors, and
 - b. Improve the quality of patient care;
 4. Utilize the findings from subsections (D)(2) and (3) to develop pharmacy systems and workflow processes designed to prevent or reduce medication errors; and
 5. Communicate periodically, and at least annually, with pharmacy personnel to review CQA program findings and inform pharmacy personnel of any changes made to pharmacy policies, procedures, systems, or processes as a result of CQA program findings.
- E.** The Board's regulatory oversight activities regarding a pharmacy's CQA program are limited to inspection of the pharmacy's CQA policies and procedures and enforcing the pharmacy's compliance with those policies and procedures.
- F.** A pharmacy's compliance with this Section shall be considered by the Board as a mitigating factor in the investigation and evaluation of a medication error.

Historical Note

New Section made by final rulemaking at 18 A.A.R. 2603, effective December 2, 2012 (Supp. 12-4).

R4-23-621. Shared Services

- A.** Before participating in shared services, a pharmacy shall have either a current resident or non-resident pharmacy permit issued by the Board.
- B.** A pharmacy may provide or utilize shared services functions only if the pharmacies involved:
1. Have the same owner; or
 2. Have a written contract or agreement that outlines the services provided and the shared responsibilities of each party in complying with federal and state pharmacy statutes and rules; and
 3. Share a common electronic file or technology that allows access to information necessary or required to perform shared services in conformance with the pharmacy act and the Board's rules.
- C.** Notifications to patients.
1. Before using shared services provided by another pharmacy, a pharmacy permittee shall:
 - a. Notify patients that their orders may be processed or filled by another pharmacy; and
 - b. Provide the name of that pharmacy or, if the pharmacy is part of a network of pharmacies under common ownership and any of the network pharmacies may process or fill the order, notify the patient of this fact. The notification may be provided through a one-time written notice to the patient or through use of a sign in the pharmacy.
 2. If an order is delivered directly to the patient by a filling pharmacy and not returned to the requesting pharmacy, the filling pharmacy permittee shall ensure that the following is placed on the prescription container or on a separate sheet delivered with the prescription container:
 - a. The local, and if applicable, the toll-free telephone number of the filling pharmacy; and
 - b. A statement that conveys to the patient or patient's care-giver the following information: "Written information about this prescription has been provided for you. Please read this information before you take the medication. If you have questions concerning this prescription, a pharmacist is available during normal

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business hours to answer these questions at (insert the filling pharmacy's local and toll-free telephone numbers)."

3. The provisions of subsection (C) do not apply to orders delivered to patients in facilities where a licensed health care professional is responsible for administering the prescription medication to the patient.

D. A pharmacy permittee engaged in shared services shall:

1. Maintain manual or electronic records that identify, individually for each order processed, the name, initials, or identification code of each pharmacist, graduate intern, pharmacy intern, pharmacy technician, and pharmacy technician trainee who took part in the order interpretation, order entry verification, drug utilization review, drug compatibility and drug allergy review, final order verification, therapeutic intervention, or refill authorization functions performed at that pharmacy;
2. Maintain manual or electronic records that identify, individually for each order filled or dispensed, the name, initials, or identification code of each pharmacist, graduate intern, pharmacy intern, pharmacy technician, and pharmacy technician trainee who took part in the filling, dispensing, and counseling functions performed at that pharmacy;
3. Report to the Board as soon as practical the results of any disciplinary action taken by another state's pharmacy regulatory agency involving shared services;
4. Maintain a mechanism for tracking the order during each step of the processing and filling procedures performed at the pharmacy;
5. Provide for adequate security to protect the confidentiality and integrity of patient information; and
6. Provide for inspection of any required record or information within 72 hours of any request by the Board or its designee.

E. Each pharmacy permittee provides or utilizes shared services shall develop, implement, review, revise, and comply with joint policies and procedures for shared services in the manner described in R4-23-610(A)(2). Each pharmacy permittee is required to maintain only those portions of the joint policies and procedures that relate to that pharmacy's operations. The policies and procedures shall:

1. Outline the responsibilities of each of the pharmacies;
2. Include a list of the name, address, telephone numbers, and all license and permit numbers of the pharmacies involved in shared services; and
3. Include policies and procedures for:
 - a. Notifying patients that their orders may be processed or filled by another pharmacy and providing the name of that pharmacy;
 - b. Protecting the confidentiality and integrity of patient information;
 - c. Dispensing orders when the filled order is not received or the patient comes in before the order is received;
 - d. Maintaining required manual or electronic records to identify the name, initials, or identification code and specific activity or activities of each pharmacist, graduate intern, pharmacy intern, pharmacy technician, or pharmacy technician trainee who performed any shared services;
 - e. Complying with federal and state laws; and
 - f. Operating a continuous quality improvement program for shared services, designed to objectively and systematically monitor and evaluate the quality and appropriateness of patient care, pursue opportu-

nities to improve patient care, and resolve identified problems.

F. Nothing in this Section shall prohibit an individual pharmacist licensed in Arizona, who is an employee of or under contract with a pharmacy, or an Arizona-licensed graduate intern, pharmacy intern, pharmacy technician, or pharmacy technician trainee, working under the supervision of the pharmacist, from accessing that pharmacy's electronic database from inside or outside the pharmacy and performing the order processing functions permitted by the pharmacy act, if both of the following conditions are met:

1. The pharmacy establishes controls to protect the confidentiality and integrity of patient information; and
2. None of the database is duplicated, downloaded, or removed from the pharmacy's electronic database.

Historical Note

New Section made by final rulemaking at 13 A.A.R. 520, effective April 7, 2007 (Supp. 07-1).

R4-23-622. Reserved

through

R4-23-650. Reserved

R4-23-651. Definitions

The following definitions apply to R4-23-651 through R4-23-659:

"Administration" means the giving of a dose of medication to a patient as a result of an order of a medical practitioner.

"Direct copy" means an electronic, facsimile or carbonized copy.

"Dispensing for hospital inpatients" means the interpreting, evaluating, and implementing a medication order including preparing for delivery a drug or device to an inpatient or inpatient's agent in a suitable container appropriately labeled for subsequent administration to, or use by, an inpatient (hereafter referred to as "dispensing").

"Drug distribution" means the delivery of drugs other than "administering" or "dispensing."

"Emergency medical situation" means a condition of emergency in which immediate drug therapy is required for the preservation of health, life, or limb of a person or persons.

"Floor stock" means a supply of essential drugs not labeled for a specific patient and maintained and controlled by the pharmacy at a patient care area for the purpose of timely administration to a patient of the hospital.

"Formulary" means a continually revised compilation of pharmaceuticals (including ancillary information) that reflects the current clinical judgment of the medical staff.

"Hospital pharmacy" means a pharmacy, as defined in A.R.S. § 32-1901, that holds a current permit issued by the Board pursuant to A.R.S. § 32-1931, and is located in a hospital as defined in A.R.S. § 32-1901.

"Inpatient" means any patient who receives non-self-administered drugs from a hospital pharmacy for use while within a facility owned by the hospital.

"Intravenous admixture" means a sterile parenteral solution to which one or more additional drug products have been added.

"Medication order" means a written, electronic, or verbal order from a medical practitioner or a medical practitioner's authorized agent for administration of a drug or device.

"On-call" means a pharmacist is available to:

Consult or provide drug information regarding drug therapy or related issues; or

Dispense a medication order and review a patient's medication order for pharmaceutical and therapeutic feasibility under R4-23-653(E)(2) before any drug is administered to a patient, except as specified in R4-23-653(E)(1).

"Patient care area" means any area for the primary purpose of providing a physical environment that is owned by or operated in conjunction with a hospital, for a patient to obtain health care services, except those areas where a physician, dentist, veterinarian, osteopath, or other medical practitioner engages primarily in private practice.

"Repackaged drug" means a drug product that is transferred by pharmacy personnel from an original manufacturer's container to another container properly labeled for subsequent dispensing.

"Satellite pharmacy" means a work area in a hospital setting under the direction of a pharmacist that is a remote extension of a centrally licensed hospital pharmacy and owned by and dependent upon the centrally licensed hospital pharmacy for administrative control, staffing, and drug procurement.

"Single unit" means a package of medication that contains one discrete pharmaceutical dosage form.

"Supervision" means the process by which a pharmacist directs the activities of hospital pharmacy personnel to a sufficient degree to ensure that all activities are performed accurately, safely, and without risk of harm to patients.

Historical Note

Former Rules 6.7110, 6.7120, and 6.7130; Amended effective August 10, 1978 (Supp. 78-4). Amended subsection (B) effective April 20, 1982 (Supp. 82-2). Section repealed, new Section adopted effective February 7, 1990 (Supp. 90-1). Amended effective November 1, 1993 (Supp. 93-4). Amended effective April 5, 1996 (Supp. 96-2). Amended by final rulemaking at 8 A.A.R. 4902, effective January 5, 2003 (Supp. 02-4).

R4-23-652. Hospital Pharmacy Permit

- A. The following rules are applicable to all hospitals as defined by A.R.S. § 32-1901 and hospital pharmacies as defined by R4-23-651.
- B. Before opening a hospital pharmacy, a person shall obtain a pharmacy permit as specified in R4-23-602 and R4-23-606.
- C. Discontinued hospitals. If a hospital license is discontinued by the state Department of Health Services, the pharmacy permittee or pharmacist-in-charge shall follow the procedures described in R4-23-613 for discontinuing a pharmacy.

Historical Note

Former Rules 6.7210, 6.7220, 6.7230, 6.7231, 6.7232, and 6.7233. Section repealed, new Section adopted effective February 7, 1990 (Supp. 90-1). Amended by final rulemaking at 8 A.A.R. 4902, effective January 5, 2003 (Supp. 02-4).

R4-23-653. Personnel: Professional or Technician

- A. Each hospital pharmacy shall be directed by a pharmacist who is licensed to engage in the practice of pharmacy in Arizona and is referred to as the Director of Pharmacy. The Director of Pharmacy shall be the pharmacist-in-charge, as defined in A.R.S. § 32-1901 or shall appoint a pharmacist-in-charge. The Director of Pharmacy and the pharmacist-in-charge, if a different individual, shall:
 1. Be responsible for all the activities of the hospital pharmacy and for meeting the requirements of the Arizona Pharmacy Act and these rules;
 2. Ensure that the policies and procedures required by these rules are prepared, implemented, and complied with;
 3. Review biennially and, if necessary, revise the policies and procedures required under these rules;
 4. Document the review required under subsection (A)(3);
 5. Assemble the policies and procedures as a written manual or by another method approved by the Board or its designee; and
 6. Make the policies and procedures available within the pharmacy for employee reference and inspection by the Board or its designee.

- B. In all hospitals, a pharmacist shall be in the hospital during the time the pharmacy is open for pharmacy services, except for an extreme emergency as defined in R4-23-110. Pharmacy services shall be provided for a minimum of 40 hours per week, unless an exception for less than the minimum hours is made upon written request by the hospital and with express permission of the Board or its designee.
- C. In a hospital where the pharmacy is not open 24 hours per day for pharmacy services, a pharmacist shall be "on-call" as defined in R4-23-651 when the pharmacy is closed.
- D. The Director of Pharmacy may be assisted by other personnel approved by the Director of Pharmacy in order to operate the pharmacy competently, safely, and adequately to meet the needs of the hospital's patients.
- E. Pharmacists. A pharmacist or a pharmacy intern or graduate intern under the supervision of a pharmacist shall perform the following professional practices:
 1. Verify a patient's medication order before administration of a drug to the patient, except:
 - a. In an emergency medical situation; or
 - b. In a hospital where the pharmacy is open less than 24 hours a day for pharmacy services, a pharmacist shall verify a patient's medication order within four hours of the time the pharmacy opens for pharmacy services;
 2. Verify a medication order's pharmaceutical and therapeutic feasibility based upon:
 - a. The patient's medical condition,
 - b. The patient's allergies,
 - c. The pharmaceutical and therapeutic incompatibilities, and
 - d. The recommended dosage limits;
 3. Measure, count, pour, or otherwise prepare and package a drug needed for dispensing, except a pharmacy technician or pharmacy technician trainee may measure, count, pour, or otherwise prepare and package a drug needed for dispensing under the supervision of a pharmacist according to written policies and procedures approved by the Board or its designee;
 4. Compound, admix, combine, or otherwise prepare and package a drug needed for dispensing, except a pharmacy technician may compound, admix, combine, or otherwise prepare and package a drug needed for dispensing under the supervision of a pharmacist according to written policies and procedures approved by the Board or its designee;
 5. Verify the accuracy, correct procedure, compounding, admixing, combining, measuring, counting, pouring, preparing, packaging, and safety of a drug prepared and packaged by a pharmacy technician or pharmacy technician trainee according to subsections (E)(3) and (4) and

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according to the policies and procedures in subsection (G);

6. Supervise drug repackaging and check the completed repackaged product as specified in R4-23-402(A);
 7. Supervise training and education in aseptic technique and drug incompatibilities for all personnel involved in the admixture of parenteral products within the hospital pharmacy;
 8. Consult with the medical practitioner regarding the patient's drug therapy or medical condition;
 9. When requested by a medical practitioner, patient, patient's agent, or when the pharmacist deems it necessary, provide consultation with a patient regarding the medication order, patient's profile, or overall drug therapy;
 10. Monitor a patient's drug therapy for safety and effectiveness;
 11. Provide drug information to patients and health care professionals;
 12. Manage the activities of pharmacy technicians, pharmacy technician trainees, other personnel, and systems to ensure that all activities are performed accurately, safely, and without risk of harm to patients;
 13. Verify the accuracy of all aspects of the original, completed medication order; and
 14. Ensure compliance by pharmacy personnel with a quality assurance program developed by the hospital.
- F.** Pharmacy technicians and pharmacy technician trainees. Before working as a pharmacy technician or pharmacy technician trainee, an individual shall meet the eligibility and licensure requirements prescribed in 4 A.A.C. 23, Article 11.
- G.** Pharmacy technician policies and procedures. Before employing a pharmacy technician or pharmacy technician trainee, a Director of Pharmacy or pharmacist-in-charge shall develop the policies and procedures required under R4-23-1104.
- H.** Pharmacy technician training program.
1. A Director of Pharmacy or pharmacist-in-charge shall comply with the training program requirements of R4-23-1105 based on the needs of the hospital pharmacy;
 2. A pharmacy technician or pharmacy technician trainee shall:
 - a. Perform only those tasks for which training and competency have been demonstrated; and
 - b. Not perform professional practices reserved for a pharmacist, graduate intern, or pharmacy intern in subsection (E), except as specified in subsections (E)(3) and (4).
- I.** Supervision. A hospital pharmacy's Director of Pharmacy and the pharmacist-in-charge, if a different individual, shall supervise all of the activities and operations of a hospital pharmacy. A pharmacist shall supervise all functions and activities of pharmacy technicians, pharmacy technician trainees, and other hospital pharmacy personnel to ensure that all functions and activities are performed competently, safely, and without risk of harm to patients.

Historical Note

Former Rules 6.7310 and 6.7320; Amended effective August 10, 1978 (Supp. 78-4). Section repealed, new Section adopted effective February 7, 1990 (Supp. 90-1). Amended effective November 1, 1993 (Supp. 93-4). Amended by final rulemaking at 8 A.A.R. 4902, effective January 5, 2003 (Supp. 02-4). Amended by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3).

R4-23-654. Absence of Pharmacist

- A.** If a pharmacist will not be on duty in the hospital, the Director of Pharmacy or pharmacist-in-charge shall arrange, before the pharmacist's absence, for the medical staff and other authorized personnel of the hospital to have access to drugs in the remote drug storage area defined in R4-23-110 or in the hospital pharmacy if a drug is not available in a remote drug storage area and is required to treat the immediate needs of a patient. A pharmacist shall be on-call during all absences.
- B.** If a pharmacist will not be on duty in the hospital pharmacy, the Director of Pharmacy or pharmacist-in-charge shall arrange, before the pharmacist's absence, for the medical staff and other authorized personnel of the hospital to have telephone access to an on-call pharmacist.
- C.** The hospital pharmacy permittee shall ensure that the hospital pharmacy is not without a pharmacist on duty in the hospital for more than 72 consecutive hours.
- D.** Remote drug storage area. The Director of Pharmacy or pharmacist-in-charge shall, in consultation with the appropriate committee of the hospital:
1. Develop and maintain an inventory listing of the drugs to be included in a remote drug storage area; and
 2. Develop, implement, review, and revise in the same manner described in R4-23-653(A) and comply with policies and procedures that ensure proper storage, access, and accountability for drugs in a remote drug storage area.
- E.** Access to hospital pharmacy. If a drug is not available from a remote drug storage area and the drug is required to treat the immediate needs of a patient whose health may be compromised, the drug may be obtained from the hospital pharmacy according to the requirements of this subsection.
1. The Director of Pharmacy or pharmacist-in-charge shall, in consultation with the appropriate committee of the hospital, develop, implement, review, and revise in the same manner described in R4-23-653(A) and comply with policies and procedures to ensure that access to the hospital pharmacy during the pharmacist's absence conforms to the following requirements:
 - a. Access is delegated to only one supervisory nurse in each shift;
 - b. The policy and name of supervisory nurse is communicated in writing to the medical staff of the hospital;
 - c. Access is delegated only to a nurse who has received training from the Director of Pharmacy, pharmacist-in-charge, or Director's designee in the procedures required for proper access, drug removal, and recordkeeping; and
 - d. Access is delegated by the supervisory nurse to another nurse only in an emergency.
 2. If a nurse to whom authority is delegated to access the hospital pharmacy removes a drug from the hospital pharmacy, the nurse shall:
 - a. Record the following information on a form or by another method approved by the Board or its designee:
 - i. Patient's name;
 - ii. Drug name, strength, and dosage form;
 - iii. Quantity of drug removed; and
 - iv. Date and time of removal;
 - b. Sign or initial, if a corresponding signature is on file in the hospital pharmacy, the form recording the drug removal;
 - c. Attach the original or a direct copy of the medication order for the drug to the form recording the drug removal; and

- d. Place the form recording the drug removal conspicuously in the hospital pharmacy.
3. Within four hours after a pharmacist returns from an absence, the pharmacist shall verify all records of drug removal that occurred during the pharmacist's absence according to R4-23-653(E).

Historical Note

Former Rules 6.7410, 6.7420, 6.7430, 6.7440, 6.7450, and 6.7460; Amended subsection (A) effective Aug. 9, 1983 (Supp. 83-4). Section repealed, new Section adopted effective February 7, 1990 (Supp. 90-1). Amended by final rulemaking at 8 A.A.R. 4902, effective January 5, 2003 (Supp. 02-4). Amended by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3).

R4-23-655. Physical Facility

- A. General. A hospital pharmacy permittee shall ensure that the hospital pharmacy has sufficient equipment and physical facilities for proper compounding, dispensing, and storage of drugs, including parenteral preparations.
- B. Minimum area of hospital pharmacy. The minimum area of a hospital pharmacy depends on the type of hospital, the number of beds, and the pharmaceutical services provided. Any hospital pharmacy permit issued or hospital pharmacy remodeled after January 31, 2003 shall provide a minimum hospital pharmacy area, the actual area primarily devoted to drug dispensing and preparation functions, exclusive of bulk drug storage, satellite pharmacy, and office areas that is not less than 500 square feet. The minimum area requirement, not including unusable area, may be varied upon approval by the Board for out-of-the-ordinary conditions or for systems that require less space.
- C. The Board may also require that a hospital pharmacy permittee or applicant provide:
 1. More than the minimum area if equipment, inventory, personnel, or other factors cause crowding to a degree that interferes with safe pharmacy practice;
 2. Additional dispensing, preparation, or storage areas because of the increased number of specific drugs prescribed per day, the increased use of intravenous and irrigating solutions, and the increased use of disposable and prepackaged products;
 3. Additional dispensing, preparation, or storage areas to handle investigational drugs, emergency drug kits, chemotherapeutics, alcohol and other flammables, poisons, external preparations, and radioisotopes, and to accommodate quality control procedures; and
 4. Additional office space to provide for an increased number of personnel, a drug information library, a poison information library, research support, teaching and conferences, and a waiting area.
- D. Hospital pharmacy area. A hospital pharmacy permittee shall ensure that the hospital pharmacy area is enclosed by a permanent barrier or partition from floor to ceiling with entry doors that can be securely locked, constructed according to R4-23-609(F).
- E. Hospital pharmacy storage areas. The hospital pharmacy permittee, Director of Pharmacy, or pharmacist-in-charge shall ensure that all undispensed or undistributed drugs are stored in designated areas within the hospital pharmacy or other locked areas under the control of a pharmacist that ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security.

Historical Note

Former Rules 6.7471, 6.7472, 6.7473, 6.7474, and 6.7490; Amended effective Aug. 9, 1983 (Supp. 83-4). Section repealed, new Section adopted effective February 7, 1990 (Supp. 90-1). Correction to Table 1 ("spare feet" changed to "square feet") (Supp. 91-1). Amended by final rulemaking at 8 A.A.R. 4902, effective January 5, 2003 (Supp. 02-4). Amended by final rulemaking at 11 A.A.R. 462, effective March 5, 2005 (Supp. 05-1).

R4-23-656. Sanitation and Equipment

A hospital pharmacy permittee or Director of Pharmacy shall ensure that a hospital pharmacy:

1. Has a professional reference library consisting of hard-copy or electronic media appropriate for the scope of pharmacy services provided by the hospital;
2. Has a sink, other than a sink in a toilet facility, that:
 - a. Has hot and cold running water;
 - b. Is within the hospital pharmacy area for use in preparing drug products; and
 - c. Is maintained in a sanitary condition and in good repair;
3. Maintains a room temperature within a range compatible with the proper storage of drugs;
4. Has a refrigerator and freezer with a temperature maintained within a range compatible with the proper storage of drugs requiring refrigeration or freezing; and
5. Has a designated area for a laminar air flow hood and other supplies required for the preparation of sterile products as specified in R4-23-670.

Historical Note

Former Rule 6.7480. Section repealed, new Section adopted effective February 7, 1990 (Supp. 90-1). Amended by final rulemaking at 8 A.A.R. 4902, effective January 5, 2003 (Supp. 02-4).

R4-23-657. Security

- A. Personnel security standards. A Director of Pharmacy shall ensure that:
 1. No one is permitted in the pharmacy unless a pharmacist is present except as provided in this Section and R4-23-654. If only one pharmacist is on duty in the pharmacy and that pharmacist must leave the pharmacy for an emergency or patient care duties, nonpharmacist personnel may remain in the pharmacy to perform duties as outlined in R4-23-653, provided that all C-II controlled substances are secured to prohibit access by other than a pharmacist, and that the pharmacist remains available in the hospital;
 2. All hospital pharmacy areas are kept locked by key or programmable lock to prevent access by unauthorized personnel; and
 3. Pharmacists, pharmacy or graduate interns, pharmacy technicians, pharmacy technician trainees, and other personnel working in the pharmacy wear identification badges, including name and position, whenever on duty.
- B. Prescription blank security. The Director of Pharmacy shall develop, implement, review, and revise in the same manner described in R4-23-653(A) and comply with policies and procedures for the safe distribution and control of prescription blanks bearing identification of the hospital.

Historical Note

Former Rule 6.7500; Amended effective Aug. 9, 1983 (Supp. 83-4). Section repealed, new Section adopted effective February 7, 1990 (Supp. 90-1). Amended by final rulemaking at 8 A.A.R. 4902, effective January 5, 2003 (Supp. 02-4). Amended by final rulemaking at 10

A.A.R. 1192, effective May 1, 2004 (Supp. 04-1).
Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3).

R4-23-658. Drug Distribution and Control

- A. General.** The Director of Pharmacy or pharmacist-in-charge shall in consultation with the medical staff, develop, implement, review, and revise in the same manner described in R4-23-653(A) and comply with written policies and procedures for the effective operation of a drug distribution system that optimizes patient safety.
- B. Responsibility.** The Director of Pharmacy is responsible for the safe and efficient procurement, dispensing, distribution, administration, and control of drugs, including the following:
1. In consultation with the appropriate department personnel and medical staff committee, develop a medication formulary for the hospital;
 2. Proper handling, distribution, and recordkeeping of investigational drugs; and
 3. Regular inspections of drug storage and preparation areas within the hospital.
- C. Physician orders.** A Director of Pharmacy or pharmacist-in-charge shall ensure that:
1. Drugs are dispensed from the hospital pharmacy only upon a written order, direct copy or facsimile of a written order, or verbal order of an authorized medical practitioner; and
 2. A pharmacist reviews the original, direct or facsimile copy, or verbal order before an initial dose of medication is administered, except as specified in R4-23-653(E)(1).
- D. Labeling.** A Director of Pharmacy or pharmacist-in-charge shall ensure that all drugs distributed or dispensed by a hospital pharmacy are packaged in appropriate containers and labeled as follows:
1. For use inside the hospital.
 - a. Labels for all single unit packages contain at a minimum, the following information:
 - i. Drug name, strength, and dosage form;
 - ii. Lot number and beyond-use-date; and
 - iii. Appropriate auxiliary labels;
 - b. Labels for repackaged preparations contain at a minimum the following information:
 - i. Drug name, strength, and dosage form;
 - ii. Lot number and beyond-use-date;
 - iii. Appropriate auxiliary labels; and
 - iv. Mechanism to identify pharmacist accountable for repackaging;
 - c. Labels for all intravenous admixture preparations contain at a minimum the following information:
 - i. Patient's name and location;
 - ii. Name and quantity of the basic parenteral solution;
 - iii. Name and amount of drug added;
 - iv. Date of preparation;
 - v. Beyond-use-date and time;
 - vi. Guidelines for administration;
 - vii. Appropriate auxiliary label or precautionary statement; and
 - viii. Initials of pharmacist responsible for admixture preparation; and
 2. For use outside the hospital. Any drug dispensed to a patient by a hospital pharmacy that is intended for self-administration outside of the hospital is labeled as specified in A.R.S. §§ 32-1963.01(C) and 32-1968(D) and A.A.C. R4-23-402.
- E. Controlled substance accountability.** A Director of Pharmacy or pharmacist-in-charge shall ensure that effective policies and

procedures are developed, implemented, reviewed, and revised in the same manner described in R4-23-653(A) and complied with regarding the use, accountability, and record-keeping of controlled substances in the hospital, including the use of locked storage areas when controlled substances are stored in patient care areas.

- F. Emergency services dispensing.** If a hospital permits dispensing of drugs from the emergency services department when the pharmacy is unable to provide this service, the Director of Pharmacy, in consultation with the appropriate department personnel and medical staff committee shall develop, implement, review, and revise in the same manner described in R4-23-653(A) and comply with written policies and procedures for dispensing drugs for outpatient use from the hospital's emergency services department. The policies and procedures shall include the following requirements:
1. Drugs are dispensed only to patients who have been admitted to the emergency services department;
 2. Drugs are dispensed only by an authorized medical practitioner, not a designee or agent;
 3. The nature and type of drugs available for dispensing are designed to meet the immediate needs of the patients treated within the hospital;
 4. Drugs are dispensed only in quantities sufficient to meet patient needs until outpatient pharmacy services are available;
 5. Drugs are prepackaged by a pharmacist or a pharmacy intern, graduate intern, pharmacy technician, or pharmacy technician trainee under the supervision of a pharmacist in suitable containers and appropriately prelabeled with the drug name, strength, dosage form, quantity, manufacturer, lot number, beyond-use-date, and any appropriate auxiliary labels;
 6. Upon dispensing, the authorized medical practitioner completes the label on the prescription container that complies with the requirements of R4-23-658(D); and
 7. The hospital pharmacy maintains a dispensing log, hard-copy prescription, or electronic record, approved by the Board or its designee and includes the patient name and address, drug name, strength, dosage form, quantity, directions for use, medical practitioner's signature or identification code, and DEA registration number, if applicable.

Historical Note

Former Rules 6.7610, 6.7620, and 6.7710; Amended effective Aug. 9, 1983 (Supp. 83-4). Section repealed, new Section adopted effective February 7, 1990 (Supp. 90-1). Correction to subsection (I)(5) ("unnecessary" changed to "necessary") (Supp. 91-1). Amended effective November 1, 1993 (Supp. 93-4). Amended by final rulemaking at 8 A.A.R. 4902, effective January 5, 2003 (Supp. 02-4). Amended by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3).

R4-23-659. Administration of Drugs

- A. Self-administration.** A hospital shall not allow self-administration of medications by a patient unless the Director of Pharmacy or pharmacist-in-charge, in consultation with the appropriate department personnel and medical staff committee, develops, implements, reviews, and revises in the same manner described in R4-23-653(A) and complies with policies and procedures for self-administration of medications by a patient. The policies and procedures shall specify that self-administration of medications, if allowed, occurs only when:

1. Specifically ordered by a medical practitioner, and
 2. The patient is educated and trained in the proper manner of self-administration.
- B.** Drugs brought in by a patient. If a hospital allows a patient to bring a drug into the hospital and before a patient brings a drug into the hospital, the Director of Pharmacy or pharmacist-in-charge shall, in consultation with the appropriate department personnel and medical staff committee, develop, implement, review, and revise in the same manner described in R4-23-653(A) and comply with policies and procedures for a patient-owned drug brought into the hospital. The policies and procedures shall specify the following criteria for a patient-owned drug brought into the hospital:
1. When policy allows the administration of a patient-owned drug, the drug is not administered to the patient unless:
 - a. A pharmacist or medical practitioner identifies the drug, and
 - b. A medical practitioner writes a medication order specifying administration of the identified patient-owned drug; and
 2. If a patient-owned drug will not be used during the patient's hospitalization, the hospital pharmacy's personnel shall:
 - a. Package, seal, and give the drug to the patient's agent for removal from the hospital; or
 - b. Package, seal, and store the drug for return to the patient at the time of discharge from the hospital.
- C.** Drug samples. The Director of Pharmacy or pharmacist-in-charge is responsible for the receipt, storage, distribution, and accountability of drug samples within the hospital, including developing, implementing, reviewing, and revising in the same manner described in R4-23-653(A) and complying with specific policies and procedures regarding drug samples.

Historical Note

Former Rules 6.7720, 6.7730, 6.7740, 6.7760, 6.7770, 6.7780, 6.7800, 6.7810, 6.7820, 6.7830, 6.7840, 6.7850, 6.7871, 6.7872, and 6.7873; Amended effective Aug. 9, 1983 (Supp. 83-4). Section repealed, new Section adopted effective February 7, 1990 (Supp. 90-1). Correction to Section heading ("rules" changed to "roles") (Supp. 91-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 4902, effective January 5, 2003 (Supp. 02-4). Amended by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3).

R4-23-660. Investigational Drugs

The Director of Pharmacy or pharmacist-in-charge shall ensure that:

1. The following information concerning an investigational drug is available for use by hospital personnel:
 - a. Composition,
 - b. Pharmacology,
 - c. Adverse reactions,
 - d. Administration guidelines, and
 - e. All other available information concerning the drug, and
2. An investigational drug is:
 - a. Properly stored in, labeled, and dispensed from the pharmacy, and
 - b. Not dispensed before the drug is approved by the appropriate medical staff committee of the hospital.

Historical Note

Former Rules 6.7881, 6.7882, and 6.7883; Amended sub-

section (A) effective Aug. 9, 1983 (Supp. 83-4).

Repealed, new Section adopted effective February 7, 1990 (Supp. 90-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 4902, effective January 5, 2003 (Supp. 02-4).

R4-23-661. Repealed**Historical Note**

Former Rules 6.7910, 6.7920, 6.7930, 6.7940, and 6.7950. Section repealed, new Section adopted effective February 7, 1990 (Supp. 90-1). Section repealed by final rulemaking at 8 A.A.R. 4902, effective January 5, 2003 (Supp. 02-4).

R4-23-662. Repealed**Historical Note**

Adopted effective February 7, 1990 (Supp. 90-1). Section repealed by final rulemaking at 8 A.A.R. 4902, effective January 5, 2003 (Supp. 02-4).

R4-23-663. Repealed**Historical Note**

Adopted effective February 7, 1990 (Supp. 90-1). Amended effective November 1, 1993 (Supp. 93-4). Section repealed by final rulemaking at 8 A.A.R. 4902, effective January 5, 2003 (Supp. 02-4).

R4-23-664. Repealed**Historical Note**

Adopted effective February 7, 1990 (Supp. 90-1). Subsection label removed (Supp. 91-1). Section repealed by final rulemaking at 8 A.A.R. 4902, effective January 5, 2003 (Supp. 02-4).

R4-23-665. Reserved

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R4-23-669. Reserved**R4-23-670. Sterile Pharmaceutical Products**

- A.** In addition to the minimum area requirement of R4-23-609(A) and R4-23-655(B) and before compounding a sterile pharmaceutical product, a pharmacy permittee, limited-service pharmacy permittee, or applicant shall provide a minimum sterile pharmaceutical product compounding area that is not less than 100 square feet of contiguous floor area, except any pharmacy permit issued or pharmacy remodeled before November 1, 2006 may continue to use a sterile pharmaceutical product compounding area that is not less than 60 square feet of contiguous floor area, until a pharmacy ownership change occurs that requires issuance of a new permit or the pharmacy is remodeled. The pharmacy permittee or the pharmacist-in-charge shall ensure that the sterile pharmaceutical product compounding area:

1. Is dedicated to the purpose of preparing and compounding sterile pharmaceutical products;
2. Is isolated from other pharmacy functions;
3. Restricts entry or access;
4. Is free from unnecessary disturbances in air flow;
5. Is made of non-porous and cleanable floor, wall, and ceiling material; and
6. Meets the minimum air cleanliness standards of an ISO Class 7 environment as defined in R4-23-110, except an ISO class 7 environment is not required if all sterile pharmaceutical product compounding occurs within an ISO class 5 environment isolator, such as a glove box, phar-

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maceutical isolator, barrier isolator, pharmacy isolator, or hospital pharmacy isolator.

- B.** In addition to the equipment requirements in R4-23-611 and R4-23-612 or R4-23-656 and before compounding a sterile pharmaceutical product, a pharmacy permittee, limited-service pharmacy permittee, or applicant shall ensure that a pharmacist who compounds a sterile pharmaceutical product has the following equipment:

1. Environmental control devices capable of maintaining a compounding area environment equivalent to an "ISO class 5 environment" as defined in R4-23-110. Devices capable of meeting these standards include: laminar air-flow hoods, hepa filtered zonal airflow devices, glove boxes, pharmaceutical isolators, barrier isolators, pharmacy isolators, hospital pharmacy isolators, and biological safety cabinets;
2. Disposal containers designed for needles, syringes, and other material used in compounding sterile pharmaceutical products and if applicable, separate containers to dispose of cytotoxic, chemotherapeutic, and infectious waste products;
3. Freezer storage units with thermostatic control and thermometer, if applicable;
4. Packaging or delivery containers capable of maintaining official compendial drug storage conditions;
5. Infusion devices and accessories, if applicable; and
6. In addition to the reference library requirements of R4-23-612, a current reference pertinent to the preparation of sterile pharmaceutical products.

- C.** Before compounding a sterile pharmaceutical product, the pharmacy permittee, limited-service pharmacy permittee, or pharmacist-in-charge shall:

1. Prepare, implement, and comply with policies and procedures for compounding and dispensing sterile pharmaceutical products,
2. Review biennially and if necessary revise the policies and procedures required under subsection (C)(1),
3. Document the review required under subsection (C)(2),
4. Assemble the policies and procedures as a written manual or by another method approved by the Board or its designee, and
5. Make the policies and procedures available in the pharmacy for employee reference and inspection by the Board or its designee.

- D.** The assembled policies and procedures shall include, where applicable, the following subjects:

1. Supervisory controls and verification procedures to ensure the quality and safety of sterile pharmaceutical products;
2. Clinical services and drug monitoring procedures for:
 - a. Patient drug utilization reviews;
 - b. Inventory audits;
 - c. Patient outcome monitoring;
 - d. Drug information; and
 - e. Education of pharmacy and other health professionals;
3. Controlled substances;
4. Supervisory controls and verification procedures for:
 - a. Cytotoxics handling, storage, and disposal;
 - b. Disposal of unused supplies and pharmaceutical products; and
 - c. Handling and disposal of infectious wastes;
5. Pharmaceutical product administration, including guidelines for the first dosing of a pharmaceutical product;
6. Drug and component procurement;

7. Pharmaceutical product compounding, dispensing, and storage;
8. Duties and qualifications of professional and support staff;
9. Equipment maintenance;
10. Infusion devices and pharmaceutical product delivery systems;
11. Investigational drugs and their protocols;
12. Patient profiles;
13. Patient education and safety;
14. Quality management procedures for:
 - a. Adverse drug reactions;
 - b. Drug recalls;
 - c. Expired pharmaceutical products;
 - d. Beyond-use-dating for both standard-risk and substantial-risk sterile pharmaceutical products consistent with the requirements of R4-23-410(B)(3)(d);
 - e. Temperature and other environmental controls;
 - f. Documented process and product validation testing; and
 - g. Semi-annual certification of the laminar air flow hood or other ISO class 5 environment, other equipment, and the ISO class 7 environment, including documentation of routine cleaning and maintenance for each laminar air flow hood or other ISO class 5 environment, other equipment, and the ISO class 7 environment; and
15. Sterile pharmaceutical product delivery requirements for:
 - a. Shipment to the patient;
 - b. Security; and
 - c. Maintaining official compendial storage conditions.

- E.** Standard-risk sterile pharmaceutical product compounding. Before compounding a standard-risk sterile pharmaceutical product, a pharmacy permittee or pharmacist-in-charge shall ensure compliance with the following minimum standards:

1. Compounding occurs only in an ISO class 5 environment within an ISO class 7 environment, and the ISO class 7 environment may have a specified prep area inside the environment;
2. Compounding sterile pharmaceutical products from sterile commercial drugs or sterile pharmaceutical otic or ophthalmic products from non-sterile ingredients occurs using procedures that involve only a few closed-system, basic, simple aseptic transfers and manipulations;
3. Each person who compounds wears adequate personnel protective clothing for sterile preparation that includes gown, gloves, head cover, and booties. Each person who compounds is not required to wear personnel protective clothing when all sterile pharmaceutical compounding occurs within an ISO class 5 environment isolator, and the ISO Class 5 environment isolator is not inside an ISO Class 7 environment; and
4. Each person who compounds completes an annual media-fill test to validate proper aseptic technique.

- F.** Substantial-risk sterile pharmaceutical product compounding. Before compounding a substantial-risk sterile pharmaceutical product, a pharmacy permittee or pharmacist-in-charge shall ensure compliance with the following minimum standards:

1. Compounding parenteral or injectable sterile pharmaceutical products from non-sterile ingredients occurs only in an ISO class 5 environment within an ISO class 7 environment and the ISO class 7 environment shall not have a prep area inside the environment;
2. Each person who compounds wears adequate personnel protective clothing for sterile preparation that includes gown, gloves, head cover, and booties. Each person who

compounds is not required to wear personnel protective clothing when all sterile pharmaceutical compounding occurs within an ISO class 5 environment isolator, and the ISO Class 5 environment isolator is not inside an ISO Class 7 environment; and

3. Each person who compounds completes a semi-annual media-fill test that simulates the most challenging or stressful conditions for compounding using dry non-sterile media to validate proper aseptic technique.

Historical Note

Adopted effective November 1, 1993 (Supp. 93-4). Amended by final rulemaking at 10 A.A.R. 3391, effective October 2, 2004 (Supp. 04-3). Amended by final rulemaking at 12 A.A.R. 3981, effective December 4, 2006 (Supp. 06-4).

R4-23-671. General Requirements for Limited-service Pharmacy

- A. Before opening a limited-service pharmacy, a person shall obtain a permit in compliance with A.R.S. §§ 32-1929, 32-1930, 32-1931, and R4-23-606.
- B. The limited-service pharmacy permittee shall secure the limited-service pharmacy by conforming with the following standards:
 1. Permit no one to be in the limited-service pharmacy unless the pharmacist-in-charge or a pharmacist authorized by the pharmacist-in-charge is present;
 2. Require the pharmacist-in-charge to designate in writing, by name, title, and specific area, those persons who will have access to particular areas of the limited-service pharmacy;
 3. Implement procedures to guard against theft or diversion of drugs, including controlled substances; and
 4. Require all persons working in the limited-service pharmacy to wear badges, with their names and titles, while on duty.
- C. To obtain permission to deviate from the minimum area requirement set forth in R4-23-609, R4-23-673, or R4-23-682, a limited-service pharmacy permittee shall submit a written request to the Board and include documentation that the deviation will facilitate experimentation or technological advances in the practice of pharmacy as defined in A.R.S. § 32-1901. If the Board determines the requested deviation from the minimum area requirement will enhance the practice of pharmacy and benefit the public, the Board shall grant the requested deviation.
- D. The Board shall require more than the minimum area in a limited-service pharmacy when the Board determines that equipment, personnel, or other factors in the limited-service pharmacy cause crowding that interferes with safe pharmacy practice.
- E. Before dispensing from a limited-service pharmacy, the limited-service pharmacy permittee or pharmacist-in-charge shall:
 1. Prepare, implement, and comply with written policies and procedures for pharmacy operations and drug dispensing and distribution,
 2. Review biennially and if necessary revise the policies and procedures required under subsection (E)(1),
 3. Document the review required under subsection (E)(2),
 4. Assemble the policies and procedures as a written manual or by another method approved by the Board or its designee, and
 5. Make the policies and procedures available in the pharmacy for employee reference and inspection by the Board or its designee.

Historical Note

Adopted effective April 5, 1996 (Supp. 96-2). Amended by final rulemaking at 9 A.A.R. 1064, effective May 4, 2003 (Supp. 03-1). Amended by final rulemaking at 10 A.A.R. 3391, effective October 2, 2004 (Supp. 04-3). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3).

R4-23-672. Limited-service Correctional Pharmacy

- A. The limited-service pharmacy permittee shall ensure that the limited-service correctional pharmacy complies with the standards for area, personnel, security, sanitation, equipment, drug distribution and control, administration of drugs, drug source, quality assurance, investigational drugs, and inspections as set forth in R4-23-608, R4-23-609(A) through (D) and (F) through (H), R4-23-610(A), R4-23-611, R4-23-612, R4-23-653(E), R4-23-658(B) through (E), R4-23-659, and R4-23-660.
- B. The pharmacist-in-charge of a limited-service correctional pharmacy shall authorize only pharmacists, interns, pharmacy technicians, pharmacy technician trainees, compliance officers, drug inspectors, peace officers, and correctional officers acting in their official capacities, other persons authorized by law, support personnel, and other designated personnel to be in the limited-service correctional pharmacy.
- C. When no pharmacist will be on duty in the correctional facility, the pharmacist-in-charge shall arrange, before there is no pharmacist on duty, for the medical staff and other authorized personnel of the correctional facility to have access to drugs in remote drug storage areas or, if a drug is not available in a remote drug storage area and is required to treat the immediate needs of a patient, in the limited-service correctional pharmacy.
 1. The pharmacist-in-charge shall, in consultation with the appropriate committee of the correctional facility, develop and implement procedures to ensure that remote drug storage areas:
 - a. Contain only properly labeled drugs that might reasonably be needed and can be administered safely during the pharmacist's absence,
 - b. Contain drugs packaged only in amounts sufficient for immediate therapeutic requirements,
 - c. Are accessible only with a physician's written order,
 - d. Provide a written record of each drug withdrawn,
 - e. Are inventoried at least once each week, and
 - f. Are audited for compliance with the requirements of this rule at least once each month.
 2. The pharmacist-in-charge shall, in consultation with the appropriate committee of the correctional facility, develop and implement procedures to ensure that access to the limited-service correctional pharmacy when no pharmacist is on duty conforms to the following requirements:
 - a. Is delegated to only one nurse, who is in a supervisory position;
 - b. Is communicated in writing to medical staff of the correctional facility;
 - c. Is delegated only to a nurse who has received training from the pharmacist-in-charge in proper methods of access, removal of drugs, and recordkeeping procedures; and
 - d. Is delegated by the supervisory nurse to another nurse only in an emergency.
 3. When a nurse to whom authority to access the limited-service correctional pharmacy is delegated removes a drug from the limited-service correctional pharmacy, the nurse shall:

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- a. Record the following information on a form:
 - i. Patient's name,
 - ii. Name of the drug and its strength and dosage form,
 - iii. Dose prescribed,
 - iv. Amount of drug removed, and
 - v. Date and time of removal;
 - b. Sign the form recording the drug removal;
 - c. Attach the original or a direct copy of a physician's written order for the drug to the form recording the drug removal; and
 - d. Place the form recording the drug removal conspicuously in the limited-service correctional pharmacy.
4. Within four hours after a pharmacist in the limited-service correctional pharmacy returns to duty following an absence in which the limited-service correctional pharmacy was accessed by a nurse to whom authority had been delegated, the pharmacist shall verify all records of drug removal according to R4-23-402.
- D.** When no pharmacist will be on duty in the correctional facility, the pharmacist-in-charge shall arrange, before there is no pharmacist on duty, for the medical staff and other authorized personnel of the correctional facility to have telephone access to a pharmacist.
- E.** The limited-service pharmacy permittee shall ensure that the limited-service correctional pharmacy is not without a pharmacist on duty for more than 96 consecutive hours.
- F.** In addition to the requirements of R4-23-671, the limited-service pharmacy permittee shall secure the limited-service correctional pharmacy as follows:
1. Permit no one to be in the limited-service correctional pharmacy unless a pharmacist is on duty except:
 - a. As provided in subsection (C)(3) when a pharmacist is not on duty; or
 - b. A pharmacy technician or pharmacy technician trainee may remain to perform duties in R4-23-1104(A), when a pharmacist is on duty and available in the correctional facility but temporarily absent from the pharmacy, provided:
 - i. All controlled substances are secured in a manner that prohibits access by persons other than a pharmacist;
 - ii. Activities performed by a pharmacy technician or pharmacy technician trainee while the pharmacist is temporarily absent are verified by the pharmacist immediately upon returning to the pharmacy;
 - iii. Any drug measured, counted, poured, or otherwise prepared and packaged by a pharmacy technician or pharmacy technician trainee while the pharmacist is temporarily absent is verified by the pharmacist immediately upon returning to the pharmacy; and
 - iv. Any drug that has not been verified by a pharmacist for accuracy is not dispensed, supplied, or distributed while the pharmacist is temporarily absent from the pharmacy; and
 2. Provide keyed or programmable locks to all areas of the limited-service correctional pharmacy.
- G.** The pharmacist-in-charge of a limited-service correctional pharmacy shall ensure that the written policies and procedures for pharmacy operations and drug distribution within the correctional facility include the following:
1. Physicians' orders, prescription orders, or both;
 2. Authorized abbreviations;
 3. Formulary system;
 4. Clinical services and drug utilization management including:
 - a. Participation in drug selection,
 - b. Drug utilization reviews,
 - c. Inventory audits,
 - d. Patient outcome monitoring,
 - e. Committee participation,
 - f. Drug information, and
 - g. Education of pharmacy and other health professionals;
 5. Duties and qualifications of professional and support staff;
 6. Products of abuse and contraband medications;
 7. Controlled substances;
 8. Drug administration;
 9. Drug product procurement;
 10. Drug compounding, dispensing, and storage;
 11. Stop orders;
 12. Pass or discharge medications;
 13. Investigational drugs and their protocols;
 14. Patient profiles;
 15. Quality management procedures for:
 - a. Adverse drug reactions;
 - b. Drug recalls;
 - c. Expired and beyond-use-date drugs;
 - d. Medication or dispensing errors;
 - e. Drug storage; and
 - f. Education of professional staff, support staff, and patients;
 16. Recordkeeping;
 17. Sanitation;
 18. Security;
 19. Access to remote drug storage areas by non-pharmacists; and
 20. Access to limited-service correctional pharmacy by non-pharmacists.

Historical Note

Adopted effective April 5, 1996 (Supp. 96-2). Amended by final rulemaking at 10 A.A.R. 4453, effective December 4, 2004 (Supp. 04-4).

R4-23-673. Limited-service Mail-order Pharmacy

- A.** The limited-service pharmacy permittee shall design and construct the limited-service mail-order pharmacy to conform with the following requirements:
1. A dispensing area devoted to stocking, compounding, and dispensing prescription medications, which is physically separate from a non-dispensing area devoted to non-dispensing pharmacy services;
 2. A dispensing area of at least 300 square feet if three or fewer persons work in the dispensing area simultaneously;
 3. A dispensing area that provides 300 square feet plus 60 square feet for each person in excess of three persons if more than three persons work in the dispensing area simultaneously;
 4. Space in the dispensing area permits efficient pharmaceutical practice, free movement of personnel, and visual surveillance by the pharmacist;
 5. A non-dispensing area of at least 30 square feet for each person working simultaneously in the non-dispensing area; and
 6. Space in the non-dispensing area permits free movement of personnel and visual surveillance by the pharmacist; or

- B.** The limited-service pharmacy permittee shall design and construct the limited-service mail-order pharmacy to conform with the following requirements:
1. A contiguous area in which both dispensing and non-dispensing pharmacy services are provided;
 2. A contiguous area of at least 300 square feet if three or fewer persons work in the area simultaneously;
 3. A contiguous area that provides 300 square feet plus 60 square feet for each person in excess of three persons if more than three persons work in the area simultaneously; and
 4. Space in the contiguous area permits efficient pharmaceutical practice, free movement of personnel, and visual surveillance by the pharmacist.
- C.** The limited-service pharmacy permittee shall ensure that the limited-service mail-order pharmacy complies with the standards for area, personnel, security, sanitation, and equipment set forth in R4-23-608, R4-23-609(B) through (H), R4-23-610 (A) and (C) through (F), R4-23-611, and R4-23-612.
- D.** The pharmacist-in-charge of a limited-service mail-order pharmacy shall authorize only pharmacists, interns, pharmacy technicians, pharmacy technician trainees, compliance officers, drug inspectors, peace officers acting in their official capacities, support personnel, other persons authorized by law, and other designated personnel to be in the limited-service mail-order pharmacy.
- E.** The pharmacist-in-charge of a limited-service mail-order pharmacy shall ensure that prescription medication is delivered to the patient or locked in the dispensing area when a pharmacist is not present in the pharmacy.
- F.** In addition to the delivery requirements of R4-23-402, the limited-service pharmacy permittee shall, during regular hours of operation but not less than five days and a minimum 40 hours per week, provide toll-free telephone service to facilitate communication between patients and a pharmacist who has access to patient records at the limited-service mail-order pharmacy. The limited-service pharmacy permittee shall disclose this toll-free number on a label affixed to each container of drugs dispensed from the limited-service mail-order pharmacy.
- G.** The pharmacist-in-charge of a limited-service mail-order pharmacy shall ensure that the written policies and procedures for pharmacy operations and drug distribution include the following:
1. Prescription orders;
 2. Clinical services and drug utilization management for:
 - a. Drug utilization reviews,
 - b. Inventory audits,
 - c. Patient outcome monitoring,
 - d. Drug information, and
 - e. Education of pharmacy and other health professionals;
 3. Duties and qualifications of professional and support staff;
 4. Controlled substances;
 5. Drug product procurement;
 6. Drug compounding, dispensing, and storage;
 7. Patient profiles;
 8. Quality management procedures for:
 - a. Adverse drug reactions,
 - b. Drug recalls,
 - c. Expired and beyond-use-date drugs,
 - d. Medication or dispensing errors, and
 - e. Education of professional and support staff;
 9. Recordkeeping;
 10. Sanitation;
 11. Security;

12. Drug delivery requirements for:
 - a. Transportation,
 - b. Security,
 - c. Temperature and other environmental controls,
 - d. Emergency provisions, and
13. Patient education.

Historical Note

Adopted effective April 5, 1996 (Supp. 96-2). Amended by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 10 A.A.R. 4453, effective December 4, 2004 (Supp. 04-4).

R4-23-674. Limited-service Long-term Care Pharmacy

- A.** A limited-service pharmacy permittee shall ensure that the limited-service long-term care pharmacy complies with:
1. The general requirements of R4-23-671;
 2. The professional practice standards of Article 4 and Article 11; and
 3. The permits and drug distribution standards of R4-23-606 through R4-23-612, R4-23-670, and this Section.
- B.** If a limited-service long-term care pharmacy permittee contracts with a long-term care facility as a Provider Pharmacy, as defined in R4-23-110, the limited-service long-term care pharmacy permittee shall ensure that:
1. The limited-service long-term care pharmacy employs or contracts with a long-term care consultant pharmacist; and
 2. The long-term care consultant pharmacist and the pharmacist-in-charge of the limited-service long-term care pharmacy comply with R4-23-701, R4-23-701.01, R4-23-701.02, and R4-23-701.03, and this Section.
- C.** The limited-service long-term care pharmacy permittee or pharmacist-in-charge shall ensure that prescription medication is delivered to the patient's long-term care facility or locked in the dispensing area of the pharmacy when a pharmacist is not present in the pharmacy.
- D.** The pharmacist-in-charge of a limited-service long-term care pharmacy shall authorize only those individuals listed in R4-23-610(B) to be in the limited-service long-term care pharmacy.
- E.** In consultation with the long-term care facility's medical director and director of nursing, the long-term care consultant pharmacist and pharmacist-in-charge of the long-term care facility's provider pharmacy may develop, if necessary, a medication formulary for the long-term care facility that ensures the safe and efficient procurement, dispensing, distribution, administration, and control of drugs in the long-term care facility.
- F.** The limited-service long-term care pharmacy permittee or pharmacist-in-charge shall ensure that the written policies and procedures required in R4-23-671(E) include the following:
1. Clinical services and drug utilization management for:
 - a. Drug utilization reviews,
 - b. Inventory audits,
 - c. Patient outcome monitoring,
 - d. Drug information, and
 - e. Education of pharmacy and other health professionals;
 2. Controlled substances;
 3. Drug compounding, dispensing, and storage;
 4. Drug delivery requirements for:
 - a. Transportation,
 - b. Security,
 - c. Temperature and other environmental controls, and
 - d. Emergency provisions;
 5. Drug product procurement;

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6. Duties and qualifications of professional and support staff;
7. Emergency drug supply unit procedures;
8. Formulary, including development, review, modification, use, and documentation, if applicable;
9. Patient profiles;
10. Patient education;
11. Prescription orders;
12. Quality management procedures for:
 - a. Adverse drug reactions,
 - b. Drug recalls,
 - c. Expired and beyond-use-date drugs,
 - d. Medication or dispensing errors, and
 - e. Education of professional and support staff;
13. Recordkeeping;
14. Sanitation; and
15. Security.

Historical Note

New Section made by final rulemaking at 9 A.A.R. 1064, effective May 4, 2003 (Supp. 03-1). Amended by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1).

R4-23-675. Limited-service Sterile Pharmaceutical Products Pharmacy

- A.** The limited-service pharmacy permittee or the pharmacist-in-charge shall ensure that the limited-service sterile pharmaceutical products pharmacy complies with the standards for area, personnel, security, sanitation, equipment, sterile pharmaceutical products, and limited-service pharmacies established in R4-23-608, R4-23-609, R4-23-610, R4-23-611, R4-23-612, R4-23-670, and R4-23-671.
- B.** The pharmacist-in-charge of a limited-service sterile pharmaceutical products pharmacy shall authorize only pharmacists, interns, compliance officers, peace officers acting in their official capacities, pharmacy technicians, pharmacy technician trainees, support personnel, and other designated personnel to be in the limited-service sterile pharmaceutical products pharmacy.
- C.** The pharmacist-in-charge of a limited-service sterile pharmaceutical products pharmacy shall ensure that prescription medication is delivered to the patient or locked in the dispensing area when a pharmacist is not present in the pharmacy.
- D.** In addition to the delivery requirements of R4-23-402, the limited-service pharmacy permittee shall, during regular hours of operation, but not less than a minimum 40 hours per week, provide toll-free telephone service to facilitate communication between patients and a pharmacist who has access to patient records at the limited-service sterile pharmaceutical products pharmacy. The limited-service pharmacy permittee shall disclose this toll-free number on a label affixed to each container dispensed from the limited-service sterile pharmaceutical products pharmacy.
- E.** The limited-service pharmacy permittee or the pharmacist-in-charge shall ensure development, implementation, review and revision in the same manner described in R4-23-671(E) and compliance with policies and procedures for pharmacy operations, including pharmaceutical product compounding, dispensing, and distribution, that comply with the requirements of R4-23-402, R4-23-410, R4-23-670, and R4-23-671.
- F.** The non-dispensing roles of the pharmacist may include chart reviews, audits, drug therapy monitoring, committee participation, drug information, and in-service training of pharmacy and other health professionals.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 3391, effective October 2, 2004 (Supp. 04-3). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3).

R4-23-676. Reserved

through

R4-23-680. Reserved**R4-23-681. General Requirements for Limited-service Nuclear Pharmacy**

- A.** To be an authorized nuclear pharmacist, a pharmacist shall:
 1. Hold a current pharmacist license issued by the Board; and
 2. Be certified as a nuclear pharmacist by:
 - a. The Board of Pharmaceutical Specialties, or
 - b. A similar group recognized by the Arizona State Board of Pharmacy; or
 3. Satisfy each of the following requirements:
 - a. Meet minimal standards of training for status as an authorized user of radioactive material, as specified by the Arizona Radiation Regulatory Agency and the United States Nuclear Regulatory Commission;
 - b. Submit certification of completion of a Board-approved nuclear pharmacy training program or other training program recognized by the Arizona Radiation Regulatory Agency, with 200 hours of didactic training in the following areas:
 - i. Radiation physics and instrumentation,
 - ii. Radiation protection,
 - iii. Mathematics pertaining to the use and measurement of radioactivity,
 - iv. Radiation biology, and
 - v. Radiopharmaceutical chemistry;
 - c. Submit evidence of a minimum of 500 hours of clinical/practical nuclear pharmacy training under the supervision of an authorized nuclear pharmacist in the following areas:
 - i. Procuring radioactive materials;
 - ii. Compounding radiopharmaceuticals;
 - iii. Performing routine quality control procedures;
 - iv. Dispensing radiopharmaceuticals;
 - v. Distributing radiopharmaceuticals;
 - vi. Implementing basic radiation protection procedures; and
 - vii. Consulting and educating the nuclear medicine community, patients, pharmacists, other health professionals, and the general public; and
 - d. Submit written certification, signed by a preceptor who is an authorized nuclear pharmacist, that the above training was satisfactorily completed.
- B.** Radiopharmaceuticals are prescription-only drugs that require specialized techniques in their handling and testing, to obtain optimum results and minimize hazards.
 1. A person shall not sell, barter, or otherwise dispose of, or be in possession of any radiopharmaceutical except under the conditions detailed in A.R.S. § 32-1929.
 2. A person shall not manufacture, compound, sell, or dispense any radiopharmaceutical unless the person is a pharmacist or a pharmacy intern acting under the direct supervision of a pharmacist in accordance with A.R.S. § 32-1961 and these rules, with the exception of the following, if the following are licensed by the Arizona Radiation Regulatory Agency to use radiopharmaceuticals in compliance with A.R.S. § 30-673;

- a. A medical practitioner who administers a radiopharmaceutical to the medical practitioner's patient as provided in A.R.S. § 32-1921(A),
 - b. A hospital nuclear medicine department, and
 - c. A medical practitioner's office.
- 3. The Board shall cooperate with the Arizona Radiation Regulatory Agency and other interested state and federal agencies, in the enforcement of these rules for the protection of the public. This cooperation may include exchange of licensing and other information, joint inspections, and other activities where indicated.
- C. In addition to compliance with all the applicable federal and state laws and rules governing drugs, whether radioactive or not, a limited-service nuclear pharmacy permittee shall comply with all laws and rules of the Arizona Radiation Regulatory Agency and the U.S. Nuclear Regulatory Commission, including emergency and safety provisions.
- D. A limited-service nuclear pharmacy permittee shall comply with the education, experience, and licensing requirements of the Arizona Radiation Regulatory Agency.
- E. A limited-service nuclear pharmacy permittee shall ensure that radiopharmaceuticals are transferred only to a person or firm that holds a current Radioactive Materials License issued by the Arizona Radiation Regulatory Agency.

Historical Note

Adopted effective December 3, 1974 (Supp. 75-1).
 Amended subsections (A), (C) and (D) effective Aug. 12, 1988 (Supp. 88-3). Amended effective July 8, 1997 (Supp. 97-3).

R4-23-682. Limited-service Nuclear Pharmacy

- A. Before operating a limited-service nuclear pharmacy, a person shall obtain a permit in compliance with A.R.S. §§ 32-1929, 32-1930, and 32-1931, and R4-23-606.
- B. A permit to operate a limited-service nuclear pharmacy shall be issued only to a person who is or employs an authorized nuclear pharmacist and holds a current Arizona Radiation Regulatory Agency Radioactive Materials License. A limited-service nuclear pharmacy permittee that fails to maintain a current Arizona Radiation Regulatory Agency Radioactive Materials License shall be immediately suspended pending revocation by the Board. A limited-service nuclear pharmacy permittee shall have copies of Arizona Radiation Regulatory Agency inspection reports available upon request for Board inspection.
 - 1. A limited-service nuclear pharmacy permittee shall designate an authorized nuclear pharmacist as the pharmacist-in-charge. The pharmacist-in-charge shall be responsible to the Board:
 - a. For the operations of the pharmacy related to the practice of pharmacy and distribution of drugs and devices;
 - b. For communicating Board directives to the management, pharmacists, interns, and other personnel of the pharmacy; and
 - c. For the pharmacy's compliance with all federal and state pharmacy laws and rules.
 - 2. An authorized nuclear pharmacist shall directly supervise all personnel performing tasks in the preparation and distribution of radiopharmaceuticals and ancillary drugs.
 - 3. An authorized nuclear pharmacist shall be present whenever the limited-service nuclear pharmacy is open for business.
- C. A limited-service nuclear pharmacy permittee shall ensure that the limited-service nuclear pharmacy complies with the standards for personnel, area, security, sanitation, and general requirements in R4-23-608, R4-23-609, R4-23-610, R4-23-611, and R4-23-671.
 - 1. A limited-service nuclear pharmacy shall contain separate areas for:
 - a. Preparing and dispensing radiopharmaceuticals,
 - b. Receiving and shipping radiopharmaceuticals,
 - c. Storing radiopharmaceuticals, and
 - d. Decaying radioactive waste.
 - 2. The Board may require more than the minimum area in instances where equipment, inventory, personnel, or other factors cause crowding to a degree that interferes with safe pharmacy practice.
- D. The pharmacist-in-charge shall designate in writing, by title and specific area, the persons who may have access to particular pharmacy areas.
- E. A limited-service nuclear pharmacy permittee shall maintain records of acquisition, inventory, and disposition of radiopharmaceuticals, other radioactive substances, and other drugs in accordance with federal and state statutes and rules.
 - 1. A prescription order, in addition to the requirements in A.R.S. § 32-1968(C) and R4-23-407(A), shall contain:
 - a. The date and time of calibration of the radiopharmaceutical,
 - b. The name of the procedure for which the radiopharmaceutical is prescribed, and
 - c. The words "Physician's Use Only" instead of the name of the patient if the radiopharmaceutical is nontherapeutic or for a nonblood product.
 - 2. The lead container used to store and transport a radiopharmaceutical shall have a label that, in addition to the requirements in A.R.S. § 32-1968(D), includes:
 - a. The date and time of calibration of the radiopharmaceutical,
 - b. The name of the radiopharmaceutical,
 - c. The molybdenum 99 content to USP limits,
 - d. The name of the procedure for which the radiopharmaceutical is prescribed,
 - e. The words "Physician's Use Only" instead of the name of the patient if the radiopharmaceutical is nontherapeutic or for a nonblood product,
 - f. The words "Caution: Radioactive Material," and
 - g. The standard radiation symbol.
 - 3. The radiopharmaceutical container shall have a label that includes:
 - a. The date and time of calibration of the radiopharmaceutical;
 - b. The name of the patient, recorded before dispensing, if the radiopharmaceutical is therapeutic or for a blood product;
 - c. The words "Physician's Use Only" instead of the name of the patient if the radiopharmaceutical is nontherapeutic or for a nonblood product;
 - d. The name of the radiopharmaceutical;
 - e. The dose of radiopharmaceutical;
 - f. The serial number;
 - g. The words "Caution: Radioactive Material"; and
 - h. The standard radiation symbol.
- F. The following minimum requirements are in addition to the requirements of the Arizona Radiation Regulatory Agency, the applicable U.S. Nuclear Regulatory Commission regulations, and the applicable regulations of the federal Food and Drug Administration. A limited-service nuclear pharmacy permittee shall provide:
 - 1. In addition to the minimum pharmacy area requirements in R4-23-609:

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- a. An area for the storing, compounding, and dispensing of radiopharmaceuticals completely separate from pharmacy areas for nonradioactive drugs;
- b. A minimum of 80 sq. ft. for a hot lab and storage area; and
- c. A minimum of 300 sq. ft. of compounding and dispensing area;
2. The following equipment:
 - a. Fume hood, approved by the Arizona Radiation Regulatory Agency;
 - b. Laminar flow hood;
 - c. Dose calibrator;
 - d. Refrigerator;
 - e. Prescription balance, Class A, and weights or an electronic balance of equal or greater accuracy;
 - f. Well scintillation counter;
 - g. Incubator oven;
 - h. Microscope;
 - i. An assortment of labels, including prescription labels and cautionary and warning labels;
 - j. Glassware necessary for compounding and dispensing radiopharmaceuticals as required by the Arizona Radiation Regulatory Agency;
 - k. Other equipment necessary for radiopharmaceutical quality control for products compounded or dispensed as required by the Arizona Radiation Regulatory Agency;
 - l. Current antidote and drug interaction information; and
 - m. Regional poison control phone number prominently displayed in the pharmacy area;
3. Supplies necessary for compounding and dispensing radiopharmaceuticals as required by the Arizona Radiation Regulatory Agency;
4. A professional reference library consisting of a minimum of one current reference or text addressing each of the following subject areas:
 - a. Therapeutics,
 - b. Nuclear pharmacy practice, and
 - c. Imaging;
5. Current editions and supplements of:
 - a. A.R.S. §§ 30-651 through 30-696 pertaining to the Arizona Radiation Regulatory Agency,
 - b. Rules of the Arizona Radiation Regulatory Agency,
 - c. Regulations of the federal Food and Drug Administration pertaining to radioactive drugs,
 - d. Arizona Pharmacy Act and rules,
 - e. Arizona Uniform Controlled Substances Act, and
 - f. Radiological Health Handbook.
- G. The pharmacist-in-charge of a limited-service nuclear pharmacy shall prepare, implement, review, and revise in the same manner described in R4-23-671(E) and comply with written policies and procedures for pharmacy operations and drug distribution.
- H. The written policies and procedures of a limited-service nuclear pharmacy shall include the following:
 1. Prescription orders;
 2. Clinical services and drug utilization management including:
 - a. Drug utilization reviews,
 - b. Inventory audits,
 - c. Patient outcome monitoring,
 - d. Drug information, and
 - e. Education of pharmacy and other health professionals;
 3. Duties and qualifications of professional and support staff;
 4. Radioactive material handling, storage, and disposal;
 5. Drug product procurement;
 6. Drug compounding, dispensing, and storage;
 7. Investigational drugs and their protocols;
 8. Patient profiles;
 9. Quality management procedures for:
 - a. Adverse drug reaction reports;
 - b. Drug recall;
 - c. Expired and beyond-use-date drugs;
 - d. Medication or dispensing errors;
 - e. Radiopharmaceutical quality assurance;
 - f. Radiological health and safety;
 - g. Drug storage and disposition; and
 - h. Education of professional staff, support staff, and patients;
 10. Recordkeeping;
 11. Sanitation;
 12. Security;
 13. Drug delivery requirements for:
 - a. Transportation,
 - b. Security,
 - c. Radiological health and safety procedures,
 - d. Temperature and other environmental controls, and
 - e. Emergency provisions; and
 14. Patient education.

Historical note

Adopted effective July 8, 1997 (Supp. 97-3). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3).

R4-23-683. Reserved

through

R4-23-690. Reserved

R4-23-691. Repealed

Historical Note

Adopted effective Dec. 3, 1974 (Supp. 75-1). Amended effective Aug. 12, 1988 (Supp. 88-3). Amended effective November 1, 1993 (Supp. 93-4). Repealed effective July 8, 1997 (Supp. 97-3).

R4-23-692. Compressed Medical Gas Distributor

A. Permit:

1. A person shall not manufacture, process, transfill, package, or label a compressed medical gas before a compressed medical gas distributor permit is issued by the Board or its designee following a satisfactory final inspection by a Board compliance officer.
2. Before operating as a compressed medical gas distributor, a person shall register with the FDA as a medical gas manufacturer and comply with the drug listing requirements of the federal act.
3. To obtain a compressed medical gas distributor permit a person shall submit a completed application, on a form furnished by the Board, to the Board's office.
4. A compressed medical gas distributor permittee shall distribute a compressed medical gas only:
 - a. Pursuant to a compressed medical gas order; and
 - b. If the compressed medical gas is listed on the distributor's permit application. To receive approval to distribute an additional compressed medical gas, the permittee shall request that the permit application be amended.

- i. The permittee shall send a written request to amend the permit application to the Board office.
 - ii. The request shall include documentation that the FDA has approved manufacture of the additional compressed medical gas not listed on the original permit application.
 - iii. If a request to amend an original permit application includes the documentation referenced in subsection (A)(4)(b)(ii) and if the Board or its designee determines that the amendment is in the interest of public health and safety, the Board or its designee shall approve the request to amend within 30 days of receipt.
- 5. A compressed medical gas distributor permit is subject to denial, suspension, or revocation under A.R.S. § 32-1932.
- B. Current Good Manufacturing Practice:** A compressed medical gas distributor permittee shall comply with the current good manufacturing practice requirements of 21 CFR 210 through 211, published April 1, 1996, (and no future amendments or editions), incorporated by reference and on file with the Board and the office of the Secretary of State.
- C. Records:** A compressed medical gas distributor permittee shall establish and implement written procedures for maintaining records pertaining to production, transfilling, process control, labeling, packaging, quality control, distribution, complaints, and any information required by federal or state law.
 - 1. A permittee shall retain the records required by this Article and 21 CFR 210 through 211 for at least two years after distribution of the compressed medical gas or one year after the expiration date of the compressed medical gas, whichever is longer.
 - 2. A permittee shall make the records required by this Article and 21 CFR 210 through 211 available within 48 hours for review by the Board, its compliance officers, or the FDA.
- D. Inspections:** A permittee shall make the compressed medical gas distributor's facility available for inspection by the Board or its compliance officers under A.R.S. § 32-1904.

Historical Note

Adopted effective January 12, 1998 (Supp. 98-1).

R4-23-693. Compressed Medical Gas Supplier

- A. Permit:**
 - 1. A person shall not supply a compressed medical gas before a compressed medical gas supplier permit is issued by the Board or its designee following a satisfactory final inspection by a Board compliance officer.
 - 2. To obtain a compressed medical gas supplier permit a person shall submit a completed application, on a form furnished by the Board, to the Board's office.
 - 3. A compressed medical gas supplier permittee shall supply a compressed medical gas only:
 - a. Pursuant to a compressed medical gas order, and
 - b. To the consumer, patient, or agent of the consumer or patient for whom the compressed medical gas order is written.
 - 4. A compressed medical gas supplier permittee shall not manufacture, process, transfill, package, or label a compressed medical gas, except as set forth in subsection (B)(2).
- B. Records:** A compressed medical gas supplier permittee shall establish and implement written procedures for maintaining records pertaining to acquisition and distribution of, and complaints related to, compressed medical gases.

- 1. A permittee shall ensure that a compressed medical gas order is obtained and filed for each compressed medical gas container supplied by the permittee.
- 2. A permittee shall ensure that each compressed medical gas container supplied by the permittee contains a label bearing the name and address of the compressed medical gas supplier.
- 3. A permittee shall retain the records required by this Article for at least two years after supplying the compressed medical gas or one year after the expiration date of the compressed medical gas, whichever is longer.
- 4. A permittee shall make the records required by this Article available within 48 hours for review by the Board or its compliance officers.
- C. Inspections:** A permittee shall make the compressed medical gas supplier's facility available for inspection by the Board or its compliance officers under A.R.S. § 32-1904.

Historical Note

Adopted effective January 12, 1998 (Supp. 98-1).

ARTICLE 7. NON-PHARMACY LICENSED OUTLETS – GENERAL PROVISIONS**R4-23-701. Long-term Care Facilities Pharmacy Services: Consultant Pharmacist**

- A.** The long-term care consultant pharmacist as defined in R4-23-110, in cooperation with the pharmacist-in-charge of a provider pharmacy shall:
 - 1. Prepare, implement, review, and revise in the same manner described in R4-23-671(E) and comply with written policies and procedures for the safe and efficient receipt, distribution, and storage of pharmaceutical products by the long-term care facility;
 - 2. Make the policies and procedures available in the provider pharmacy and long-term care facility for employee reference and inspection by the Board or its designee; and
 - 3. Ensure that the written policies and procedures required under (A)(1) include the following:
 - a. Specification for the storage, distribution, and procurement of drugs and biologicals;
 - b. Resident evaluation programs that relate to monitoring the therapeutic response and use of all drugs and biologicals prescribed or administered to residents, using as guidelines the most current indicators established by the Centers for Medicare and Medicaid Services, United States Department of Health and Human Services as required in 42 CFR 483.60, published October 1, 2001, and no future amendments or editions, incorporated by reference and on file with the Board and the Office of the Secretary of State;
 - c. Pharmacist assistance in drug-related emergency situations on a 24-hour basis;
 - d. Controlled substance accountability including:
 - i. Date and time of administration,
 - ii. Name of the person who administers the controlled substance,
 - iii. Documenting and verifying of any wasted or partial doses, and
 - iv. Exception reports for refused doses;
 - e. Prescription order requirements;
 - f. Approved abbreviations;
 - g. Stop-order procedures;
 - h. Pass and discharge prescription order procedures;
 - i. Emergency drug supply unit procedures;

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- j. Formulary procedures, including development, review, modification, use, and documentation, if applicable;
 - k. Security and temperature control procedures for all drugs and biologicals;
 - l. Disposal procedures that comply with subsection (D) for discontinued or outdated, prescription-only drugs or containers with illegible or missing labels; and
 - m. Procedures for identifying and reporting to proper authorities drug irregularities and dispensing errors.
- B.** A long-term care consultant pharmacist shall ensure that:
- 1. A pharmacist evaluates and verifies a prescription order of a long-term care facility resident in compliance with R4-23-402(A)(5) and (6);
 - 2. The prescription order of a long-term care facility resident contains:
 - a. Resident's name;
 - b. Facility name or address;
 - c. Drug name, strength, and dosage form;
 - d. Directions for use;
 - e. Date issued; and
 - f. Name of prescriber;
 - 3. When a provider pharmacy is not open for business, arrangements are made in advance by the long-term care consultant pharmacist, in cooperation with the pharmacist-in-charge of the provider pharmacy and the director of nursing and medical staff of the long-term care facility, for providing emergency drugs for the licensed nursing staff to administer to the residents of the facility using an emergency drug supply unit located at the facility;
 - 4. The label and packaging of prescription-only and nonprescription drugs intended for use within a long-term care facility complies with R4-23-701.01 and state and federal law; and
 - 5. A long-term care facility's personnel is informed that laws governing controlled substances require that a long-term care facility:
 - a. Store controlled substances listed in A.R.S. § 36-2513 in a separately locked and permanently affixed compartment, unless the facility uses a single-unit package medication distribution system, and
 - b. Maintain accurate records of controlled substance administration or ultimate disposition.
- C.** The long-term care consultant pharmacist shall ensure availability of records and reports designed to provide the data necessary to evaluate the drug use of each long-term care facility resident that include the following:
- 1. Provider pharmacy patient profiles and long-term care facility medication administration records;
 - 2. Reports of suspected adverse drug reactions;
 - 3. Inspection reports of drug storage areas with emphasis on detecting outdated drugs; and
 - 4. Accountability reports, including all drug destruction forms.
- D.** A long-term care consultant pharmacist or pharmacist-in-charge of a provider pharmacy shall ensure that:
- 1. Discontinued or outdated drugs, including controlled substances, are destroyed or disposed of:
 - a. Under the supervision of either a long-term care consultant pharmacist or a pharmacist employed by a provider pharmacy and witnessed by the long-term care facility administrator or the administrator's designee;
 - b. List by drug name, strength, dosage form, and quantity; and
 - 2. In a timely manner using methods consistent with state and local requirements and subject to review by the Board or its designee; and
 - 3. Drug containers with illegible or missing labels are:
 - a. Identified; and
 - b. Replaced or relabeled by a pharmacist employed by the pharmacy that dispensed the prescription medication.

Historical Note

Former Rules 6.8110, 6.8120, 6.8130, 6.8140, 6.8150, 6.8160, and 6.8170; Amended effective Aug. 10, 1978 (Supp. 78-4). Section repealed, new Section adopted effective December 18, 1992 (Supp. 92-4). Amended by final rulemaking at 9 A.A.R. 1064, effective May 4, 2003 (Supp. 03-1). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3).

R4-23-701.01. Long-term Care Facilities Pharmacy Services: Provider Pharmacy

The limited-service pharmacy permittee or pharmacist-in-charge of a provider pharmacy shall ensure that:

- 1. A prescription medication is provided only by a valid prescription order for an individual long-term care facility resident, properly labeled for that resident, as specified in this subsection. Nothing in this Section shall prevent a provider pharmacy from supplying nonprescription drugs in a manufacturer's unopened container or emergency drugs using an emergency drug supply unit as specified in R4-23-701.02;
- 2. A prescription medication label for a long-term care facility resident complies with A.R.S. §§ 32-1963.01(C) and (I), 32-1968, and 36-2525 and the applicable parts of R4-23-658(D), and contains:
 - a. The drug name, strength, dosage form, and quantity; and
 - b. The beyond-use-date;
- 3. Only a pharmacist employed by the pharmacy that dispensed the prescription medication may, through the exercise of professional judgement, relabel or alter a prescription medication label that is illegible or missing;
- 4. The long-term care facility develops and implements drug recall policies and procedures that protect the health and safety of facility residents. The drug recall procedures shall include immediate discontinuation of any recalled drug and notification of the prescriber and director of nursing of the facility; and
- 5. The provider pharmacy or any of its employees does not pay any rebate under A.R.S. § 32-1932(D) and R4-23-404.

Historical Note

Adopted effective December 18, 1992 (Supp. 92-4). Amended by final rulemaking at 9 A.A.R. 1064, effective May 4, 2003 (Supp. 03-1).

R4-23-701.02. Long-term Care Facilities Pharmacy Services: Emergency Drugs

- A.** The limited-service pharmacy permittee or pharmacist-in-charge of a provider pharmacy shall ensure that an emergency drug supply unit is available within the long-term care facility.
- B.** An emergency drug supply unit shall contain only a drug that meets the following criteria:
 - 1. The drug is necessary to meet the emergent and immediate needs of long-term care facility residents as determined by the provider pharmacy's pharmacist-in-charge in consultation with the long-term care facility's medical director and nursing director; and

2. The drug is packaged and labeled to include the drug name, strength, dosage form, manufacturer, lot number, and expiration date and provider pharmacy's name, address, telephone number, and pharmacist's initials.
- C. The limited-service pharmacy permittee or pharmacist-in-charge of a provider pharmacy shall ensure that an emergency drug supply unit:
 1. Is stored in an area that:
 - a. Is temperature controlled; and
 - b. Prevents unauthorized access;
 2. Contains on the exterior of the emergency drug supply unit a label to indicate that the contents are for emergency use only;
 3. Contains on the exterior of the emergency drug supply unit a complete list of the contents of the unit by drug name, strength, dosage form, expiration date, and quantity and the provider pharmacy's name, address, and telephone number; and
 4. Contains on the exterior of the emergency drug supply unit a label that indicates the date of and person responsible for the last inspection of the emergency drug supply unit.
- D. The limited-service pharmacy permittee or pharmacist-in-charge of a provider pharmacy shall:
 1. Prepare, implement, review, and revise in the same manner described in R4-23-671(E) and comply with written policies and procedures for the storage and use of an emergency drug supply unit in a long-term care facility;
 2. Make the policies and procedures available in the provider pharmacy and long-term care facility for employee reference and inspection by the Board or its designee; and
 3. Ensure that the written policies and procedures include the following:
 - a. Drug removal procedures that requires:
 - i. The long-term care facility's personnel receive a valid prescription order for each drug removed from the emergency drug supply unit,
 - ii. The long-term care facility's personnel notify the provider pharmacy when a drug is removed from the emergency drug supply unit, and
 - iii. The provider pharmacy's personnel restock the emergency drug supply unit within 48 hours of receiving the notification required in subsection (D)(3)(a)(ii),
 - b. Outdated drug replacement procedures that requires:
 - i. The provider pharmacy's personnel check for outdated drugs in the emergency drug supply unit once a month,
 - ii. The long-term care facility's personnel notify the provider pharmacy when an outdated drug is found in the emergency drug supply unit,
 - iii. The provider pharmacy's personnel remove an outdated drug from the emergency drug supply unit within 48 hours of receiving the notification required in subsection (D)(3)(b)(ii), and
 - iv. The provider pharmacy's personnel restock the emergency drug supply unit within 48 hours of receiving the notification required in subsection (D)(3)(b)(ii), and
 - c. Security and inspection procedures; and
 4. Educate pharmacy and long-term care facility personnel in the storage and use of an emergency drug supply unit.

Historical Note

Adopted effective December 18, 1992 (Supp. 92-4).
Amended by final rulemaking at 9 A.A.R. 1064, effective

May 4, 2003 (Supp. 03-1). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3).

R4-23-701.03. Long-term Care Facilities Pharmacy Services: Emergency Drug Prescription Order

The limited-service pharmacy permittee or pharmacist-in-charge of a provider pharmacy shall ensure that every emergency drug prescription order is evaluated according to the requirements of R4-23-402(A) by a pharmacist within 72 hours of the first dose of drug administered by long-term care facility personnel under the emergency drug prescription order.

Historical Note

Adopted effective December 18, 1992 (Supp. 92-4).
Amended by final rulemaking at 9 A.A.R. 1064, effective May 4, 2003 (Supp. 03-1).

R4-23-702. Repealed**Historical Note**

Former Rules 6.8210, 6.8211, 6.8212, 6.8213, 6.8214, 6.8221, 6.8222, 6.8223, 6.8824, 6.8231, 6.8232, 6.8233, 6.8241, 6.8242, and 6.8243; Amended effective August 10, 1978 (Supp. 78-4). Repealed effective December 18, 1992 (Supp. 92-4).

R4-23-703. Assisted Living Facilities

- A. Assisted living facilities are licensed by the state Department of Health Services.
- B. A pharmacy shall:
 1. Only dispense, sell, or deliver a prescription or nonprescription drug to an assisted living facility resident after receiving a prescription order for the drug from the resident's medical practitioner;
 2. Label, in accordance with A.R.S. §§ 32-1963.01 and 32-1968, all drugs dispensed, sold, or delivered to an assisted living facility resident;
 3. Obtain a copy of the current Arizona Department of Health Services license issued to an assisted living facility before dispensing drugs to that facility's resident; and
 4. Maintain, for inspection by a Board compliance officer, a file containing the license copy required in subsection (B)(3).
- C. In addition to the labeling requirements of A.R.S. §§ 32-1963.01 and 32-1968, the label on a prescription medication for an assisted living facility resident shall include the name, strength, and quantity of the drug and a beyond-use date.
- D. If the label on an assisted living facility resident's drug container becomes damaged or soiled, a pharmacist employed by the pharmacy that dispensed the drug container, through the exercise of professional judgment, may relabel the drug container. Only a pharmacist is permitted to label a drug container or alter the label of a drug container.
- E. A pharmacist may help assisted living facility personnel to develop written policies and procedures for the procurement, administration, storage, control, recordkeeping, and disposal of drugs in the facility and provide other information concerning drugs that assisted living facilities should have for safe and effective supervision of drug self-administration.
- F. A pharmacist shall not pay any rebate to an assisted living facility according to R4-23-404 and A.R.S. § 32-1932(B)(1).

Historical Note

Former Rules 6.8310, 6.8320, 6.8330, 6.8340, 6.8350, 6.8360, and 6.8370; Amended effective August 10, 1978 (Supp. 78-4). Amended by final rulemaking at 5 A.A.R. 2561, effective July 16, 1999 (Supp. 99-3).

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R4-23-704. Repealed**Historical Note**

Former Rules 6.8410, 6.8411, 6.8412, 6.8413, 6.8414, 6.8415, 6.8416, and 6.8417. Section R4-23-704 repealed by final rulemaking at 5 A.A.R. 862, effective March 3, 1999 (Supp. 99-1).

R4-23-705. Repealed**Historical Note**

Former Rules 6.8420, 6.8421, 6.8422, 6.8423, 6.8424, 6.8425, 6.8426, 6.8427, 6.8428, and 6.8429. Amended effective August 10, 1978 (Supp. 78-4). Amended effective August 24, 1992 (Supp. 92-3). Repealed effective December 18, 1992 (Supp. 92-4).

R4-23-706. Repealed**Historical Note**

Former Rules 6.8431, 6.8432, 6.8433, 6.8434, 6.8435, 6.8436, and 6.8437. Amended effective August 10, 1978 (Supp. 78-4). Amended subsections (C), (E), (F), and (G) effective April 20, 1982 (Supp. 82-2). Section R4-23-706 repealed by final rulemaking at 5 A.A.R. 862, effective March 3, 1999 (Supp. 99-1).

R4-23-707. Repealed**Historical Note**

Former Rules 6.8441, 6.8442, 6.8450, 6.8451, 6.8452, 6.8453, 6.8454, 6.8455, 6.8456, and 6.8457. Section R4-23-707 repealed by final rulemaking at 5 A.A.R. 862, effective March 3, 1999 (Supp. 99-1).

R4-23-708. Repealed**Historical Note**

Former Rules 6.8461, 6.8462, 6.8463, and 6.8464. Section R4-23-708 repealed by final rulemaking at 5 A.A.R. 862, effective March 3, 1999 (Supp. 99-1).

R4-23-709. Repealed**Historical Note**

Former Rules 6.8471, 6.8472, and 6.8473. Section R4-23-709 repealed by final rulemaking at 5 A.A.R. 862, effective March 3, 1999 (Supp. 99-1).

ARTICLE 8. DRUG CLASSIFICATION

Article 8, consisting of Sections R4-23-801 and R4-23-802, recodified from Article 5 at 9 A.A.R. 4011, effective August 18, 2003 (Supp. 03-3).

R4-23-801. Dietary Supplements

A person who sells, distributes, or provides a product that is labeled as a dietary supplement and is labeled or marketed as a treatment for any deficiency disease, for the correction of any symptom of disease, or for the prevention, mitigation, or cure of any disease, either by direct statement or by inference, is selling, distributing, or providing a drug and is subject to the requirements of A.R.S. Title 32, Chapter 18 and 4 A.A.C. 23.

Historical Note

Former Rules 7.1110, 7.1120, and 7.1130. Repealed effective November 4, 1998 (Supp. 98-4). Recodified from R4-23-501 at 9 A.A.R. 4011, effective August 18, 2003 (Supp. 03-3).

R4-23-802. Veterinary

Veterinary preparation: A veterinary drug manufacturer or supplier may distribute:

1. A prescription-only veterinary drug to:

- a. A veterinary medical practitioner licensed under A.R.S. Title 32, Chapter 21,
 - b. A full-service drug wholesaler permitted under A.R.S. Title 32, Chapter 18, or
 - c. A pharmacy permitted under A.R.S. Title 32, Chapter 18, and
2. A nonprescription veterinary drug to:
 - a. A veterinary medical practitioner licensed under A.R.S. Title 32, Chapter 21,
 - b. A nonprescription drug retailer permitted under A.R.S. Title 32, Chapter 18,
 - c. A full-service or nonprescription drug wholesaler permitted under A.R.S. Title 32, Chapter 18, or
 - d. A pharmacy permitted under A.R.S. Title 32, Chapter 18.

Historical Note

Former Rules 7.1210, 7.1220, and 7.1230. Repealed effective November 4, 1998 (Supp. 98-4). Recodified from R4-23-502 at 9 A.A.R. 4011, effective August 18, 2003 (Supp. 03-3).

R4-23-803. Repealed**Historical Note**

Former Rules 7.1300, 7.1400, 7.1500, and 7.1000. Repealed effective November 4, 1998 (Supp. 98-4).

R4-23-804. Repealed**Historical Note**

Former Rules 7.2100, 7.2200, 7.2300, 7.2410, 7.2420, and 7.2430. Repealed effective November 4, 1998 (Supp. 98-4).

ARTICLE 9. PENALTIES AND MISCELLANEOUS**R4-23-901. Penalty for Violations**

Any person, firm, or corporation violating any provision of 4 A.A.C. 23 is subject to the penalties in A.R.S. § 32-1996. In addition, a license or permit issued under the provisions of A.R.S. Title 32, Chapter 18 is subject to suspension or revocation for violation of 4 A.A.C. 23.

Historical Note

Former Rule 9.0000. Amended by final rulemaking at 6 A.A.R. 3177, effective August 3, 2000 (Supp. 00-3).

ARTICLE 10. UNIFORM CONTROLLED SUBSTANCES AND DRUG OFFENSES**R4-23-1001. Repealed****Historical Note**

Adopted effective August 2, 1982 (Supp. 82-4). Section repealed by final rulemaking at 6 A.A.R. 3177, effective August 3, 2000 (Supp. 00-3).

R4-23-1002. Repealed**Historical Note**

Adopted effective August 2, 1982 (Supp. 82-4). Repealed effective November 4, 1998 (Supp. 98-4).

R4-23-1003. Records and Order Forms**A. Records.**

1. If the pharmacist-in-charge of a pharmacy is replaced by another pharmacist-in-charge, the new pharmacist-in-charge shall complete an inventory of all controlled substances in the pharmacy within 10 days of assuming the responsibility. This inventory and any other required controlled substance inventory shall:

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- a. Include an exact count of all Schedule II controlled substances;
- b. Include an exact count of all Schedule III through Schedule V controlled substances or an estimated count if the stock container contains fewer than 1001 units;
- c. Indicate the date the inventory is taken and whether the inventory is taken before opening of business or after close of business for the pharmacy;
- d. Be signed by:
 - i. The pharmacist-in-charge; or
 - ii. For other required inventories, the pharmacist who does the inventory;
 - e. Be kept separately from all other records; and
 - f. Be available in the pharmacy for inspection by the Board or its designee for not less than three years.
- 2. A loss of a controlled substance shall be reported:
 - a. Within 10 days of discovery;
 - b. On a DEA form 106;
 - c. By the pharmacist-in-charge of a pharmacy or a manufacturer;
 - d. By the permittee or designated representative of a full-service wholesaler; and
 - e. To the federal Drug Enforcement Administration (DEA), the Narcotic Division of the Department of Public Safety (DPS), and the Board of Pharmacy. A copy of the DEA form 106 shall be kept on file by the pharmacy permittee. The DEA form 106 shall state whether the police investigated the loss.
- 3. Every person manufacturing any controlled substance, including repackaging or relabeling, shall record and retain for not less than three years the manufacturing, repackaging, or relabeling date for each controlled substance.
- 4. Every person receiving, selling, delivering, or disposing of any controlled substance shall record and retain for not less than three years the following information:
 - a. The name, strength, dosage form, and quantity of each controlled substance received, sold, delivered, or disposed;
 - b. The name, address, and DEA registration number of the person from whom each controlled substance is received;
 - c. The name, address, and DEA registration number of the person to whom each controlled substance is sold or delivered or who disposes of each controlled substance; and
 - d. The date of each transaction.
- 5. A full-service drug wholesale permittee or the designated representative shall complete an inventory of all controlled substances in the manner prescribed in subsection (A)(1). The permittee or designated representative shall conduct this inventory:
 - a. On May 1 of each year or as directed by the Board; and
 - b. If there is a change of ownership, or discontinuance of business, or within 10 days of a change of a designated representative.
- 6. A drug manufacturer permittee or the pharmacist-in-charge shall complete an inventory of all controlled substances in the manner prescribed in subsection (A)(1). The permittee or pharmacist-in-charge shall conduct this inventory:
 - a. On May 1 of each year or as directed by the Board; and

- b. If there is a change of ownership, or discontinuance of business, or within 10 days of a change of a pharmacist-in-charge.

- B.** Order form. For purposes of A.R.S. § 36-2524, "Order Form" means DEA Form 222c.

Historical Note

Adopted effective August 2, 1982 (Supp. 82-4).

Amended effective November 1, 1993 (Supp. 93-4).

Amended effective April 1, 1995; filed January 31, 1995 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 3177, effective August 3, 2000 (Supp. 00-3). Amended by final rulemaking at 12 A.A.R. 1912, effective July 1, 2006 (Supp. 06-2). Amended by final rulemaking at 14 A.A.R. 3670, effective November 8, 2008 (Supp. 08-3).

R4-23-1004. Repealed**Historical Note**

Adopted effective August 2, 1982 (Supp. 82-4). Repealed effective November 4, 1998 (Supp. 98-4).

R4-23-1005. Substances Excepted from the Schedules of Controlled Substances

- A.** All over-the-counter non-narcotic substances containing limited amounts of controlled substances that are excluded from all controlled substance schedules by 21 CFR 1308.22 (Revised April 1, 2012, incorporated by reference and on file with the Board. This incorporated material contains no future editions or amendments.), are excluded from all controlled substance schedules in Arizona.
- B.** All chemical preparations or mixtures containing one or more controlled substances listed in any schedule that are exempted from all controlled substance schedules by 21 CFR 1308.24 (Revised April 1, 2012, incorporated by reference and on file with the Board. This incorporated material contains no future editions or amendments.), are excluded from all controlled substance schedules in Arizona.
- C.** All prescription-only drugs that are exempted by 21 CFR 1308.32 (Revised April 1, 2012, incorporated by reference and on file with the Board. This incorporated material contains no future editions or amendments.), are excluded from all controlled substance schedules in Arizona.

Historical Note

Adopted effective August 2, 1982 (Supp. 82-4).

Amended by final rulemaking at 6 A.A.R. 3177, effective August 3, 2000 (Supp. 00-3). Amended by final rulemaking at 18 A.A.R. 2609, effective December 2, 2012 (Supp. 12-4).

R4-23-1006. Substances Excepted from Drug Offenses

The following materials, compounds, mixtures, or preparations containing any stimulant or depressant substance included in A.R.S. §§ 13-3401(6)(b) or 13-3401(6)(c) are excepted from the definition of dangerous drugs under the authority of A.R.S. § 32-1904(B)(14):

- 1. Over-the-counter drugs excepted in R4-23-1005(A).
- 2. Chemical preparations excepted in R4-23-1005(B).
- 3. Prescription-only drugs excepted in R4-23-1005(C).

Historical Note

Adopted effective August 2, 1982 (Supp. 82-4).

Amended by final rulemaking at 6 A.A.R. 3177, effective August 3, 2000 (Supp. 00-3).

ARTICLE 11. PHARMACY TECHNICIANS

Article 11, consisting of R4-23-1101 through R4-23-1105, made by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1).

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R4-23-1101. Licensure and Eligibility

A. License required. A person shall not work as a pharmacy technician or pharmacy technician trainee in Arizona, unless the person:

1. Possesses a pharmacy technician or pharmacy technician trainee license issued by the Board;
2. Reads and discusses with the pharmacist-in-charge of the pharmacy where employed, the Board rules concerning pharmacy technicians and pharmacy technician trainees, the pharmacy technician and pharmacy technician trainee job description, and the policies and procedures manual of that pharmacy; and
3. Dates and signs a statement that the person has complied with subsection (A)(2).

B. Eligibility.

1. To be eligible for licensure as a pharmacy technician trainee, a person shall:
 - a. Be of good moral character,
 - b. Be at least 18 years of age, and
 - c. Have a high school diploma or the equivalent of a high school diploma.
2. To be eligible for licensure as a pharmacy technician, a person shall:
 - a. Meet the requirements of subsection (B)(1),
 - b. Complete a pharmacy technician training program that meets the standards prescribed in R4-23-1105, and
 - c. Pass the Pharmacy Technician Certification Board (PTCB) examination or another Board-approved pharmacy technician examination.

C. A pharmacy technician delinquent license. Before an Arizona pharmacy technician license will be reinstated, a pharmacy technician whose Arizona pharmacy technician license is delinquent for five or more consecutive years shall furnish to the Board satisfactory proof of fitness to be licensed as a pharmacy technician and pay all past due biennial renewal fees and penalty fees. Satisfactory proof includes:

1. For a person with a delinquent license who is practicing as a pharmacy technician out-of-state with a pharmacy technician license issued by another jurisdiction:
 - a. Proof of current, unrestricted pharmacy technician licensure in another jurisdiction; and
 - b. Proof of employment as a pharmacy technician during the last 12 months; or
2. For a person with a delinquent license who did not practice as a pharmacy technician within the last 12 months:
 - a. Take and pass a Board-approved pharmacy technician examination, and
 - b. Complete 120 hours of pharmacy technician training as a pharmacy technician trainee licensed under R4-23-1103, or
 - c. Complete 480 hours of pharmacy technician training as a pharmacy technician trainee licensed under R4-23-1103.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1).

R4-23-1102. Pharmacy Technician Licensure

A. Application. An applicant for licensure as a pharmacy technician shall:

1. Provide the Board proof that the applicant is eligible under R4-23-1101(B)(2), including documentation that the applicant:

- a. Completed a pharmacy technician training program that meets the standards prescribed in R4-23-1105; and
 - b. Passed the Pharmacy Technician Certification Board (PTCB) examination or another Board-approved pharmacy technician examination;
2. File an application on a form furnished by the Board, that includes:
 - a. Applicant's name, address, mailing address, if different, telephone number, and social security number;
 - b. Whether the applicant has ever been convicted of an offense involving moral turpitude, a felony offense, or any drug-related offense or has any currently pending felony or drug-related charge, and if so, indicate charge, charge date, conviction date, and jurisdiction;
 - c. Whether the applicant has ever had a pharmacy technician license revoked, suspended, or has a pending revocation or suspension action, or denied in this state or any other jurisdiction, and if so, indicate where and when;
 - d. Pharmacy name and address where the pharmacy technician will practice;
 - e. Date signed and applicant's verified signature; and
 - f. The wall license and initial licensure fees specified in R4-23-205.

B. Licensure. Within seven business days of receipt of a completed application, fees, and other information specified in subsection (A), the Board office shall determine whether the application is complete. If the application is complete, the Board shall assess whether the applicant is qualified under statute and rule. If the applicant is qualified, the Board office shall issue a license number and mail a license to the applicant. An applicant who is issued a license number may begin practice as a pharmacy technician. The Board office shall mail a wall license to the licensee within 14 days of issuing the license number.

C. License renewal. To renew a license, a pharmacy technician shall submit a license renewal form supplied by the Board with the biennial renewal fee specified in R4-23-205. The Board office will process the application for renewal in the same manner described in subsection (B).

D. If the biennial renewal fee is not paid by November 1 of the renewal year specified in A.R.S. § 32-1925, the pharmacy technician license is suspended and the licensee shall pay a penalty as provided in A.R.S. § 32-1925 and R4-23-205 to vacate the suspension.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1).

R4-23-1103. Pharmacy Technician Trainee Licensure

A. Application. An applicant for licensure as a pharmacy technician trainee shall:

1. Provide the Board proof that the applicant is eligible under R4-23-1101(B)(1); and
2. File an application on a form furnished by the Board, that includes:
 - a. Applicant's name, address, mailing address, if different, telephone number, and social security number;
 - b. Whether the applicant has ever been convicted of an offense involving moral turpitude, a felony offense, or any drug-related offense or has any currently pending felony or drug-related charge, and if so,

indicate charge, charge date, conviction date, and jurisdiction;

- c. Whether the applicant has ever had a pharmacy technician or pharmacy technician trainee license revoked, suspended, or has a pending revocation or suspension action, or denied in this state or any other jurisdiction, and if so, indicate where and when;
- d. Pharmacy name and address where the pharmacy technician trainee will complete the pharmacy technician training program;
- e. Date signed and applicant's verified signature; and
- f. The wall license and initial licensure fees specified in R4-23-205.

B. Licensure.

1. Within seven business days of receipt of a completed application, fees, and other information specified in subsection (A), the Board office shall determine whether the application is complete. If the application is complete, the Board shall assess whether the applicant is qualified under statute and rule. If the applicant is qualified, the Board office shall issue a license number and mail a license to the applicant. An applicant who is issued a license number may begin practice as a pharmacy technician trainee. The Board office shall mail a wall license to the licensee within 14 days of issuing the license number. A pharmacy technician trainee license is valid for 24 months from the date issued.
2. A pharmacy technician trainee who does not complete the prescribed training program and pass the Pharmacy Technician Certification Board (PTCB) examination or another Board-approved pharmacy technician examination before the pharmacy technician trainee's license expires is not eligible for licensure as a pharmacy technician and shall not practice as a pharmacy technician or pharmacy technician trainee.

- C.** The Board may allow a pharmacy technician trainee whose license expires before the pharmacy technician trainee completes the prescribed training program and passes the Pharmacy Technician Certification Board (PTCB) examination or another Board-approved pharmacy technician examination to reapply for licensure not more than one time. A pharmacy technician trainee whose license has expired may make a special request to the Board under R4-23-401 for approval to reapply for licensure.

- D.** The Board shall base its decision to grant or deny a special request to reapply for licensure on an assessment of:

1. The reasons the pharmacy technician trainee did not complete a pharmacy technician training program and the likelihood that the pharmacy technician trainee will complete a pharmacy technician training program within the next 24 months,
2. The reasons the pharmacy technician trainee failed the pharmacy technician examination and the likelihood that the pharmacy technician trainee will pass the pharmacy technician examination within the next 24 months, and
3. Other extenuating circumstances.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1).

R4-23-1104. Pharmacy Technicians and Pharmacy Technician Trainees

- A.** Permissible activities of a pharmacy technician trainee. Acting in compliance with all applicable statutes and rules and under the supervision of a pharmacist, a pharmacy technician trainee may assist a graduate intern, pharmacy intern, or pharmacist

with the following when applicable to the pharmacy practice site:

1. Record on the original prescription order the prescription serial number and date dispensed;
2. Initiate or accept verbal or electronic refill authorization from a medical practitioner or medical practitioner's agent and record, on the original prescription order or by an alternative method approved by the Board or its designee, the medical practitioner's name, patient name, name and quantity of prescription medication, specific refill information, and name of medical practitioner's agent, if any;
3. Record information in the refill record or patient profile;
4. Type and affix a label for a prescription medication or enter information for a new or refill prescription medication into a computer, if a pharmacist verifies the accuracy and initials in handwriting or by another method approved by the Board or its designee the finished label prepared by the technician before the prescription medication is dispensed to the patient;
5. Reconstitute a prescription medication, if a pharmacist checks the ingredients and procedure before reconstitution and verifies the final product after reconstitution;
6. Retrieve, count, or pour a prescription medication, if a pharmacist verifies the contents of the prescription medication against the original prescription medication container or by an alternative drug identification method approved by the Board or its designee;
7. Prepackage drugs in accordance with R4-23-402(A); and
8. Measure, count, pour, or otherwise prepare and package a drug needed for hospital inpatient dispensing, if a pharmacist verifies the accuracy, measuring, counting, pouring, preparing, packaging, and safety of the drug before the drug is delivered to a patient care area.

- B.** Permissible activities of a pharmacy technician. Acting in compliance with all applicable statutes and rules and under the supervision of a pharmacist, a pharmacy technician may:

1. Perform the activities listed in subsection (A); and
2. After completing a drug compounding training program developed by the pharmacy permittee or pharmacist-in-charge under R4-23-1105, assist a pharmacist, graduate intern, or pharmacy intern in compounding prescription medications and sterile or non-sterile pharmaceuticals in accordance with written policies and procedures, if the preparation, accuracy, and safety of the final product is verified by a pharmacist before dispensing.

- C.** Prohibited activities. A pharmacy technician or pharmacy technician trainee shall not perform a function reserved for a pharmacist, graduate intern, or pharmacy intern in accordance with R4-23-402 or R4-23-653.

- D.** A pharmacy technician or pharmacy technician trainee shall wear a badge indicating name and title while on duty.

- E.** Before employing a pharmacy technician or pharmacy technician trainee, a pharmacy permittee or pharmacist-in-charge shall develop, implement, review, and revise in the same manner described in R4-23-653(A) and comply with policies and procedures for pharmacy technician and pharmacy technician trainee activities as specified in subsection (F).

- F.** The policies and procedures shall include the following:

1. For all practice sites:
 - a. Supervisory controls and verification procedures to ensure the quality and safety of pharmaceutical service;
 - b. Employment performance expectations for a pharmacy technician and pharmacy technician trainee;

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- c. The activities a pharmacy technician or pharmacy technician trainee may perform as specified in R4-23-1104(A) and (B);
 - d. Pharmacist and patient communication;
 - e. Reporting, correcting, and avoiding medication and dispensing errors;
 - f. Security procedures for:
 - i. Confidentiality of patient prescription records, and
 - ii. The pharmacy area;
 - g. Automated medication distribution system;
 - h. Compounding procedures for pharmacy technicians; and
 - i. Brief overview of state and federal pharmacy statutes and rules;
2. For community and limited-service pharmacy practice sites:
- a. Prescription dispensing procedures for:
 - i. Accepting a new written prescription,
 - ii. Accepting a refill request,
 - iii. Selecting a drug product,
 - iv. Counting and pouring,
 - v. Labeling, and
 - vi. Obtaining refill authorization;
 - b. Computer data entry procedures for:
 - i. New and refill prescriptions,
 - ii. Patient's drug allergies,
 - iii. Drug-drug interactions,
 - iv. Drug-food interactions,
 - v. Drug-disease state contraindications,
 - vi. Refill frequency,
 - vii. Patient's disease and medical condition,
 - viii. Patient's age or date of birth and gender, and
 - ix. Patient profile maintenance; and
3. For hospital pharmacy practice sites:
- a. Medication order procurement and data entry,
 - b. Drug preparation and packaging,
 - c. Outpatient and inpatient drug delivery, and
 - d. Inspection of drug storage and preparation areas and patient care areas.
3. A pharmacist-in-charge shall:
- a. Document a pharmacy technician trainee's progress throughout the training program,
 - b. Date and sign a statement attesting that a pharmacy technician trainee has successfully completed the training program,
 - c. Maintain the documentation required in this subsection and R4-23-1101(A)(3) for inspection by the Board or its designee, and
 - d. Provide to the pharmacy technician trainee a copy of the statement required in subsection (B)(3)(b).
- C. Drug compounding training program.**
- 1. A pharmacy permittee or pharmacist-in-charge shall develop, implement, review, and revise in the same manner described in R4-23-653(A) and comply with a drug compounding training program based on the needs of the individual pharmacy;
 - 2. A pharmacy permittee or pharmacist-in-charge shall ensure that the drug compounding training program includes training guidelines that:
 - a. Define the specific tasks a pharmacy technician is expected to perform,
 - b. Specify how and when the pharmacist-in-charge will access the pharmacy technician's competency, and
 - c. Address the following procedures and tasks:
 - i. Area preparation,
 - ii. Component preparation,
 - iii. Aseptic technique and product preparation,
 - iv. Packaging and labeling, and
 - v. Area clean up;
 - 3. A pharmacist-in-charge shall:
 - a. Document a pharmacy technician's progress throughout the training program,
 - b. Date and sign a statement attesting that a pharmacy technician has successfully completed the training program, and
 - c. Maintain the documentation required in this subsection for inspection by the Board or its designee.
- D.** A pharmacy technician shall perform only those tasks, listed in R4-23-1104(B), for which training and competency has been demonstrated.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3).

R4-23-1105. Pharmacy Technician Training Program

- A.** Nothing in this Section prevents additional offsite training of a pharmacy technician.
- B.** Pharmacy technician training program.
- 1. A pharmacy permittee or pharmacist-in-charge shall develop, implement, review, and revise in the same manner described in R4-23-653(A) and comply with a pharmacy technician training program based on the needs of the individual pharmacy;
 - 2. A pharmacy permittee or pharmacist-in-charge shall ensure that the pharmacy technician training program includes training guidelines that:
 - a. Define the specific tasks a pharmacy technician trainee is expected to perform,
 - b. Specify how and when the pharmacist-in-charge will access the pharmacy technician trainee's competency, and
 - c. Address the policies and procedures specified in R4-23-1104(F) and the permissible activities specified in R4-23-1104(A) and (B);

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3).

R4-23-1106. Continuing Education Requirements

- A.** General. According to A.R.S. § 32-1925(I), the Board shall not renew a pharmacy technician license unless the applicant has during the two years preceding the application for renewal:
- 1. Participated in 20 contact hours or two CEUs of continuing education activity sponsored by an Approved Provider defined in R4-23-110, and
 - 2. At least two of the contact hours or 0.2 of the CEUs are approved courses in pharmacy law. For a pharmacy technician licensed less than 24 months the continuing education contact hours are calculated by multiplying 0.83 hours times the number of months between the date of initial licensure and the licensee's next license renewal date.
- B.** Valid CEUs. The Board shall:
- 1. Only accept CEUs for continuing education activities sponsored by an Approved Provider;
 - 2. Only accept CEUs accrued during the two-year period immediately before licensure renewal;

3. Not allow CEUs accrued in a biennial renewal period in excess of the required two CEUs to be carried forward to the succeeding biennial renewal period;
 4. Allow a pharmacy technician who leads, instructs, or lectures to a group of health professionals on pharmacy-related topics in continuing education activities sponsored by an Approved Provider to receive CEUs for a presentation by following the same attendance procedures as any other attendee of the continuing education activity; and
 5. Not accept as a CEU a pharmacy technician's normal teaching duties within a learning institution if the pharmacy technician's primary responsibility is the education of health professionals.
- C.** Continuing education records and reporting CEUs. A pharmacy technician shall:
1. Maintain continuing education records that:
 - a. Verify the continuing education activities the pharmacy technician participated in during the preceding five years; and
 - b. Consist of a statement of credit or a certificate issued by an Approved Provider at the conclusion of a continuing education activity;
 2. At the time of licensure renewal, attest to the number of CEUs the pharmacy technician participated in during the renewal period on the biennial renewal form; and
 3. When requested by the Board office, submit proof of continuing education participation within 20 days of the request.
- D.** The Board shall deem a pharmacy technician's failure to comply with the continuing education participation, recording, or reporting requirements of this Section as unprofessional conduct and grounds for disciplinary action by the Board under A.R.S. § 32-1927.01.
- E.** A pharmacy technician who is aggrieved by any decision of the Board concerning continuing education units may request a hearing before the Board.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 1105, effective April 30, 2005 (Supp. 05-1).

ARTICLE 12. PRESCRIPTION MEDICATION DONATION PROGRAM

R4-23-1201. Eligibility Requirements for Participation in the Program

A physician's office, a pharmacy, or a health care institution may participate in the prescription medication donation program, under A.R.S. § 32-1909, if all of the following requirements, as applicable, are met:

1. The physician-in-charge of the participating physician's office has a current license issued under A.R.S. Title 32, Chapter 13 or 17;
2. The pharmacy has a current permit issued under A.R.S. Title 32, Chapter 18;
3. The health care institution has a current license issued under A.R.S. Title 36, Chapter 4 and has a physician-in-charge or pharmacist-in-charge of dispensing; and
4. The physician's office, the pharmacy, or the health care institution complies with all federal and state drug laws, rules, and regulations.

Historical Note

New Section made by final rulemaking at 14 A.A.R. 4320, effective January 3, 2009 (Supp. 08-4).

R4-23-1202. Donating Medications

- A.** The following may donate an eligible prescription medication, as specified in R4-23-1203, to a physician's office, a pharmacy, or a health care institution that participates in the prescription medication donation program:
1. An individual for whom the prescription medication was prescribed on a patient-specific prescription order or that individual's health care decision maker;
 2. A manufacturer that has a current permit issued under A.R.S. Title 32, Chapter 18; or
 3. A health care institution that has a current license issued under A.R.S. Title 36, Chapter 4.
- B.** An individual or health care decision maker electing to donate an eligible prescription medication shall not have taken possession of the prescription medication before the donation and shall make the donation through a medical practitioner, pharmacy, or health care institution.

Historical Note

New Section made by final rulemaking at 14 A.A.R. 4320, effective January 3, 2009 (Supp. 08-4).

R4-23-1203. Eligible Prescription Medications

A prescription medication may be donated to a physician's office, a pharmacy, or a health care institution that participates in the prescription medication donation program if the prescription medication:

1. Is not a:
 - a. Controlled substance;
 - b. Drug sample; or
 - c. Drug that can only be dispensed to a patient registered with the drug's manufacturer, because donation could prevent the manufacturer from maintaining required patient registration data;
2. Is in its original sealed and tamper-evident unit dose packaging that is unopened or has only its outside packaging opened and its single unit dose packaging undisturbed;
3. Has been in the possession of a licensed health care professional, manufacturer, pharmacy, or health care institution and not in the possession of the individual specified in R4-23-1202(A)(1);
4. Has been stored according to federal and state drug law and the requirements of the manufacturer's package insert;
5. Has an expiration date or beyond-use-date later than six months after the date of donation;
6. Is in packaging that shows the lot number and expiration date or beyond-use-date of the prescription medication;
7. Does not have any physical signs of tampering or adulteration; and
8. Is in packaging that does not have any physical signs of tampering, except for the outside packaging as specified in subsection (2).

Historical Note

New Section made by final rulemaking at 14 A.A.R. 4320, effective January 3, 2009 (Supp. 08-4).

R4-23-1204. Eligibility Requirements to Receive Donated Prescription Medications

An individual is eligible to receive donated prescription medications from the prescription medication donation program if the individual:

1. Is a resident of Arizona;
2. Has an annual family income that is less than or equal to 300% of the poverty level;
3. Satisfies one of the following:

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- a. Has no health insurance coverage;
- b. Has health insurance coverage that does not pay for the prescription medication prescribed;
- c. Is an American or Alaska Native who:
 - i. Is eligible for, but chooses not to use, the Indian Health Service to receive prescription medications; and
 - ii. Either has no other health insurance coverage or has health insurance coverage that does not pay for the prescription medication prescribed; or
- d. Is a veteran who:
 - i. Is eligible for, but chooses not to use, Veterans Health Administration benefits to receive prescription medications; and
 - ii. Either has no other health insurance coverage or has health insurance coverage that does not pay for the prescription medication prescribed;
- 4. Is ineligible for enrollment in AHCCCS; and
- 5. If eligible for Medicare, is ineligible for a full low-income subsidy.

Historical Note

New Section made by final rulemaking at 14 A.A.R. 4320, effective January 3, 2009 (Supp. 08-4).

R4-23-1205. Donor Form

A. Before donating a prescription medication, a donor shall sign a form that includes:

1. A statement attesting that the donor is one of the entities identified in R4-23-1202(A) and intends to voluntarily donate the prescription medication to the prescription medication donation program;
2. If the donor is the individual named on the prescription or the individual's health care decision maker:
 - a. The individual's name and address;
 - b. The name of the individual's health care decision maker, if applicable;
 - c. The name of the medical practitioner, pharmacy, or health care institution through which the donation is being made;
 - d. The following information about the donated prescription medication:
 - i. The brand name or generic name of the prescription medication donated;
 - ii. If a generic medication, the name of the manufacturer or the national drug code number of the prescription medication donated;
 - iii. The strength of the prescription medication donated;
 - iv. The quantity of the prescription medication donated;
 - v. The lot number of the prescription medication donated; and
 - vi. The expiration date or beyond-use-date of the prescription medication donated;
 - e. A statement attesting that the individual or the individual's health care decision maker has not had possession of the donated prescription medication;
 - f. The dated signature of the individual or the individual's health care decision maker;
 - g. If the donation is an ongoing donation as authorized under subsection (B), a statement that conforms to subsection (B);
 - h. A statement by the medical practitioner, pharmacy, or health care institution attesting that the medical practitioner, pharmacy, or health care institution

through which the donation is being made has stored the donated prescription medication as required in R4-23-1203(4);

- i. A statement by the medical practitioner, pharmacy, or health care institution attesting that the drugs being donated meet the specific requirements of R4-23-1203(1); and
 - j. The dated signature of the medical practitioner or of an authorized agent for the pharmacy or health care institution through which the donation is being made;
3. If the donor is a manufacturer:
 - a. The name and address of the manufacturer;
 - b. The information about the donated prescription medication specified in subsection (A)(2)(d);
 - c. A statement by the manufacturer that the manufacturer has stored the donated prescription medication as required in R4-23-1203(4); and
 - d. The dated signature of the manufacturer's authorized agent; and
 4. If the donor is a health care institution:
 - a. The name and address of the health care institution;
 - b. The information about the donated prescription medication specified in subsection (A)(2)(d);
 - c. A statement attesting that the health care institution has stored the donated prescription medication as required in R4-23-1203(4);
 - d. A statement by the health care institution attesting that the drugs being donated meet the specific requirements of R4-23-1203(1); and
 - e. The dated signature of the health care institution's authorized agent.
- B.** An individual who resides in a health care institution, or the individual's health care decision maker, may elect to make an ongoing donation of future unused eligible prescription medication:
1. When future unused eligible prescription medication is a result of the individual's prescription medication being changed or discontinued by the individual's primary care provider; and
 2. By indicating the following on a donor form that complies with subsection (A): "From this day forward, I wish to donate all my remaining unused prescription medications that are eligible, under R4-23-1203, to the prescription medication donation program."
- C.** To stop an ongoing donation, an individual who resides in a health care institution, or the individual's health care decision maker, shall submit written notice to the receiving physician's office, pharmacy, or health care institution indicating the individual's, or the health care decision maker's, desire to stop the ongoing donation.

Historical Note

New Section made by final rulemaking at 14 A.A.R. 4320, effective January 3, 2009 (Supp. 08-4).

R4-23-1206. Recipient Form

Before receiving a donated prescription medication from the prescription medication donation program, a recipient of a donated prescription medication shall sign a form:

1. Identifying the physician's office, pharmacy, or health care institution that is dispensing the donated prescription medication;
2. Stating that the recipient has been advised of and understands the immunity provisions of the program under A.R.S. § 32-1909(E) and (F);

3. Attesting that the recipient meets the eligibility requirements specified in R4-23-1204; and
4. Including the following:
 - a. The brand name or generic name of the prescription medication received;
 - b. If a generic medication, the name of the manufacturer or the national drug code number of the prescription medication received;
 - c. The strength of the prescription medication received;
 - d. The quantity of the prescription medication received;
 - e. The recipient's name and address; and
 - f. The dated signature of the recipient.

Historical Note

New Section made by final rulemaking at 14 A.A.R.
4320, effective January 3, 2009 (Supp. 08-4).

R4-23-1207. Recordkeeping

- A. Before transferring possession of a prescription medication donated by an individual or an individual's health care decision maker, a medical practitioner, pharmacy, or health care institution that has possession of the donated prescription medication and through which the donation is being made shall create an invoice that includes the following:
 1. The name and address of the medical practitioner, pharmacy, or health care institution that has possession of the donated prescription medication;
 2. The name of the individual who made the donation;
 3. The brand name or generic name of the prescription medication transferred;
 4. If a generic medication, the name of the manufacturer or the national drug code number of the prescription medication transferred;
 5. The strength of the prescription medication transferred;
 6. The quantity of the prescription medication transferred;
 7. The lot number of the prescription medication transferred;
 8. The expiration date or beyond-use-date of the prescription medication transferred;
 9. The date the prescription medication is transferred to a participating physician's office, pharmacy, or health care institution; and
 10. The name and address of the participating physician's office, pharmacy, or health care institution to which the donated prescription medication is transferred.
- B. Before transferring possession of a prescription medication donated by a manufacturer, the manufacturer shall create an invoice that includes the manufacturer's name and address and the information described in subsections (A)(3) through (10).
- C. Before transferring possession of a prescription medication donated by a health care institution, the health care institution shall create an invoice that includes the health care institution's name and address and the information described in subsections (A)(3) through (10).
- D. A medical practitioner, pharmacy, health care institution, or manufacturer required to create an invoice under subsection (A), (B), or (C) shall:
 1. Transmit a copy of the invoice and the donor form required under R4-23-1205 to the participating physician's office, pharmacy, or health care institution to which a donated prescription medication is transferred;
 2. Maintain a copy of the invoice for a minimum of three years from the date of the invoice;
 3. Maintain a copy of the donor form for a minimum of three years from the date signed; and

4. Make a copy of the invoice or donor form available upon request for inspection by the Board, its designee, or other authorized officers of the law.

- E. A physician's office, a pharmacy, or a health care institution that participates in the prescription medication donation program shall:
 1. Maintain:
 - a. The documents required under R4-23-1206 for a minimum of three years from the date signed; and
 - b. Each invoice and donor form received under subsection (D)(1) for a minimum of three years from the date received; and
 2. Make the documents required under R4-23-1206 and subsection (D)(1) available upon request for inspection by the Board, its designee, or other authorized officers of the law.

Historical Note

New Section made by final rulemaking at 14 A.A.R.
4320, effective January 3, 2009 (Supp. 08-4).

R4-23-1208. Handling Fee

A physician's office, a pharmacy, or a health care institution that dispenses a donated prescription medication may charge a recipient of a donated prescription medication a handling fee of no more than \$4.50 per prescription to cover inspection, stocking, and dispensing costs.

Historical Note

New Section made by final rulemaking at 14 A.A.R.
4320, effective January 3, 2009 (Supp. 08-4).

R4-23-1209. Policies and Procedures

A physician's office, a pharmacy, or a health care institution that participates in the prescription medication donation program shall:

1. Develop, implement, and comply with policies and procedures for the receipt, storage, and distribution of prescription medications donated to the physician's office, the pharmacy, or the health care institution;
2. Review biennially and, if necessary, revise the policies and procedures required under this Section;
3. Document the review required under subsection (2);
4. Assemble the policies and procedures as a written manual or in a readily accessible electronic format;
5. Make the policies and procedures available for reference by a physician's office, pharmacy, or health care institution personnel and, upon request, for inspection by the Board or its designee; and
6. Ensure that the written or electronic policies and procedures required under subsection (1) include provisions to ensure:
 - a. That each transferred prescription medication meets the eligibility requirements of Sections R4-23-1202 and R4-23-1203;
 - b. That each individual who receives a donated prescription medication under the prescription medication donation program signs the recipient form specified in R4-23-1206;
 - c. Compliance with the applicable requirements for recordkeeping in Section R4-23-1207;
 - d. Compliance with the requirements of Section R4-23-1210; and
 - e. Compliance with the requirements of Section R4-23-1211.

Historical Note

New Section made by final rulemaking at 14 A.A.R.
4320, effective January 3, 2009 (Supp. 08-4).

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R4-23-1210. Dispensing Donated Prescription Medications

- A.** Before dispensing a donated prescription medication under the program, a participating physician's office, pharmacy, or health care institution shall:
1. Obtain and maintain a current drug identification reference or text in hard-copy or electronic media format;
 2. Inspect the donated prescription medication to ensure that the prescription medication has not been adulterated;
 3. Certify that the donated prescription medication has been stored in compliance with the requirements of the manufacturer's package insert;
 4. Comply with all federal and state laws regarding storage and distribution of a donated prescription medication;
 5. Obtain a prescription order of a licensed medical practitioner for the recipient to receive the donated prescription medication; and
 6. Properly label the donated prescription medication to be dispensed.
- B.** As specified in subsection (C) a participating physician's office, pharmacy, or health care institution may transfer a prescription medication donated under this Article to another participating physician's office, pharmacy, or health care institution, but the donated prescription medication shall not be resold.
- C.** A participating physician's office, pharmacy, or health care institution may transfer a donated prescription medication to another participating physician's office, pharmacy, or health care institution, if:
1. The transferring physician's office, pharmacy, or health care institution has available a prescription medication that the receiving physician's office, pharmacy, or health care institution needs;
 2. The transferring physician's office, pharmacy, or health care institution prepares an invoice that includes its name and address and the information described in R4-23-1207(B)(3) through (10);
 3. A copy of the invoice required in subsection (C)(2) is sent to the receiving physician's office, pharmacy, or health care institution with the transferred prescription medication; and
 4. The transferring physician's office, pharmacy, or health care institution and the receiving physician's office, pharmacy, or health care institution each:
 - a. Keep a copy of the invoice required in subsection (C)(2) on file for three years from the date of transfer; and
 - b. Make the invoice records available, upon request, for inspection by the Board or its designee.

Historical Note

New Section made by final rulemaking at 14 A.A.R. 4320, effective January 3, 2009 (Supp. 08-4).

R4-23-1211. Responsibilities of the Physician-in-charge or Pharmacist-in-charge of a Participating Physician's Office, Pharmacy, or Health Care Institution

The physician-in-charge of a participating physician's office; the pharmacist-in-charge of a participating pharmacy; or the physician-

in-charge or pharmacist-in-charge of dispensing for a participating health care institution shall, either personally or through a designee:

1. Coordinate the receipt of prescription medications donated by manufacturers or health care institutions or through medical practitioners, pharmacies, or health care institutions from eligible donors;
2. Check each donated prescription medication against the invoice and any additional alternate record and resolve any discrepancies;
3. Store and secure donated prescription medications as required by federal and state law;
4. Inspect each donated prescription medication for adulteration;
5. Certify that each donated prescription medication has been stored in compliance with the manufacturer's package insert;
6. Ensure that expired, adulterated, or unidentifiable donated prescription medication is not dispensed;
7. Ensure that prescription medications identified under subsection (6) are destroyed within 30 days of identification as specified in subsection (9);
8. Ensure safety in drug recalls by destroying any donated prescription medication that may be subject to recall if its lot number cannot exclude it from recall;
9. Ensure destruction of expired, adulterated, unidentifiable, and recalled donated prescription medication by:
 - a. Following federal, state, and local guidelines for drug destruction;
 - b. Creating a list of expired, adulterated, unidentifiable, or recalled donated prescription medications to be destroyed;
 - c. Following the destruction, signing the list described in subsection (9)(b) and having the list signed by a witness verifying the destruction; and
 - d. Keeping the list described in subsection (9)(b) on file for three years from the date of destruction;
10. Redact or remove all previous patient or pharmacy labeling on a donated prescription medication before dispensing the donated prescription medication;
11. Ensure that all dispensed donated prescription medications comply with the labeling requirements of A.R.S. § 32-1968(D);
12. Place on the label of each dispensed donated prescription medication a beyond-use-date that does not exceed the beyond-use-date or expiration date from the original label of the donated prescription medication or, if the dispensed donated prescription medication comes from multiple packages, the earliest beyond-use-date or expiration date from the donated prescription medication packages; and
13. Maintain the records required in this Article.

Historical Note

New Section made by final rulemaking at 14 A.A.R. 4320, effective January 3, 2009 (Supp. 08-4).

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Supplement to the

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The official compilation of Arizona Rules

Arizona Secretary of State's Office

Public Services Division

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Phoenix, AZ 85007

Replacement Check List

For rules filed within the

4th Calendar Quarter

October 1 - December 31, 2012

Code Release Number: Supp. 12-4

Within the stated calendar quarter, this Title contains all rules made, amended, repealed, renumbered, and recodified, or rules that have expired or were terminated due to an agency being eliminated under sunset law. These rules were either certified by the Governor's Regulatory Review Council or the Attorney General's Office, or exempt from the rulemaking process, and filed with the Office of the Secretary of State. Refer to the historical notes for more information. Please note that some rules you are about to remove may still be in effect after the publication date of this Supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

Follow the instructions to replace the updated Chapters.

TITLE 6. ECONOMIC SECURITY

Chapter 5. Department of Economic Security - Social Services

Sections, Parts, Exhibits, Tables or Appendices modified

R6-5-5601 through R6-5-5612

REMOVE Supp. 12-3

Pages: 1 - 168

REPLACE with Supp. 12-4

Pages: 1 - 168

Chapter 8. Department of Economic Security - Aging and Adult Administration

Sections, Parts, Exhibits, Tables or Appendices modified

R6-8-201, R6-8-204 through R6-8-206, R6-8-210

REMOVE Supp. 96-3

Pages: 1 - 7

REPLACE with Supp. 12-4

Pages: 1 - 7

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TITLE 6. ECONOMIC SECURITY
CHAPTER 5. DEPARTMENT OF ECONOMIC SECURITY
SOCIAL SERVICES

(Authority: A.R.S. § 41-1954 et seq.)

Editor's Note: The Office of the Secretary of State publishes all Chapters on white paper (Supp. 01-2).

Editor's Note: Sections and Appendices of this Chapter were adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to A.R.S. § 41-1005 (A)(27). Exemption from A.R.S. Title 41, Chapter 6 means the Department did not submit these rules to the Governor's Regulatory Review Council for review and approval; and the Department was not required to hold public hearings on these rules (Supp. 98-2).

Editor's Note: Sections of this Chapter were adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1997, Chapter 300, § 74(A). Exemption from A.R.S. Title 41, Chapter 6 means the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review and approval; and the Department was not required to hold public hearings on these rules. Under Laws 1997, Chapter 300, § 74(B), the Department is required to institute the formal rulemaking process on these Sections on or before December 31, 1997. Because these rules are exempt from the regular rulemaking process, the Chapter is printed on blue paper.

ARTICLE 1. REPEALED

Former Article 1 consisting of Sections R6-5-01 through R6-5-103 repealed effective August 3, 1978.

ARTICLE 2. REPEALED

Former Article 2 consisting of Sections R6-5-201 through R6-5-209 repealed effective August 8, 1978.

ARTICLE 3. REPEALED

Former Article 3 consisting of Sections R6-5-301 through R6-5-308 repealed effective July 6, 1976.

ARTICLE 4. REPEALED

Former Article 4 consisting of Sections R6-5-401 through R6-5-420 repealed effective August 3, 1978.

ARTICLE 5. REPEALED

Former Article 5 consisting of Sections R6-5-501 through R6-5-504 repealed effective July 6, 1976.

ARTICLE 6. REPEALED

Former Article 6 consisting of Sections R6-5-601 through R6-5-622 repealed effective July 6, 1977.

ARTICLE 7. REPEALED

Former Article 7 consisting of Sections R6-5-701 through R6-5-716 repealed effective August 3, 1978.

ARTICLE 8. REPEALED

Former Article 8 consisting of Sections R6-5-801 through R6-5-808 repealed effective September 16, 1976.

ARTICLE 9. REPEALED

Former Article 9 consisting of Sections R6-5-901 through R6-5-904 repealed effective August 3, 1978.

ARTICLE 10. REPEALED

Former Article 10 consisting of Sections R6-5-1001 through R6-5-1003 repealed effective August 3, 1978.

ARTICLE 11. REPEALED

Former Article 11 consisting of Sections R6-5-1101 through R6-5-1109 repealed effective August 11, 1976.

ARTICLE 12. REPEALED

Former Article 12 consisting of Sections R6-5-1201 through R6-5-1206 repealed effective May 17, 1976.

ARTICLE 13. REPEALED

Former Article 13 consisting of Sections R6-5-1301 through R6-5-1309 repealed effective November 23, 1976.

ARTICLE 14. REPEALED

Former Article 14 consisting of Sections R6-5-1401 through R6-5-1413 repealed effective May 24, 1976.

ARTICLE 15. REPEALED

Former Article 15 consisting of Sections R6-5-1501 through R6-5-1504 repealed effective August 11, 1976.

ARTICLE 16. RESERVED

ARTICLE 17. REPEALED

Former Article 17 consisting of Sections R6-5-1701 through R6-5-1704 repealed effective August 11, 1976.

ARTICLE 18. REPEALED

Former Article 18 consisting of Sections R6-5-1801 through R6-5-1804 repealed effective August 11, 1976.

ARTICLE 19. REPEALED

Former Article 19 consisting of Sections R6-5-1901 through R6-5-1906 repealed effective July 6, 1976.

ARTICLE 20. REPEALED

Former Article 20 consisting of Sections R6-5-2001 through R6-5-2006 repealed effective December 17, 1993.

ARTICLE 21. REPEALED

Former Article 21 consisting of Sections R6-5-2101 through R6-5-2110 repealed effective November 8, 1982.

ARTICLE 22. REPEALED

Former Article 22 consisting of Sections R6-5-2202 through R6-5-2209 repealed effective November 8, 1982.

ARTICLE 23. REPEALED

Article 23, consisting of Sections R6-5-2301 through R6-5-2310, repealed by final rulemaking at 5 A.A.R. 1804, effective May 18, 1999 (Supp. 99-2).

ARTICLE 24. APPEALS AND HEARINGS

Article 24 consisting of Sections R6-5-2401 through R6-5-2405 adopted effective March 1, 1978.

Former Article 24 consisting of Sections R6-5-2401 through R6-5-2404 repealed effective March 1, 1978.

Section

R6-5-2401.	Expired
R6-5-2402.	Expired
R6-5-2403.	Expired
R6-5-2404.	Basis for a hearing
R6-5-2405.	Hearing process

ARTICLE 25. REPEALED

Former Article 25, consisting of Sections R6-5-2501 through R6-5-2503, repealed effective June 5, 1997 (Supp. 97-2).

ARTICLE 26. REPEALED

Former Article 26, consisting of Sections R6-5-2601 through R6-5-2607, repealed effective June 5, 1997 (Supp. 97-2).

ARTICLE 27. REPEALED

Former Article 27, consisting of Sections R6-5-2701 through R6-5-2707, repealed effective June 5, 1997 (Supp. 97-2).

ARTICLE 28. REPEALED

Former Article 28, consisting of Sections R6-5-2801 through R6-5-2804, repealed effective November 8, 1982.

ARTICLE 29. REPEALED

Article 29, consisting of Sections R6-5-2901 through R6-5-2912, repealed effective December 17, 1993 (Supp. 93-4).

ARTICLE 30. REPEALED

Former Article 30, consisting of Sections R6-5-3001 through R6-5-3007, repealed effective August 29, 1984.

ARTICLE 31. REPEALED

Former Article 31, consisting of Sections R6-5-3101 through R6-5-3110, repealed effective November 8, 1982.

ARTICLE 32. REPEALED

Article 32, consisting of Sections R6-5-3201 through R6-5-3211, repealed effective December 17, 1993 (Supp. 93-4).

ARTICLE 33. RESERVED

ARTICLE 34. RESERVED

ARTICLE 35. RESERVED

ARTICLE 36. RESERVED

ARTICLE 37. RESERVED

ARTICLE 38. RESERVED

ARTICLE 39. RESERVED

ARTICLE 40. RESERVED

ARTICLE 41. RESERVED

ARTICLE 42. RESERVED

ARTICLE 43. RESERVED

ARTICLE 44. RESERVED

ARTICLE 45. RESERVED

ARTICLE 46. RESERVED

ARTICLE 47. RESERVED

ARTICLE 48. RESERVED

ARTICLE 49. CHILD CARE ASSISTANCE

Article 49, consisting of Sections R6-5-4901 through R6-5-4922 and Appendix A, adopted effective July 31, 1997 (Supp. 97-3).

Section

R6-5-4901.	Definitions
R6-5-4902.	Repealed
R6-5-4903.	Repealed
R6-5-4904.	Access to Child Care Assistance
R6-5-4905.	Initial Eligibility Interview
R6-5-4906.	Verification of Eligibility Information
R6-5-4907.	Withdrawal of an Application
R6-5-4908.	Child Care Assistance Approvals and Denials
R6-5-4909.	12-Month Review
R6-5-4910.	Reinstatement of Assistance
R6-5-4911.	General Eligibility Criteria
R6-5-4912.	Eligible Activity or Need
R6-5-4913.	Applicants and Recipients as Child Care Providers
R6-5-4914.	Income Eligibility Criteria
R6-5-4915.	Fee Level and Copayment Assignment
R6-5-4916.	Special Eligibility Criteria
R6-5-4917.	Waiting List for Child Care Assistance
R6-5-4918.	Authorization of Child Care Assistance
R6-5-4919.	Time Limit for Child Care Assistance
R6-5-4920.	Denial or Termination of Child Care Assistance
R6-5-4921.	Notification Requirements
R6-5-4922.	Repealed
R6-5-4923.	Overpayments
R6-5-4924.	Appeals
R6-5-4925.	Maximum Reimbursement Rates For Child Care
Appendix A.	Child Care Assistance Gross Monthly Income Eligibility Chart and Fee Schedule
Appendix B.	Maximum Reimbursement Rates for Child Care

ARTICLE 50. CHILD CARE RESOURCE AND REFERRAL SYSTEM

New Article 50, consisting of Sections R6-5-5001 through R6-5-5010, adopted effective November 19, 1996 (Supp. 96-4).

Former Article 50, consisting of Sections R6-5-5001 through R6-5-5007, repealed effective November 8, 1982 (Supp. 82-6).

Section

R6-5-5001.	Definitions
R6-5-5002.	Provider Participation Requirements
R6-5-5003.	Notification of Changes
R6-5-5004.	Referrals Not Guaranteed
R6-5-5005.	Referral Process
R6-5-5006.	Monitoring; Complaint Recording and Reporting Requirements
R6-5-5007.	Provider Listing Status
R6-5-5008.	Provider Exclusion or Removal
R6-5-5009.	Administrative Review Process
R6-5-5010.	Administrative Appeal Process

ARTICLE 51. EXPIRED

Article 51, consisting of Sections R6-5-5101 through R6-5-5107, expired under A.R.S. § 41-1056(E) at 7 A.A.R. 5257, effective October 31, 2001 (Supp. 01-4).

Article 51, consisting of Sections R6-5-5101 through R6-5-5107, adopted effective June 17, 1985.

Former Article 51, consisting of Sections R6-5-5101 through R6-5-5104, repealed effective June 17, 1985.

Section

R6-5-5101.	Expired
R6-5-5102.	Expired

R6-5-5103. Expired
 R6-5-5104. Expired
 R6-5-5105. Expired
 R6-5-5106. Expired
 R6-5-5107. Expired

ARTICLE 52. CERTIFICATION AND SUPERVISION OF FAMILY CHILD CARE HOME PROVIDERS

Article 52, consisting of Sections R6-5-5201 through R6-5-5211, repealed effective May 11, 1994 (Supp. 94-2).

Article 52, consisting of Sections R6-5-5201 through R6-5-5227, adopted effective May 11, 1994 (Supp. 94-2).

Section

R6-5-5201. Definitions
 R6-5-5202. Initial Application for Certification
 R6-5-5203. Initial Certification: The Home Facility
 R6-5-5204. Initial Certification: Department Responsibilities
 R6-5-5205. Certification Time-frames
 R6-5-5206. Certificates: Issuance; Nontransferability
 R6-5-5207. Maintenance of Certification: General Requirements; Training
 R6-5-5208. Recertification Requirements
 R6-5-5209. Program and Equipment
 R6-5-5210. Safety; Supervision
 R6-5-5211. Sanitation
 R6-5-5212. Discipline
 R6-5-5213. Evening And Nighttime Care
 R6-5-5214. Children Younger than Age 2
 R6-5-5215. Children with Special Needs
 R6-5-5216. Transportation
 R6-5-5217. Meals and Nutrition
 R6-5-5218. Health Care; Medications
 R6-5-5219. Recordkeeping; Unusual incidents; Immunizations
 R6-5-5220. Provider/Child Ratios
 R6-5-5221. Change Reporting Requirements
 R6-5-5222. Use of a Backup Provider
 R6-5-5223. Claims For Payment
 R6-5-5224. Complaints; Investigations
 R6-5-5225. Probation
 R6-5-5226. Certification, Denial, Suspension, and Revocation
 R6-5-5227. Adverse Actions; Notice Effective Date
 R6-5-5228. Appeals

ARTICLE 53. REPEALED

Former Article 53 consisting of Sections R6-5-5301 through R6-5-5305 repealed effective April 9, 1981.

ARTICLE 54. REPEALED

Former Article 54 consisting of Sections R6-5-5401 through R6-5-5411 repealed effective November 8, 1982.

ARTICLE 55. CHILD PROTECTIVE SERVICES

Article 55, consisting of Sections R6-5-5501 through R6-5-5504, adopted effective December 8, 1983.

Former Article 55, consisting of Sections R6-5-5501 through R6-5-5526, repealed effective December 8, 1983.

Section

R6-5-5501. Definitions
 R6-5-5502. Receipt and Screening of Information; Child Abuse Hotline
 R6-5-5503. Non-Reports
 R6-5-5504. Preliminary Screening Classifications
 R6-5-5505. Priority Codes; Initial Response Time
 R6-5-5506. Methods for Investigation of Reports

R6-5-5507. Alternative Investigation
 R6-5-5508. Conduct of a Field Investigation
 R6-5-5509. Establishing Probable Cause of Child Maltreatment
 R6-5-5510. Investigation Findings; Required Documentation
 R6-5-5511. Ongoing Services; Imminent Harm Not Identified; Case Closure
 R6-5-5512. Procedures for Substantiated Reports; Removal; Imminent Harm
 R6-5-5513. Alternatives to Involuntary Removal; Voluntary Placement; Removal
 R6-5-5514. Removal Review
 R6-5-5515. Procedures for Investigations of Maltreatment in a Licensed Child Welfare Agency
 R6-5-5516. Procedures for Investigations of Out-of-Home Care Providers
 R6-5-5517. Repealed
 R6-5-5518. Repealed
 R6-5-5519. Repealed
 R6-5-5520. Repealed
 R6-5-5521. Repealed
 R6-5-5522. Repealed
 R6-5-5523. Repealed
 R6-5-5524. Repealed
 R6-5-5525. Repealed
 R6-5-5526. Repealed
 Appendix 1. Pre-screening Cue Questions
 Appendix 2. Cue Questions

ARTICLE 56. CONFIDENTIALITY AND RELEASE OF CPS INFORMATION

Article 56, consisting of new Sections R6-5601 through R6-5-5612, adopted by final rulemaking at 5 A.A.R. 1804, effective May 18, 1999 (Supp. 99-2).

Article 56, consisting of Sections R6-5-5601 through R6-5-5624, recodified to A.A.C. R6-8-201 through R6-8-224 effective February 13, 1996 (Supp. 96-1).

Section

R6-5-5601. Definitions
 R6-5-5602. Scope and Application
 R6-5-5603. Procedures for Requesting CPS Information
 R6-5-5604. Procedures for Processing a Request for CPS Information
 R6-5-5605. Procedures for Processing a Request for CPS Information from a Person or Entity Providing Services in Official Capacity
 R6-5-5606. Release of Summary CPS Information to a Person Who Reported Suspected Child Abuse and Neglect
 R6-5-5607. Release of CPS Information for a Research or Evaluation Project
 R6-5-5608. Release of CPS Information to a Legislator or Another Person that Provides Oversight
 R6-5-5609. Release of CPS Information in a Case of Child Abuse, Abandonment, or Neglect that has Resulted in a Fatality or Near Fatality
 R6-5-5610. Fees
 R6-5-5611. Repealed
 R6-5-5612. Renumbered

ARTICLE 57. REPEALED

Article 57, consisting of Sections R6-5-5701 thru R6-5-5709, repealed effective April 9, 1998 (Supp. 98-2).

Article 57, consisting of Sections R6-5-5701 through R6-5-5709, adopted effective November 5, 1984.

Former Article 57, consisting of Sections R6-5-5701 through R6-5-5711, repealed effective November 5, 1984.

ARTICLE 58. FAMILY FOSTER PARENT LICENSING REQUIREMENTS

Article 58, consisting of Sections R6-5-5801 through R6-5-5850, adopted effective January 10, 1997 (Supp. 97-1).

Former Article 58, consisting of Sections R6-5-5801 through R6-5-5807, repealed effective January 10, 1997 (Supp. 97-1).

Article 58, consisting of Sections R6-5-5801 through R6-5-5807, adopted effective April 1, 1981.

Former Article 58, consisting of Sections R6-5-5801 through R6-5-5811, repealed effective April 1, 1981.

Section	
R6-5-5801.	Definitions
R6-5-5802.	Application for Initial License
R6-5-5803.	Investigation of the Applicant
R6-5-5804.	Inspection of the Foster Home; DHS Inspection Report
R6-5-5805.	Investigative Report and Licensing Recommendation
R6-5-5806.	Complete Application Package: Contents
R6-5-5807.	CPSCR Check; Additional Investigation by Licensing Authority
R6-5-5808.	License: Form; Issuance; Denial; Term; Termination
R6-5-5809.	Provisional License
R6-5-5810.	Application for License Renewal
R6-5-5811.	Renewal Investigation; Licensing Report and Recommendation
R6-5-5812.	Renewal License
R6-5-5813.	Licensing Time-frames
R6-5-5814.	Amended License; Change in Household Members
R6-5-5815.	Monitoring the Foster Home and Family
R6-5-5816.	Investigation of Complaints about a Foster Home
R6-5-5817.	Licensing Authority Action On Complaints
R6-5-5818.	Corrective Action
R6-5-5819.	License Denial, Suspension, and Revocation
R6-5-5820.	Adverse Action; Notice; Effective Date
R6-5-5821.	Appeals
R6-5-5822.	Alternative Methods of Compliance
R6-5-5823.	Foster Parent: General Qualifications
R6-5-5824.	Foster Parent: Personal Characteristics
R6-5-5825.	Training and Development
R6-5-5826.	Compliance With Licensing Limitations; Adult - Child Ratios
R6-5-5827.	Placement Agreement
R6-5-5828.	Participation in Case Planning
R6-5-5829.	Daily Care and Treatment of a Foster Child; Foster Child Rights
R6-5-5830.	Medical and Dental Care
R6-5-5831.	Child Care
R6-5-5832.	Transportation
R6-5-5833.	Behavior Management; Discipline; Prohibitions
R6-5-5834.	Notification of Foster Child Death, Illness, Accident, Unauthorized Absence, or Other Unusual Events
R6-5-5835.	Notification of Events or Changes Involving the Foster Family or the Foster Home
R6-5-5836.	Maintenance of a Foster Child's Records
R6-5-5837.	Confidentiality
R6-5-5838.	Foster Home: General Requirements
R6-5-5839.	Foster Home: General Safety Measures
R6-5-5840.	Exterior Environment; Play Area; Play Equipment

R6-5-5841.	Swimming Pools and Pool Safety
R6-5-5842.	Bedrooms; Bedding; Sleeping Arrangements
R6-5-5843.	Bathrooms
R6-5-5844.	Kitchen
R6-5-5845.	Fire Safety and Prevention
R6-5-5846.	Emergencies, Exits, and Evacuation
R6-5-5847.	Special Provisions for a Receiving Foster Home
R6-5-5848.	Special Provisions for a Respite Foster Home
R6-5-5849.	Special Provisions for an In-home Respite Foster Parent
R6-5-5850.	Special Provisions for a Professional Foster Home

ARTICLE 59. GROUP FOSTER HOME LICENSING STANDARDS

Section	
R6-5-5901.	Expired
R6-5-5902.	Expired
R6-5-5903.	Definitions
R6-5-5904.	Responsibilities of the Department
R6-5-5905.	Expired
R6-5-5906.	Licensing Requirements
R6-5-5907.	Denial, Suspension, or Revocation of a License
R6-5-5908.	Re-licensing Requirements
R6-5-5909.	Standards for Licensing and Operating Group Foster Homes
R6-5-5910.	Confidentiality
R6-5-5911.	Expired
R6-5-5912.	Expired

ARTICLE 60. COMPREHENSIVE MEDICAL/DENTAL PROGRAM FOR FOSTER CHILDREN

Section	
R6-5-6001.	Objective
R6-5-6002.	Authority
R6-5-6003.	Definitions
R6-5-6004.	Eligibility
R6-5-6005.	Definition of Covered Services
R6-5-6006.	Exceptions, Limitations and Exclusions
R6-5-6007.	Prior Authorization
R6-5-6008.	Coordination of Benefits
R6-5-6009.	Identification Card
R6-5-6010.	Payment and Review of Claims
R6-5-6011.	Abuse and Misuse of the Program
R6-5-6012.	Consent for Treatment
R6-5-6013.	Administration of the Program
R6-5-6014.	Case Management
R6-5-6015.	Fee Schedule
Exhibit 1.	Repealed

ARTICLE 61. REPEALED

Article 61, consisting of Sections R6-5-6101 through R6-5-6104, repealed effective June 5, 1997 (Supp. 97-2).

Article 61, consisting of Sections R6-5-6101 through R6-5-6104, adopted effective August 29, 1984.

Former Article 61, consisting of Sections R6-5-6101 through R6-5-6108, repealed effective August 29, 1984.

ARTICLE 62. REPEALED

Former Article 62 consisting of Sections R6-5-6201 through R6-5-6209 repealed effective August 29, 1984.

ARTICLE 63. REPEALED

Former Article 63 consisting of Sections R6-5-6301 through R6-5-6304 repealed effective November 8, 1982.

ARTICLE 64. REPEALED

Former Article 64 consisting of Sections R6-5-6401 through R6-5-6408 repealed effective February 1, 1979.

ARTICLE 65. DEPARTMENT ADOPTION FUNCTIONS AND PROCEDURES FOR PROVIDING ADOPTION SERVICES

Article 65, consisting of Sections R6-5-6501 through R6-5-6511, adopted effective January 2, 1996 (Supp. 96-1).

Article 65, consisting of Sections R6-5-6501 through R6-5-6509, repealed effective January 2, 1996 (Supp. 96-1).

Section

- R6-5-6501. Definitions
- R6-5-6502. Central Adoption Registry; Information Maintained; Confidentiality
- R6-5-6503. Expired
- R6-5-6503.01. Expired
- R6-5-6504. Department Adoption Services
- R6-5-6505. Department Procedures for Processing Certification Applications
- R6-5-6506. Department Priorities for Receipt of Services
- R6-5-6507. Department Recruitment Efforts
- R6-5-6508. Referrals to Other Sources
- R6-5-6509. Fees
- R6-5-6510. International Adoptions
- R6-5-6511. Termination of Services

ARTICLE 66. ADOPTION SERVICES

Article 66, consisting of Sections R6-5-6601 through R6-5-6624, adopted effective January 2, 1996 (Supp. 96-1).

Article 66, consisting of Sections R6-5-6601 through R6-5-6610, repealed effective January 2, 1996 (Supp. 96-1).

Section

- R6-5-6601. Definitions
- R6-5-6602. Recruitment
- R6-5-6603. Orientation: Persons Interested in Adoption
- R6-5-6604. Application for Certification; Fees; Waiver
- R6-5-6605. Certification Investigation
- R6-5-6606. Certification Report and Recommendation
- R6-5-6607. Renewal of Certification
- R6-5-6608. Communications with Certified Parents Awaiting Placement
- R6-5-6609. Prohibitions Regarding Birth Parents
- R6-5-6610. Information about Birth Parents
- R6-5-6611. Pre-consent Conferences with Birth Parents
- R6-5-6612. Consent to Adopt; Unknown Birth Parent
- R6-5-6613. Adoptable Child: Assessment and Service Plan
- R6-5-6614. Placement Determination
- R6-5-6615. Provision of Information on Placed Child
- R6-5-6616. Transportation
- R6-5-6617. Expired
- R6-5-6618. Placement Services
- R6-5-6619. Post-placement Supervision: Non-foster Parent Placements
- R6-5-6620. Post-placement Supervision: Foster Parent Placements
- R6-5-6621. Protracted Placements
- R6-5-6622. Finalizing the Placement
- R6-5-6623. Placement Disruption
- R6-5-6624. Confidentiality

ARTICLE 67. ADOPTION SUBSIDY

Section

- R6-5-6701. Definitions
- R6-5-6702. Eligibility Criteria
- R6-5-6703. Eligibility Determination
- R6-5-6704. Adoption Subsidy Agreement
- R6-5-6705. Medical, Dental, and Mental Health Subsidy
- R6-5-6706. Maintenance Subsidy
- R6-5-6707. Special Services Subsidy
- R6-5-6708. Nonrecurring Adoption Expenses
- R6-5-6709. Annual Review; Reporting Change
- R6-5-6710. Termination of Adoption Subsidy
- R6-5-6711. New or Amended Adoption Subsidy Agreement
- R6-5-6712. Appeals
- R6-5-6713. Renumbered

ARTICLE 68. REPEALED

Former Article 68, consisting of Sections R6-5-6801 through R6-5-6808, repealed effective June 5, 1997 (Supp. 97-2).

ARTICLE 69. CHILD PLACING AGENCY LICENSING STANDARDS

Section

- R6-5-6901. Objectives
- R6-5-6902. Authority
- R6-5-6903. Definitions
- R6-5-6904. Licensing Requirements
- R6-5-6905. Denial, Suspension, or Revocation of a License
- R6-5-6906. License Renewal Requirements
- R6-5-6907. Standards for Licensing and Operating a Child Placing Agency
- R6-5-6908. Confidentiality
- R6-5-6909. Civil Rights
- R6-5-6910. Fair Labor Standards Act

ARTICLE 70. ADOPTION AGENCY LICENSING

Article 70, consisting of Sections R6-5-7001 through R6-5-7040, adopted effective January 2, 1996 (Supp. 96-1).

Article 70, consisting of Sections R6-5-7001 through R6-5-7040, repealed effective January 2, 1996 (Supp. 96-1).

Article 70 consisting of Sections R6-5-7001 through R6-5-7040 adopted as permanent rules effective January 23, 1987.

Article 70 consisting of Sections R6-5-7001 through R6-5-7040 adopted as an emergency effective October 17, 1986, pursuant to A.R.S. § 41-1003, valid for only 90 days. Emergency expired.

Article 70 consisting of Sections R6-5-7001 through R6-5-7006 adopted as an emergency effective January 1, 1986, pursuant to A.R.S. § 41-1003, valid for only 90 days. Emergency renewed effective April 1, 1986, pursuant to A.R.S. § 41-1003, valid for only 90 days. Emergency expired.

Section

- R6-5-7001. Definitions
- R6-5-7002. Who Shall Be Licensed
- R6-5-7003. Licensing: Initial Application; Fee
- R6-5-7004. Licensing: Out-of-state Agencies
- R6-5-7005. Department Procedures for Processing License Applications
- R6-5-7006. License: Issuance; Denial
- R6-5-7007. License: Term; Nontransferability
- R6-5-7008. Application for License Renewal; Fee
- R6-5-7009. Renewal License: Issuance
- R6-5-7010. Amended License
- R6-5-7011. Governing Body
- R6-5-7012. Agency Administrator
- R6-5-7013. Social Services Director

R6-5-7014.	Social Workers
R6-5-7015.	Agency Employees: Hiring; References; Fingerprinting
R6-5-7016.	Agency Volunteers; Interns
R6-5-7017.	Personnel Records
R6-5-7018.	Training Requirements
R6-5-7019.	Contracted Services
R6-5-7020.	Staffing Ratios
R6-5-7021.	Operations Manual
R6-5-7022.	Agency Operations Budget; Financial Records
R6-5-7023.	Annual Financial Audit
R6-5-7024.	Insurance Coverage
R6-5-7025.	Protecting Confidentiality of Adoption Records
R6-5-7026.	Recordkeeping Requirements: Adoptive Children
R6-5-7027.	Recordkeeping Requirements: Adoptive Parents
R6-5-7028.	Reporting Requirements: Abuse; Unauthorized Practice; Changes; Registry Information
R6-5-7029.	Birth Parent: Service Agreement; Prohibitions
R6-5-7030.	Adoption Fees; Reasonableness
R6-5-7031.	Adoption Fee Agreement
R6-5-7032.	AHCCCS Reimbursement; Disclosure of Third-party Coverage
R6-5-7033.	Monitoring: Inspections and Interviews; Compliance Audit
R6-5-7034.	Complaints; Investigations
R6-5-7035.	Noncompliance Status
R6-5-7036.	Suspension
R6-5-7037.	Revocation
R6-5-7038.	Adverse Action: Procedures
R6-5-7039.	Appeals
R6-5-7040.	International Adoptions

ARTICLE 71. REPEALED

Article 71, consisting of Sections R6-5-7101 through R6-5-7104, repealed effective April 9, 1998 (Supp. 98-2).

Article 71, consisting of Sections R6-5-7101 through R6-5-7104, adopted as permanent rules effective July 11, 1986.

Former Article 71, consisting of Sections R6-5-7101 through R6-5-7104, adopted as an emergency effective January 1, 1986 and renewed as an emergency effective April 1, 1986, pursuant to A.R.S. § 41-1003, valid for only 90 days. Emergency effective April 1, 1986 expired.

Former Article 71, consisting of Sections R6-5-7101 through R6-5-7104, repealed effective November 8, 1982.

ARTICLE 72. REPEALED

Former Article 72 consisting of Sections R6-5-7201 through R6-5-7214 repealed effective July 12, 1984.

ARTICLE 73. REPEALED & RENUMBERED

Article 73, consisting of Sections R6-5-7301 through R6-5-7306 and R6-5-7309, repealed; Sections R6-5-7307 and R6-5-7308 renumbered to Sections in Article 74, filed with the Secretary of State's Office May 15, 1997; effective July 1, 1997 (Supp. 97-2). Effective date corrected Supp. 98-2.

Article 73 consisting of Sections R6-5-7301 through R6-5-7309 adopted effective January 21, 1985.

Former Article 73, consisting of Sections R6-5-7301 through R6-5-7320, repealed effective February 26, 1979.

ARTICLE 74. LICENSING PROCESS AND LICENSING REQUIREMENTS FOR CHILD WELFARE AGENCIES

OPERATING RESIDENTIAL GROUP CARE FACILITIES AND OUTDOOR EXPERIENCE PROGRAMS

Article 74, consisting of Sections R6-5-7401 through R6-5-7469, and Appendix 1 adopted; and Sections R6-5-7470 and R6-5-7471 renumbered from Article 73 and amended effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2). Effective date corrected Supp. 98-2.

Former Article 74, consisting of Sections R6-5-7401 through R6-5-7413, repealed effective May 15, 1997 (Supp. 97-2).

Section	
R6-5-7401.	Definitions
R6-5-7402.	Request for Initial Application - New Applicant
R6-5-7403.	Letter of Intent - New Applicant
R6-5-7404.	The Licensing Consultation; Time for Completion of Application
R6-5-7405.	Complete Application; Initial License - New Applicant
R6-5-7406.	Site Inspection
R6-5-7407.	Licensing Study
R6-5-7408.	Licensing Decision: Issuance; Denial; Time-Frames
R6-5-7409.	Licenses and Operating Certificates: Form; Term; Nontransferability
R6-5-7410.	Licensed Agency: Application for an Operating Certificate for an Additional Satellite Facility
R6-5-7411.	Application for Renewal of License and Operating Certificates
R6-5-7412.	Renewal of License and Operating Certificates: Site Inspection; Time-frames; Standard for Issuance
R6-5-7413.	Notification to Licensing Authority of Changes Affecting License; Staff Changes
R6-5-7414.	Amended License or Operating Certificate
R6-5-7415.	Alternative Method of Compliance
R6-5-7416.	Monitoring
R6-5-7417.	Complaints; Investigations
R6-5-7418.	Corrective Action
R6-5-7419.	Provisional License
R6-5-7420.	Denial, Suspension, and Revocation of a License or Operating Certificate
R6-5-7421.	Adverse Action; Procedures; Effective Date
R6-5-7422.	Appeals
R6-5-7423.	Statement of Purpose; Program Description and Evaluation; Compliance With Adopted Policies; Client Rights; Single Category of Care
R6-5-7424.	Governing Body
R6-5-7425.	Business and Fiscal Management; Annual Audit
R6-5-7426.	Insurance Coverage
R6-5-7427.	Confidentiality
R6-5-7428.	Children's Records: Contents; Maintenance; Destruction
R6-5-7429.	Grievances
R6-5-7430.	Staff Management and Staff Records
R6-5-7431.	General Qualifications for Staff
R6-5-7432.	Qualifications for Specific Positions or Tasks; Exclusions
R6-5-7433.	Orientation and Training for Staff
R6-5-7434.	Notification of Unusual Incidents and Other Occurrences
R6-5-7435.	Investigations of Child Maltreatment
R6-5-7436.	Runaways and Missing Children
R6-5-7437.	Staff Coverage; Staff-child Ratios
R6-5-7438.	Admission and Intake; Criteria; Process; Restrictions
R6-5-7439.	Information and Services Provided to Placing Agency or Person
R6-5-7440.	Orientation Process for a Child in Care

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- R6-5-7441. Child's Service Plan: Preparation; Review; Planning Participants
- R6-5-7442. Discharge; Discharge Summary
- R6-5-7443. Personal Care of Children
- R6-5-7444. Children's Clothing and Personal Belongings
- R6-5-7445. Children's Money; Restitution
- R6-5-7446. Nutrition, Menus, and Food Service
- R6-5-7447. Sleeping Arrangements
- R6-5-7448. Visitation, Outings, Mail, and Telephones
- R6-5-7449. Educational and Vocational Services; Work Assignments
- R6-5-7450. Recreation, Leisure, Cultural Activities, and Community Interaction
- R6-5-7451. Religion, Culture, and Ethnic Heritage
- R6-5-7452. Medical and Health Care
- R6-5-7453. Medications
- R6-5-7454. Storage of Medications
- R6-5-7455. Children's Medical and Dental Records
- R6-5-7456. Behavior Management
- R6-5-7457. Body Searches
- R6-5-7458. Buildings; Grounds; Water Supply
- R6-5-7459. Building Interior
- R6-5-7460. Kitchens; Food Preparation; and Dining Areas
- R6-5-7461. Sleeping Areas and Furnishings
- R6-5-7462. Bathrooms
- R6-5-7463. Other Facility Space; Staff Quarters
- R6-5-7464. Fire, Emergency, and Fire Prevention
- R6-5-7465. General Safety
- R6-5-7466. Swimming Areas
- R6-5-7467. Access; Transportation; Outings
- R6-5-7468. Special Provisions for Shelter Care Facilities
- R6-5-7469. Special Provisions and Exemptions for Outdoor Experience Programs
- R6-5-7470. Planning Requirements for Outdoor Experience Programs
- R6-5-7471. Special Physical Environment and Safety Requirements for Outdoor Experience Programs

Appendix 1.

ARTICLE 75. APPEAL AND HEARING PROCEDURES FOR ADVERSE ACTION AGAINST FAMILY FOSTER HOMES, ADOPTION AGENCIES, FAMILY CHILD CARE HOME PROVIDERS, AND PERSONS LISTED ON THE CHILD CARE RESOURCE AND REFERRAL SYSTEM

New Article 75, consisting of Sections R6-5-7501 through R6-5-7508, adopted effective June 4, 1998 (98-2).

Former Article 75, consisting of Sections R6-5-7501 through R6-5-7508, repealed effective November 8, 1982.

Section

- R6-5-7501. Definitions
- R6-5-7502. Entitlement to a Hearing; Appealable Action
- R6-5-7503. Computation of Time
- R6-5-7504. Request for Hearing: Form; Time Limits; Presumptions
- R6-5-7505. Administration: Transmittal of Appeal
- R6-5-7506. Stay of Adverse Action Pending Appeal
- R6-5-7507. Hearings: Location; Notice; Time
- R6-5-7508. Rescheduling the Hearing
- R6-5-7509. Hearing Officer: Duties and Qualifications
- R6-5-7510. Change of Hearing Officer; Challenges for Cause
- R6-5-7511. Subpoenas
- R6-5-7512. Parties' Rights
- R6-5-7513. Withdrawal of an Appeal
- R6-5-7514. Failure to Appear; Default; Reopening

- R6-5-7515. Hearing Proceedings
- R6-5-7516. Hearing Decision
- R6-5-7517. Effect of the Decision
- R6-5-7518. Further Administrative Appeal
- R6-5-7519. Appeals Board
- R6-5-7520. Judicial Review

ARTICLE 76. REPEALED

Article 76, consisting of Sections R6-5-7601 through R6-5-7639, repealed effective December 17, 1993 (Supp. 93-4).

ARTICLE 77. REPEALED

Former Article 77 consisting of Sections R6-5-7701 through R6-5-7704 repealed effective November 8, 1982.

ARTICLE 78. REPEALED

Former Article 78 consisting of Sections R6-5-7801 through R6-5-7804 repealed effective November 8, 1982.

ARTICLE 79. REPEALED

Former Article 79 consisting of Sections R6-5-7901 through R6-5-7913 repealed effective November 8, 1982.

ARTICLE 80. INTERSTATE COMPACT ON THE PLACEMENT OF CHILDREN

Section

- R6-5-8001. Goals
- R6-5-8002. Objectives
- R6-5-8003. Authority
- R6-5-8004. Definitions
- R6-5-8005. Placement Agreement
- R6-5-8006. Financial Responsibility
- R6-5-8007. Eligibility
- R6-5-8008. Placement Approval
- R6-5-8009. Case Management
- R6-5-8010. Terminating the Service

ARTICLE 81. REPEALED

Former Article 81 consisting of Sections R6-5-8101 through R6-5-8104 repealed effective November 8, 1982.

ARTICLE 82. REPEALED

Former Article 82 consisting of Sections R6-5-8201 through R6-5-8204 repealed effective November 8, 1982.

ARTICLE 83. REPEALED

Article 83, consisting of Sections R6-5-8301 through R6-5-8308, repealed effective December 17, 1993 (Supp. 93-4).

ARTICLE 84. REPEALED

Former Article 84 consisting of Sections R6-5-8401 through R6-5-8404 repealed effective November 8, 1982.

ARTICLE 85. REPEALED

Former Article 85 consisting of Sections R6-5-8501 through R6-5-8508 repealed effective November 8, 1982.

ARTICLE 86. REPEALED

Article 86, consisting of Sections R6-5-8601 through R6-5-8604, repealed effective December 17, 1993 (Supp. 93-4).

Article 86 consisting of Sections R6-5-8601 through R6-5-8604 adopted effective March 8, 1979.

Former Article 86 consisting of Sections R6-5-8601 through R6-5-8611 repealed effective March 8, 1979.

ARTICLE 87. REPEALED

Article 87, consisting of Sections R6-5-8701 through R6-5-8704, repealed effective December 17, 1993 (Supp. 93-4).

ARTICLE 88. REPEALED

Former Article 88 consisting of Sections R6-5-8801 through R6-5-8804 repealed effective November 8, 1982.

ARTICLE 89. RESERVED**ARTICLE 90. RESERVED****ARTICLE 91. REPEALED**

Article 91, consisting of Sections R6-5-9101 through R6-5-9104, repealed effective December 17, 1993 (Supp. 93-4).

ARTICLE 92. REPEALED

Article 92, consisting of Sections R6-5-9201 through R6-5-9204, repealed effective December 17, 1993 (Supp. 93-4).

ARTICLE 93. REPEALED

Former Article 93 consisting of Sections R6-5-9301 through R6-5-9304 repealed effective November 8, 1982.

ARTICLE 94. REPEALED

Former Article 94 consisting of Sections R6-5-9401 through R6-5-9404 repealed effective November 8, 1982.

ARTICLE 95. REPEALED

Former Article 95 consisting of Sections R6-5-9501 through R6-5-9504 repealed effective November 8, 1982.

ARTICLE 96. REPEALED

Former Article 96 consisting of Sections R6-5-9601 through R6-5-9604 repealed effective November 8, 1982.

ARTICLE 97. REPEALED

Former Article 97 consisting of Sections R6-5-9701 through R6-5-9704 repealed effective November 8, 1982.

ARTICLE 98. REPEALED

Former Article 98 consisting of Sections R6-5-9801 through R6-5-9804 repealed effective November 8, 1982.

ARTICLE 99. REPEALED

Former Article 99 consisting of Sections R6-5-9901 through R6-5-9904 repealed effective November 8, 1982.

ARTICLE 100. REPEALED

Former Article 100 consisting of Sections R6-5-10001 through R6-5-10004 repealed effective November 8, 1982.

ARTICLE 101. REPEALED

Former Article 101 consisting of Sections R6-5-10101 through R6-5-10104 repealed effective November 8, 1982.

ARTICLE 102. REPEALED

Former Article 102 consisting of Sections R6-5-10201 through R6-5-10204 repealed effective November 8, 1982.

ARTICLE 103. REPEALED

Former Article 103 consisting of Sections R6-5-10301 through R6-5-10304 repealed effective November 8, 1982.

ARTICLE 104. REPEALED

Article 104, consisting of Sections R6-5-10401 through R6-5-10404, repealed effective December 17, 1993 (Supp. 93-4).

ARTICLE 105. REPEALED

Article 105, consisting of Sections R6-5-10501 through R6-5-10504, repealed effective December 17, 1993 (Supp. 93-4).

ARTICLE 106. REPEALED

Former Article 106 consisting of Sections R6-5-10601 through R6-5-10604 repealed effective November 8, 1982.

ARTICLE 107. REPEALED

Former Article 107 consisting of Sections R6-5-10701 through R6-5-10704 repealed effective November 8, 1982.

ARTICLE 108. REPEALED

Former Article 108 consisting of Sections R6-5-10801 through R6-5-10804 repealed effective November 8, 1982.

ARTICLE 109. REPEALED

Former Article 109 consisting of Sections R6-5-10901 through R6-5-10904 repealed effective November 8, 1982.

ARTICLE 110. REPEALED

Former Article 110 consisting of Sections R6-5-11001 through R6-5-11004 repealed effective November 8, 1982.

ARTICLE 1. REPEALED

Former Article 1 consisting of Sections R6-5-01 through R6-5-103 repealed effective August 3, 1978.

ARTICLE 2. REPEALED

Former Article 2 consisting of Sections R6-5-201 through R6-5-209 repealed effective August 8, 1978.

ARTICLE 3. REPEALED

Former Article 3 consisting of Sections R6-5-301 through R6-5-308 repealed effective July 6, 1976.

ARTICLE 4. REPEALED

Former Article 4 consisting of Sections R6-5-401 through R6-5-420 repealed effective August 3, 1978.

ARTICLE 5. REPEALED

Former Article 5 consisting of Sections R6-5-501 through R6-5-504 repealed effective July 6, 1976.

ARTICLE 6. REPEALED

Former Article 6 consisting of Sections R6-5-601 through R6-5-622 repealed effective July 6, 1977.

ARTICLE 7. REPEALED

Former Article 7 consisting of Sections R6-5-701 through R6-5-716 repealed effective August 3, 1978.

ARTICLE 8. REPEALED

Former Article 8 consisting of Sections R6-5-801 through R6-5-808 repealed effective September 16, 1976.

ARTICLE 9. REPEALED

Former Article 9 consisting of Sections R6-5-901 through R6-5-904 repealed effective August 3, 1978.

ARTICLE 10. REPEALED

Former Article 10 consisting of Sections R6-5-1001 through R6-5-1003 repealed effective August 3, 1978.

ARTICLE 11. REPEALED

Former Article 11 consisting of Sections R6-5-1101 through R6-5-1109 repealed effective August 11, 1976.

ARTICLE 12. REPEALED

Former Article 12 consisting of Sections R6-5-1201 through R6-5-1206 repealed effective May 17, 1976.

ARTICLE 13. REPEALED

Former Article 13 consisting of Sections R6-5-1301 through R6-5-1309 repealed effective November 23, 1976.

ARTICLE 14. REPEALED

Former Article 14 consisting of Sections R6-5-1401 through R6-5-1413 repealed effective May 24, 1976.

ARTICLE 15. REPEALED

Former Article 15 consisting of Sections R6-5-1501 through R6-5-1504 repealed effective August 11, 1976.

ARTICLE 16. RESERVED

ARTICLE 17. REPEALED

Former Article 17 consisting of Sections R6-5-1701 through R6-5-1704 repealed effective August 11, 1976.

ARTICLE 18. REPEALED

Former Article 18 consisting of Sections R6-5-1801 through R6-5-1804 repealed effective August 11, 1976.

ARTICLE 19. REPEALED

Former Article 19 consisting of Sections R6-5-1901 through R6-5-1906 repealed effective July 6, 1976.

ARTICLE 20. REPEALED

R6-5-2001. Repealed

Historical Note

Adopted as an emergency effective October 2, 1975 (Supp. 75-1). Former Section R6-5-2001 repealed, new Section R6-5-2001 adopted effective May 17, 1976 (Supp. 76-3). Amended as an emergency effective August 3, 1976 (Supp. 76-4). Former Section R6-5-2001 repealed, new Section R6-5-2001 adopted effective November 8, 1982 (Supp. 82-6). Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-2002. Repealed

Historical Note

Adopted as an emergency effective October 2, 1975 (Supp. 75-1). Former Section R6-5-2002 repealed, new Section R6-5-2002 adopted effective May 17, 1976 (Supp. 76-3). Amended effective February 10, 1977 (Supp. 77-1). Former Section R6-5-2002 repealed, new Section R6-5-2002 adopted effective November 8, 1982 (Supp. 82-6). Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-2003. Repealed

Historical Note

Adopted as an emergency effective October 2, 1975 (Supp. 75-1). Former Section R6-5-2003 repealed, new Section R6-5-2003 adopted effective May 17, 1976 (Supp. 76-3). Amended effective February 10, 1977 (Supp. 77-1). Amended effective October 31, 1978 (Supp. 78-5). Former Section R6-5-2003 repealed, new Section R6-5-2003 adopted effective November 8, 1982

(Supp. 82-6). Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-2004. Repealed

Historical Note

Adopted as an emergency effective October 2, 1975 (Supp. 75-1). Former Section R6-5-2004 repealed, new Section R6-5-2004 adopted effective May 17, 1976 (Supp. 76-3). Amended as an emergency effective August 3, 1976 (Supp. 76-4). Amended effective February 10, 1977 (Supp. 77-1). Amended effective October 31, 1978 (Supp. 78-5). Former Section R6-5-2004 repealed, new Section R6-5-2004 adopted effective November 8, 1982 (Supp. 82-6). Exhibit I, Title XX, Social Services Plan, incorporated by reference in subsection (C), paragraph (2) of this rule, is adopted for the program period July 1, 1983, through June 30, 1984, and the former Exhibit I, Title XX, Social Services Plan is repealed accordingly (Supp. 83-3). Exhibit I, Title XX, Social Services Plan, incorporated herein by reference, amended as an emergency effective September 30, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-5). Emergency expired. Permanent amendment adopted effective January 3, 1984 (Supp. 84-1). Exhibit I, Title XX, Social Services Plan, incorporated by reference in subsection (C), paragraph (2) of this rule, is adopted for the program period July 1, 1984, through June 30, 1985, and the former Exhibit I, Title XX, Social Services Plan is repealed accordingly (Supp. 84-3). Exhibit I, Title XX, Social Services Plan, incorporated by reference in subsection (C), paragraph (2) of this rule, is adopted for the program period July 1, 1985, through June 30, 1986, and the former Exhibit I, Title XX, Social Services Plan is repealed accordingly (Supp. 85-3). Exhibit I, Title XX, Social Services Plan, incorporated by reference in subsection (C), paragraph (2) of this rule, is adopted for the program period July 2, 1986, through June 30, 1987, and the former Exhibit I, Title XX, Social Services Plan is repealed accordingly (Supp. 86-4). Exhibit I, Title XX, Social Services Plan, incorporated by reference in subsection (C), paragraph (2) of this rule, is adopted for the program period September 24, 1987, through June 30, 1988, and the former Exhibit I, Title XX, Social Services Plan is repealed accordingly (Supp. 87-3). Exhibit I, Title XX, Social Services Plan, incorporated by reference in subsection (C), paragraph (2) of this rule, is adopted for the program period September 22, 1988, through June 30, 1989, and the former Exhibit I, Title XX, Social Services Plan is repealed accordingly (Supp. 88-3). Exhibit I, Title XX, Social Services Plan, incorporated by reference in subsection (C), paragraph (2), of this rule, is adopted for the program period July 1, 1989, through June 30, 1990, and the former Exhibit I, Title XX, Social Services Plan is repealed accordingly (Supp. 89-3). Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-2005. Repealed

Historical Note

Adopted effective May 17, 1976 (Supp. 76-3). Amended effective February 10, 1977 (Supp. 77-1). Amended effective October 31, 1978 (Supp. 78-5). Former Section R6-5-2005 repealed, new Section R6-5-2005 adopted effective November 8, 1982 (Supp. 82-6). A new Exhibit I, Title XX, Social Services Plan, referred to in subsection (1) of this rule, is adopted for the program period Septem-

ber 22, 1988 through July 30, 1989 (Supp. 88-3).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-2006. Repealed**Historical Note**

Adopted effective May 17, 1976 (Supp. 76-3). Amended effective February 10, 1977 (Supp. 77-1). Amended effective October 31, 1978 (Supp. 78-5). Repealed effective November 8, 1982 (Supp. 82-6).

ARTICLE 21. REPEALED

Former Article 21 consisting of Sections R6-5-2101 through R6-5-2110 repealed effective November 8, 1982.

ARTICLE 22. REPEALED

Former Article 22 consisting of Sections R6-5-2202 through R6-5-2209 repealed effective November 8, 1982.

ARTICLE 23. REPEALED**R6-5-2301. Repealed****Historical Note**

Adopted as an emergency effective October 2, 1975 (Supp. 75-1). Former Section R6-5-2301 repealed, new Section R6-5-2301 adopted effective May 17, 1976 (Supp. 76-3). Repealed by final rulemaking at 5 A.A.R. 1804, effective May 18, 1999 (Supp. 99-2).

R6-5-2302. Repealed**Historical Note**

Adopted as an emergency effective October 2, 1975 (Supp. 75-1). Former Section R6-5-2302 repealed, new Section R6-5-2302 adopted effective May 17, 1976 (Supp. 76-3). Repealed by final rulemaking at 5 A.A.R. 1804, effective May 18, 1999 (Supp. 99-2).

R6-5-2303. Repealed**Historical Note**

Adopted as an emergency effective October 2, 1975 (Supp. 75-1). Former Section R6-5-2303 repealed, new Section R6-5-2303 adopted effective May 17, 1976 (Supp. 76-3). Repealed by final rulemaking at 5 A.A.R. 1804, effective May 18, 1999 (Supp. 99-2).

R6-5-2304. Repealed**Historical Note**

Adopted as an emergency effective October 2, 1975 (Supp. 75-1). Former Section R6-5-2304 repealed, new Section R6-5-2304 adopted effective May 17, 1976 (Supp. 76-3). Repealed by final rulemaking at 5 A.A.R. 1804, effective May 18, 1999 (Supp. 99-2).

R6-5-2305. Repealed**Historical Note**

Adopted as an emergency effective October 2, 1975 (Supp. 75-1). Former Section R6-5-2305 repealed, new Section R6-5-2305 adopted effective May 17, 1976 (Supp. 76-3). Repealed by final rulemaking at 5 A.A.R. 1804, effective May 18, 1999 (Supp. 99-2).

R6-5-2306. Repealed**Historical Note**

Adopted as an emergency effective October 2, 1975 (Supp. 75-1). Former Section R6-5-2306 repealed, new Section R6-5-2306 adopted effective May 17, 1976 (Supp. 76-3). Repealed by final rulemaking at 5 A.A.R. 1804, effective May 18, 1999 (Supp. 99-2).

R6-5-2307. Repealed**Historical Note**

Adopted effective May 17, 1976 (Supp. 76-3). Repealed by final rulemaking at 5 A.A.R. 1804, effective May 18, 1999 (Supp. 99-2).

R6-5-2308. Repealed**Historical Note**

Adopted effective May 17, 1976 (Supp. 76-3). Repealed by final rulemaking at 5 A.A.R. 1804, effective May 18, 1999 (Supp. 99-2).

R6-5-2309. Repealed**Historical Note**

Adopted effective May 17, 1976 (Supp. 76-3). Repealed by final rulemaking at 5 A.A.R. 1804, effective May 18, 1999 (Supp. 99-2).

R6-5-2310. Repealed**Historical Note**

Adopted effective May 17, 1976 (Supp. 76-3). Repealed by final rulemaking at 5 A.A.R. 1804, effective May 18, 1999 (Supp. 99-2).

ARTICLE 24. APPEALS AND HEARINGS

Article 24 consisting of Sections R6-5-2401 through R6-5-2405 adopted effective March 1, 1978.

Former Article 24 consisting of Sections R6-5-2401 through R6-5-2404 repealed effective March 1, 1978.

R6-5-2401. Expired**Historical Note**

Adopted as an emergency effective October 2, 1975 (Supp. 75-1). Former Section R6-5-2401 repealed, new Section R6-5-2401 adopted effective May 17, 1976 (Supp. 76-3). Former Section R6-5-2401 repealed, new Section R6-5-2401 adopted effective March 1, 1978 (Supp. 78-2). Section expired under A.R.S. § 41-1056(E) at 18 A.A.R. 607, effective October 31, 2011 (Supp. 12-1).

R6-5-2402. Expired**Historical Note**

Adopted as an emergency effective October 2, 1975 (Supp. 75-1). Former Section R6-5-2402 repealed, new Section R6-5-2402 adopted effective May 17, 1976 (Supp. 76-3). Former Section R6-5-2402 repealed, new Section R6-5-2402 adopted effective March 1, 1978 (Supp. 78-2). Section expired under A.R.S. § 41-1056(E) at 18 A.A.R. 607, effective October 31, 2011 (Supp. 12-1).

R6-5-2403. Expired**Historical Note**

Adopted as an emergency effective October 2, 1975 (Supp. 75-1). Former Section R6-5-2403 repealed, new Section R6-5-2403 adopted effective May 17, 1976 (Supp. 76-3). Former Section R6-5-2403 repealed, new Section R6-5-2403 adopted effective March 1, 1978 (Supp. 78-2). Section expired under A.R.S. § 41-1056(E) at 18 A.A.R. 607, effective October 31, 2011 (Supp. 12-1).

R6-5-2404. Basis for a hearing

- A.** A person will be granted a hearing for any of the following reasons:
1. Right to apply for social services has been denied.
 2. Application is denied in whole or in part.

3. Action on an application has not been taken by the Department within 30 days of the date of application.
4. Service is suspended, terminated or reduced when such action has occurred as a result of an eligibility determination.

B. Change in law or policy. A hearing shall not be granted when a change in federal or state law or policy requires service adjustments or discontinuance for classes of recipients.

Historical Note

Adopted effective May 17, 1976 (Supp. 76-3). Former Section R6-5-2404 repealed, new Section R6-5-2404 adopted effective March 1, 1978 (Supp. 78-2).

R6-5-2405. Hearing process

A. Filing of appeal

1. A request for a hearing shall be filed in writing with the Department or provider within 15 calendar days after the mailing date of the decision letter, except that for appeals on denying, revoking or suspending a license of a child welfare agency or foster home the request shall be filed within 20 calendar days.
2. Except as otherwise provided by statute or by Department regulation, any appeal, application, request, notice, report, or other information or document submitted to the Department shall be considered received by and filed with the Department:
 - a. If transmitted via the United States Postal Service or its successor, on the date it is mailed. The mailing date will be as follows:
 - i. As shown by the postmark.
 - ii. In the absence of a postmark the postage-meter mark of the envelope in which it is received;
 - iii. If not postmarked or postage-meter marked, or if the mark is illegible, the date entered on the document as the date of completion.
 - b. If transmitted by any means other than the United States Postal Service or its successor, on the date it is received by the Department.
 - c. The submission of any appeal, application, request, notice, report or other information or document not within the specified statutory or regulatory period shall be considered timely if it is established to the satisfaction of the Department that the delay in submission was due to Department error or misinformation or to delay or other action of the United States Postal Service or its successor.
 - d. Any notice, determination, decision or other data mailed by the Department shall be considered as having been given to the addressee to whom it is directed on the date it is mailed to the addressee's last known address. The date mailed shall be presumed to be the date of the notice, determination, decision or other data unless otherwise indicated by the facts. Computation of time shall be made in accordance with Rule 6(a) of the Rules of Civil Procedure, 16 A.R.S.
3. Benefits shall not be reduced or terminated prior to a hearing decision unless due to a subsequent change in household eligibility another notice of adverse action is received and not timely appealed.
4. The local office or provider shall advise the client of any community legal services available and, when requested, shall assist in completing the hearing request.

B. Notice of hearing

1. Hearings will be held at the local office or any other place mutually agreed upon by the hearing officer and appel-

lant. They shall be scheduled not less than 20 nor more than 30 days from the date of filing of the request for hearing. The appellant shall be given no less than 15 days notice of hearing, except that the appellant may waive the notice period or request a delay. For appeals on denying, revoking or suspending a license of a child welfare agency or foster home, however, the hearing shall be held within ten days of the date of filing of the request for hearing.

2. The notice of hearing shall inform the appellant of the date, time, and place of the hearing, the name of the hearing officer, the issues involved, and of his rights to: present his case in person or through a representative; examine and copy any documents in his case file and all documents and records to be used by the agency at the hearing at a reasonable time prior to the hearing as well as at the hearing; obtain assistance from the local office in preparing his case; and of his opportunity to make inquiry at the local office about the availability of community legal resources which could provide representation at the hearing.
3. Appellant, in lieu of a personal appearance, may submit a written statement, under oath or affirmation, setting forth the facts of the case provided that the statement is submitted to the Department prior to or at the time of the hearing. All parties shall be ready and present with all witnesses and documents at the time and place specified in the notice of hearing, and shall be prepared at such time to dispose of all issues and questions involved in the appeal.
4. The hearing officer may take such action for the proper disposition of an appeal as he deems necessary, and on his own motion, or at the request of any interested party upon a showing of good cause disqualify himself, or may continue the hearing to a future time or reopen a hearing before a decision is final to take additional evidence. If an interested party fails to appear at a scheduled hearing, the hearing officer may adjourn the hearing to a later date or may make his decision upon record and such evidence as may be presented at the scheduled hearing. If, within ten days of the scheduled hearing, appellant files a written application requesting reopening of the proceedings and establishes good cause for failure to appear at the scheduled hearing, the hearing shall be rescheduled. Notice of the time, place, and purpose of any continued, reopened or rescheduled hearing shall be given to all interested parties.

C. Prehearing summary

1. A prehearing summary of the facts and grounds for the action taken shall be prepared and forwarded to the hearing officer no less than four days prior to the hearing.
2. The summary shall be provided to the appellant prior to the commencement of the hearing.

D. Subpoena of witnesses. The hearing officer may subpoena any witnesses or documents requested by the Department or claimant to be present at the hearing. The request shall be in writing and shall state the name and address of the witness and the nature of his testimony. The nature of the witnesses' testimony must be relevant to the issues of the hearing, otherwise the hearing officer may deny the request. The request for the issuance of a subpoena shall be made to give sufficient time, a minimum of three working days, prior to the hearing. A subpoena requiring the production of records and documents shall specifically describe them in detail and further set forth the name and address of the custodian thereof.

- E.** Review of file. In the presence of a Department representative, the appellant and/or his authorized representative shall be permitted to review, obtain or copy any Department record necessary for the proper presentation of the case.
- F.** Conduct of the hearing
- Hearings shall be conducted in an orderly and dignified manner.
 - Hearings are opened, conducted and closed by the hearing officer who shall rule on the admissibility of evidence and shall direct the order of proof. He shall have power to administer oaths and affirmations, take depositions, certify to official acts and issue subpoenas to compel the attendance of witnesses, the production of books, papers, correspondence, memoranda and other records he deems necessary as evidence in connection with a hearing.
 - Evidence not related to the issue shall not be allowed to become a part of the record.
 - The hearing officer may, on his own motion, or at the request of the appellant or Department representative, exclude witnesses from the hearing room.
 - The worker, supervisor or other appropriate person may be designated Department representative for the hearing.
 - The appellant and Department representative may testify, present evidence, cross-examine witnesses and present arguments.
 - The appellant may appear for himself or be represented by an attorney or any other person he designates.
 - A full and complete record shall be kept of all proceedings in connection with an appeal, and such records shall be open for inspection by the claimant or his representative at a place accessible to him. A transcript of the proceedings need not, however, be made unless it is required for further proceedings. When a transcript has been made for further proceedings, a copy shall be furnished without cost to each interested party.
- G.** Hearing decision
- The hearing decision shall be rendered exclusively on the evidence and testimony produced at the hearing, appropriate state and federal law, and Department rules governing the issues in dispute.
 - The decision shall set forth the pertinent facts involved, the conclusions drawn from such facts, the sections of applicable law or rule, the decision and the reasons thereof. A copy of such decision, together with an explanation of the appeal rights, shall be delivered or mailed to each interested party and their attorneys of record not more than 60 days from the date of filing the request for appeal, unless the delay was caused by the appellant.
 - In those cases where the local office must take additional action as a result of a decision, such action must be taken immediately.
 - All decisions in favor of the appellant apply retroactively to the date of the action being appealed, or to the date the hearing officer specifically finds appropriate.
 - When a hearing decision upholds the proposed action of reducing, suspending or terminating a grant, an overpayment is the result.
 - All hearing decisions will be made accessible to the public, subject to meeting the provision for safeguarding confidential information relating to the client.
 - Decision of the hearing officer will be the final decision of the Department unless a reconsideration is requested in accordance with subsection (I).
- H.** Withdrawal of appeal. An appeal may be withdrawn as follows:
- Voluntary withdrawal. This may be accomplished by completing and signing the proper Department form or by submitting a letter properly signed.
 - Abandonment or involuntary withdrawal. This occurs when an appellant fails to appear at a scheduled hearing and within ten days thereof fails to request a rescheduled hearing or fails to appear at a rescheduled hearing which he has requested. A hearing may not be considered abandoned if the claimant provides notification up to the time of the hearing that he is unable, due to good cause, to keep the appointment and that he still wishes a hearing.
- I.** Reconsideration
- An appellant, within ten calendar days after the decision was mailed or otherwise delivered to him, may request the Director to review the decision. The request shall be in writing and should set forth a statement of the grounds for review, and may be filed personally or by mail.
 - After receipt of an application for leave to appeal, the Director shall:
 - Deny the application, or
 - Remand the case for rehearing, specifying the nature of any additional evidence required and/or issues to be considered, or
 - Grant the application and decide the appeal on the record.
 - The Director shall promptly adopt his decision which shall be the final decision of the Department. A copy of the decision, together with a statement specifying the rights for judicial review, shall be distributed to each interested party.

Historical Note

Adopted effective March 1, 1978 (Supp. 78-2).

ARTICLE 25. REPEALED**R6-5-2501. Repealed****Historical Note**

Adopted effective September 16, 1976 (Supp. 76-4). Former Section R6-5-2501 repealed, new Section R6-5-2501 adopted effective February 26, 1979 (Supp. 79-1).
Repealed effective June 5, 1997 (Supp. 97-2).

R6-5-2502. Repealed**Historical Note**

Adopted effective September 16, 1976 (Supp. 76-4). Former Section R6-5-2502 repealed, new Section R6-5-2502 adopted effective February 26, 1979 (Supp. 79-1).
Repealed effective June 5, 1997 (Supp. 97-2).

R6-5-2503. Repealed**Historical Note**

Adopted effective August 11, 1976 (Supp. 76-4).
Repealed effective June 5, 1997 (Supp. 97-2).

ARTICLE 26. REPEALED**R6-5-2601. Repealed****Historical Note**

Adopted effective August 11, 1976 (Supp. 76-4).
Repealed effective June 5, 1997 (Supp. 97-2).

R6-5-2602. Repealed**Historical Note**

Adopted effective August 11, 1976 (Supp. 76-4).
Repealed effective June 5, 1997 (Supp. 97-2).

R6-5-2603. Repealed**Historical Note**

Adopted effective August 11, 1976 (Supp. 76-4).
Repealed effective June 5, 1997 (Supp. 97-2).

R6-5-2604. Repealed**Historical Note**

Adopted effective August 11, 1976 (Supp. 76-4).
Repealed effective June 5, 1997 (Supp. 97-2).

R6-5-2605. Repealed**Historical Note**

Adopted effective August 11, 1976 (Supp. 76-4).
Repealed effective June 5, 1997 (Supp. 97-2).

R6-5-2606. Repealed**Historical Note**

Adopted effective August 11, 1976 (Supp. 76-4).
Repealed effective June 5, 1997 (Supp. 97-2).

R6-5-2607. Repealed**Historical Note**

Adopted effective August 11, 1976 (Supp. 76-4).
Repealed effective June 5, 1997 (Supp. 97-2).

ARTICLE 27. REPEALED**R6-5-2701. Repealed****Historical Note**

Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective June 5, 1997 (Supp. 97-2).

R6-5-2702. Repealed**Historical Note**

Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective June 5, 1997 (Supp. 97-2).

R6-5-2703. Repealed**Historical Note**

Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective June 5, 1997 (Supp. 97-2).

R6-5-2704. Repealed**Historical Note**

Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective June 5, 1997 (Supp. 97-2).

R6-5-2705. Repealed**Historical Note**

Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective June 5, 1997 (Supp. 97-2).

R6-5-2706. Repealed**Historical Note**

Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective June 5, 1997 (Supp. 97-2).

R6-5-2707. Repealed**Historical Note**

Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective June 5, 1997 (Supp. 97-2).

ARTICLE 28. REPEALED

Former Article 28 consisting of Sections R6-5-2801 through R6-5-2804 repealed effective November 8, 1982.

ARTICLE 29. REPEALED**R6-5-2901. Repealed****Historical Note**

Adopted effective August 11, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-2902. Repealed**Historical Note**

Adopted effective August 11, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-2903. Repealed**Historical Note**

Adopted effective August 11, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-2904. Repealed**Historical Note**

Adopted effective August 11, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-2905. Repealed**Historical Note**

Adopted effective August 11, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-2906. Repealed**Historical Note**

Adopted effective August 11, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-2907. Repealed**Historical Note**

Adopted effective August 11, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-2908. Repealed**Historical Note**

Adopted effective August 11, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-2909. Repealed**Historical Note**

Adopted effective August 11, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-2910. Repealed**Historical Note**

Adopted effective August 11, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-2911. Repealed**Historical Note**

Adopted effective August 11, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-2912. Repealed**Historical Note**

Adopted effective August 11, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

ARTICLE 30. REPEALED

Former Article 30, consisting of Sections R6-5-3001 through R6-5-3007, repealed effective August 29, 1984.

ARTICLE 31. REPEALED

Former Article 31, consisting of Sections R6-5-3101 through R6-5-3110, repealed effective November 8, 1982.

ARTICLE 32. REPEALED

R6-5-3201. Repealed

Historical Note

Adopted effective November 22, 1978 (Supp. 78-6).

Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-3202. Repealed

Historical Note

Adopted effective November 22, 1978 (Supp. 78-6).

Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-3203. Repealed

Historical Note

Adopted effective November 22, 1978 (Supp. 78-6).

Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-3204. Repealed

Historical Note

Adopted effective November 22, 1978 (Supp. 78-6).

Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-3205. Repealed

Historical Note

Adopted effective November 22, 1978 (Supp. 78-6).

Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-3206. Repealed

Historical Note

Adopted effective November 22, 1978 (Supp. 78-6).

Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-3207. Repealed

Historical Note

Adopted effective November 22, 1978 (Supp. 78-6).

Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-3208. Repealed

Historical Note

Adopted effective November 22, 1978 (Supp. 78-6).

Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-3209. Repealed

Historical Note

Adopted effective November 22, 1978 (Supp. 78-6).

Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-3210. Repealed

Historical Note

Adopted effective November 22, 1978 (Supp. 78-6).

Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-3211. Repealed

Historical Note

Adopted effective November 22, 1978 (Supp. 78-6).

Repealed effective December 17, 1993 (Supp. 93-4).

ARTICLE 33. RESERVED

ARTICLE 34. RESERVED

ARTICLE 35. RESERVED

ARTICLE 36. RESERVED

ARTICLE 37. RESERVED

ARTICLE 38. RESERVED

ARTICLE 39. RESERVED

ARTICLE 40. RESERVED

ARTICLE 41. RESERVED

ARTICLE 42. RESERVED

ARTICLE 43. RESERVED

ARTICLE 44. RESERVED

ARTICLE 45. RESERVED

ARTICLE 46. RESERVED

ARTICLE 47. RESERVED

ARTICLE 48. RESERVED

ARTICLE 49. CHILD CARE ASSISTANCE

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1997, Ch. 300, § 74(A). Exemption from A.R.S. Title 41, Chapter 6 means the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review and approval; and the Department was not required to hold public hearings on this Section.

R6-5-4901. Definitions

The following definitions apply to this Article:

1. "Adequate notice" means written notification that explains the action the Department intends to take, the reason for the action, the specific authority for the action, the client's appeal rights, and right to benefits pending appeal, and that is mailed before the effective date of the action.
2. "Appellant" means an applicant or recipient of assistance who is appealing a negative action by the Department.
3. "Availability" means the portion of time that a parent or caretaker can provide care to their own child, as determined by the Department, because the parent or caretaker is not participating in an eligible activity.
4. "Applicant" means a person who has filed an application for Child Care Assistance.
5. "Authorized" means the specific amount of Child Care Assistance approved by the Department for an eligible family for a specific period of time.
6. "CCA" means the DES Child Care Administration.
7. "Caretaker relative" means a relative who exercises the responsibility for the day-to-day physical care, guidance, and support of a child who physically resides with the relative.
8. "Cash Assistance" means the program administered by the Family Assistance Administration that provides temporary Cash Assistance to needy families.
9. "Cash Assistance participant" means a recipient of Cash Assistance.
10. "Child care" means the compensated service the Department provides to a child who is unaccompanied by a parent or guardian during a portion of a 24-hour day.
11. "Child Care Assistance" means money payments for child care services paid by the Department for the benefit of an eligible family.
12. "Child Care Provider" means a child care facility licensed under A.R.S. Title 36, Chapter 7.1, Article 4, child care home providers, in-home providers, noncertified relative

- providers, and regulated child care on military installations or federally recognized Indian Tribes.
13. “Client” means a person who has requested, has been referred for, or who is currently receiving Child Care Assistance.
 14. “Countable income” means the gross income of individuals included in family size that the Department considers to determine eligibility and calculate an assistance amount.
 15. “CPS or Child Protective Services” means the child welfare services administration within the Department’s Division of Children, Youth, and Family Services.
 16. “Day” means a calendar day unless otherwise specified.
 17. “DDD” means the Division of Developmental Disabilities.
 18. “Denial” means a formal decision of ineligibility on an application, referral, or request for Child Care Assistance.
 19. “Department” means the Arizona Department of Economic Security.
 20. “Dependent” child means a person less than age 18, who resides with the applicant and whom the applicant has the legal financial obligation to support.
 21. “DES-certified child care provider” means a provider who is certified by the Department of Economic Security under A.R.S. § 46-807 and who provides care in either the child’s or the provider’s own home.
 22. “DHS-certified group home” means a provider who is certified by the Department of Health Services under A.R.S. § 36-897.01.
 23. “DHS-licensed child care center” means a provider who is licensed by the Department of Health Services as prescribed in A.R.S. § 36-881.
 24. “EITC” means Earned Income Tax Credit and is a federal income tax credit for low-income working individuals and families.
 25. “Eligibility criteria” means the requirements an individual or family must meet to receive Child Care Assistance.
 26. “Eligible activity” means a specific type of activity that causes an applicant or recipient and any other parent or responsible person in the eligible family to be unavailable to provide care to their children for a portion of a 24-hour day, and that partially determines the amount of Child Care Assistance an eligible family shall receive.
 27. “Eligible child” means a child less than 13 years of age.
 28. “Eligible family” means a group of persons whose needs, income, and other circumstances are considered as a whole for the purpose of determining eligibility and amount of Child Care Assistance.
 29. “Eligible need” means a specific type of need that causes an applicant or recipient, or any other parent or responsible person in the eligible family, to be unavailable or incapable to provide child care to their children for a portion of a 24-hour day, and that partially determines the amount of Child Care Assistance an eligible family shall receive.
 30. “E.S.O.L.” means English for Speakers of Other Languages.
 31. “Existing client” means an individual who is currently receiving Child Care Assistance or who has an open Child Care Assistance case with the Department.
 32. “Family size” means the number of individuals considered when determining income eligibility, and includes the applicant, other parent or responsible person, and their dependent children who reside in the same household, subject to R6-5-4914 (D).
 33. “Federal poverty level” (FPL) means the poverty guidelines issued by the United States Department of Health and Human Services under Section 673(2) of the Omnibus Reconciliation Act of 1981; and reported annually in the Federal Register; which are converted into monthly amounts by the Department; which shall become effective for use in determining eligibility for Child Care Assistance on the first day of the state fiscal year immediately following the publication of the annual amount in the Federal Register.
 34. “Foster care” means that the Department or an Arizona Tribe placed a child in the custody of a licensed foster parent.
 35. “Foster parent” means any person licensed by the Department or an Arizona Tribe to provide for the out of home care, custody, and control of a child.
 36. “Gap in employment” means a period of 30 consecutive days of Child Care Assistance that begins the first day after the last day worked and ends the 30th day after the last day worked for an existing client who has lost employment.
 37. “G.E.D.” means General Equivalency Diploma.
 38. “Homebound” means a person who is confined to their home because of physical or mental incapacity.
 39. “Homeless shelter” means a public or private nonprofit program that is targeted to assist homeless families and is designed to provide temporary or transitional living accommodations and services to assist such families toward self-sufficiency.
 40. “Income” means earned and unearned income combined.
 41. “Jobs” means the Department program that assists Cash Assistance participants to prepare for, obtain, and retain employment. “Jobs” Program also includes the Tribal Jobs Program and any other entities that contract with the state to perform this function.
 42. “Jobs participant” means a Cash Assistance participant who is participating in the Jobs program as a condition of receiving Cash Assistance.
 43. “Local office” means a CCA location that is designated as the location in which Child Care Assistance applications and other documents are filed with the Department and in which eligibility and assistance amounts are determined for a particular geographic area of the state.
 44. “Lump sum income” means a single payment of earned or unearned income, such as a retroactive monthly benefit, non-recurring pay adjustment or bonus, inheritance, or personal injury and workers’ compensation award.
 45. “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.
 46. “Minor parent” means a parent less than the age of 18 years.
 47. “Negative action” means one of the Department actions described in R6-5-4918, including action to terminate assistance or increase the fee level and copayment for Child Care Assistance.
 48. “Noncertified relative provider” means a person who is at least 18 years of age, who is by blood, marriage, or adoption the grandparent, great grandparent, sibling not residing in the same household, aunt, great aunt, uncle or great

- uncle of the eligible child, who provides child care services to an eligible child, and meets the Department's requirements to be a noncertified relative provider.
49. "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.
 50. "OSI" or "Office of Special Investigations" means the Department office to which CCA 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.
 51. "Other related child" means a child who is related to the applicant or recipient by blood, marriage, or adoption, and who is not the applicant's or recipient's natural, step, or adoptive child.
 52. "Overpayment" means a Child Care Assistance payment received by a child care provider or for an eligible family that exceeds the amount to which the provider or family was lawfully entitled.
 53. "Parent" means the biological mother or father whose name appears on the birth certificate, the person legally acknowledged as a mother or father, a father who has had an adjudication of paternity, or the adoptive mother or father of the child.
 54. "Positive action" means the approval, increase, or resumption of service such as increasing the amount of assistance or decreasing the fee level and copayment.
 55. "Recipient" means a person who is a member of an eligible family receiving Child Care Assistance.
 56. "Relative" means a person who is by blood, adoption, or marriage a parent, grandparent, great-grandparent, sibling of the whole or half blood, stepbrother, stepsister, aunt, uncle, great-aunt, great-uncle, or first cousin.
 57. "Request for Hearing" means a clear written expression by an applicant or recipient, or such person's representative, indicating a desire to appeal a Department decision to a higher authority.
 58. "Responsible person" means one or more persons, residing in the same household, who have the legal responsibility to financially support:
 - a. One or more of the children for whom Child Care Assistance is being requested, or
 - b. The applicant or recipient of Child Care Assistance.
 59. "Review" means the Department's review of all factors affecting an eligible family's eligibility and assistance amount.
 60. "Self-Sufficiency Declaration" means a written statement signed and dated by the child care recipient that lists the specific actions the recipient has taken during the most recent six or 12-month period to maintain or increase self-sufficiency.
 61. "Tax Claimant" means a relative more than age 17 who resides with a parent who has applied for or is receiving Child Care Assistance, and who states their intention to claim any member of the eligible family as a tax dependent on a federal or state income tax return for the current calendar year, to be filed in the following calendar year.
 62. "Tax Dependent" means a member of an eligible family applying for or receiving Child Care Assistance who is included in family size, and who the tax claimant states an intention to claim as a dependent on a federal or state income tax return for the current calendar year, to be filed in the following calendar year.
 63. "Time Limit" means that each child in the eligible family may receive no more than 60 cumulative months of Child Care Assistance in a lifetime, unless the parent, caretaker relative, or legal guardian of the child needing care can prove they are making efforts to improve skills and move toward self-sufficiency, under A.R.S. § 46-803(K)(1).
 64. "Unit" means a part or full day measurement of Child Care Assistance authorized by the Department to meet the needs of an eligible family based on the participation of parents, caretaker relatives, or legal guardians of the children needing care in an eligible activity.
 65. "Waiting List" means the prioritization of applicants by the Department to manage resources within available funding by placing applicants determined eligible for Child Care Assistance on a list, until the Department determines that sufficient funds are available to fund Child Care Assistance for families on the list.
 66. "Work" means the performance of duties on a regular basis for wages or salary.

Historical Note

Adopted effective July 31, 1997, under an exemption from the provisions of A.R.S. Title 41, Chapter 6 (Supp. 97-3). Amended by exempt rulemaking at 13 A.A.R. 92, effective December 31, 2006 (Supp. 06-4).

Editor's Note: The following Section was adopted and repealed under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1997, Ch. 300, § 74(A). Exemption from A.R.S. Title 41, Chapter 6 means the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review and approval; and the Department was not required to hold public hearings on this Section.

R6-5-4902. Repealed

Historical Note

Adopted effective July 31, 1997, under an exemption from the provisions of A.R.S. Title 41, Chapter 6 (Supp. 97-3). Section automatically repealed July 31, 1998 (Supp. 98-3).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1997, Ch. 300, § 74(A). Exemption from A.R.S. Title 41, Chapter 6 means the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review and approval; and the Department was not required to hold public hearings on this Section.

R6-5-4903. Repealed

Historical Note

Adopted effective July 31, 1997, under an exemption from the provisions of A.R.S. Title 41, Chapter 6 (Supp. 97-3). Section repealed by exempt rulemaking at 13 A.A.R. 92, effective December 31, 2006 (Supp. 06-4).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1997, Ch. 300, § 74(A). Exemption from A.R.S. Title 41, Chapter 6 means the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for

review and approval; and the Department was not required to hold public hearings on this Section.

R6-5-4904. Access to Child Care Assistance

A. Application for Child Care Assistance.

1. Any person may apply for Child Care Assistance by filing, either in person or by mail, a Department-approved application form with any CCA office.
2. The application file date is the date any CCA office receives an identifiable application. An identifiable application contains, at a minimum, the following information:
 - a. The legible name and address of the person requesting assistance; and
 - b. The signature, under penalty of perjury, of the applicant or, if the applicant is incompetent or incapacitated, someone legally authorized to act on behalf of the applicant.
3. In addition to the identifiable information described in subsection (A)(2), a completed application shall contain:
 - a. The names of all persons living with the applicant and the relationship of those persons to the applicant, and
 - b. All other eligibility information requested on the application form.

B. Request for Child Care Assistance.

1. Cash Assistance participants who need Child Care Assistance for employment activities are not required to complete an application.
2. Child Care Assistance for Cash Assistance participants may begin effective the start date of the eligible activity but not earlier than the date that the participant requests Child Care Assistance from a local CCA office after the Department has verified eligibility criteria.

C. Referral for Child Care Assistance.

1. Jobs Participants. Cash Assistance participants in Jobs-approved work participation activities who request child care shall be referred by the Jobs Program for Child Care Assistance.
2. Child Protective Services Families (CPS). CPS shall refer families that CPS deems eligible for Child Care Assistance on a case-by-case basis.
3. CPS and DDD Foster Families - CPS or DDD shall determine eligibility for and refer children in the care, custody, and control of DES who need child care services as documented in a foster care case plan.

Historical Note

Adopted effective July 31, 1997, under an exemption from the provisions of A.R.S. Title 41, Chapter 6 (Supp. 97-3). Amended by exempt rulemaking at 13 A.A.R. 92, effective December 31, 2006 (Supp. 06-4).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1997, Ch. 300, § 74(A). Exemption from A.R.S. Title 41, Chapter 6 means the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review and approval; and the Department was not required to hold public hearings on this Section.

R6-5-4905. Initial Eligibility Interview

- ##### **A. Upon receipt of an identifiable application, the Department shall schedule an initial eligibility interview for the applicant. Upon request, the Department shall conduct the interview at the residence of a person who is homebound.**

- B.** The applicant shall attend the interview. A person of the applicant's choosing may also attend the interview.
- C.** The Department may conduct a telephone interview if the applicant has previously verified citizenship or legal residency status as prescribed in R6-5-4911(E).
- D.** During the interview, a Department representative shall:
 1. Assist the applicant in completing the application form;
 2. Witness the signature of the applicant;
 3. Discuss information pertinent to the applicant's child care needs;
 4. Provide the applicant with written information explaining:
 - a. The terms, conditions, and obligations of the Child Care Assistance program;
 - b. Any additional verification information as prescribed in R6-5-4906 which the applicant must provide for the Department to conclude the eligibility evaluation;
 - c. The Department practice of exchanging eligibility and income information among Department programs;
 - d. The coverage and scope of the Child Care Assistance program;
 - e. The applicant's rights, including the right to appeal a negative action; and
 - f. The requirement to report all changes within two work days from the date the change becomes known;
 5. Review the penalties for perjury and fraud, as printed on the application;
 6. Explain to the applicant who is included in family size for the purpose of determining income eligibility, and whose availability is considered in determining the amount of Child Care Assistance authorized for each child needing care as prescribed in R6-5-4914(D);
 7. If the applicant is the parent of the children needing care, explain the tax claimant provision under R6-5-4914(D)(3);
 8. Provide the applicant with the tax claimant declaration form if there is a potential tax claimant in the household;
 9. Provide the following information to assist the family in continuing to move toward self-sufficiency:
 - a. Availability of the Earned Income Tax Credit (EITC). Provide the applicant with the current U.S. Department of Internal Revenue Service (IRS) EITC information if the applicant comes into the office for the initial interview;
 - b. Availability of child support services through the Division of Child Support Enforcement (DCSE) to assist with paternity establishment, establishment of a child support order, or enforcement of an existing child support order. Provide the applicant with written information regarding child support services if the applicant comes into the office for the initial interview; and
 - c. Availability of Department-sponsored or contracted employment services that may assist the applicant and spouse or other parent in finding a job, or pursuing a better job or career. Provide the applicant with written information regarding employment services if the applicant comes into the office for the initial interview;
 10. Explain to the applicant the 60-month per child time limit for Child Care Assistance:
 - a. Describe the child care programs to which the 60-month time limit applies;

- b. Describe how child care utilization is measured per child to calculate the 60-month limit; and
- c. Explain the criteria for extensions of the time limit based on continued efforts to improve job skills and move toward self-sufficiency;
- 11. Discuss the six-child limit for Child Care Assistance:
 - a. Explain that no more than six children in a family may receive Child Care Assistance at any point in time; and
 - b. Explain the child care programs to which the six-child limit applies;
- 12. Discuss the waiting list for Child Care Assistance:
 - a. Describe the programs to which it applies;
 - b. Explain prioritization for assistance based upon income for families on the waiting list;
 - c. Indicate whether the waiting list is currently in effect; and
 - d. Explain that, based on funding availability, the Department may implement a waiting list at any point in time;
- 13. Review any verification information already provided;
- 14. Explain the applicant's duties to:
 - a. Notify the Department regarding initial provider selection or changes in provider in advance of using services or changing providers;
 - b. Pay DES required copayments to the child care provider as assigned by the Department; and
 - c. Pay any additional charges to the provider for the cost of care in excess of the amount paid by the Department; and
- 15. Review all ongoing reporting requirements, and explain that the applicant may incur overpayments for failure to make timely reports.

Historical Note

Adopted effective July 31, 1997, under an exemption from the provisions of A.R.S. Title 41, Chapter 6 (Supp. 97-3). Amended by exempt rulemaking at 13 A.A.R. 92, effective December 31, 2006 (Supp. 06-4).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1997, Ch. 300, § 74(A). Exemption from A.R.S. Title 41, Chapter 6 means the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review and approval; and the Department was not required to hold public hearings on this Section.

R6-5-4906. Verification of Eligibility Information

- A. The Department shall obtain independent verification or corroboration of information provided by the client when required by law, or when it is necessary to determine eligibility, fee level and copayment assignment, or service authorization amount.
- B. The Department may verify or corroborate information by any reasonable means including:
 - 1. Contacting third parties such as employers and educational institutions,
 - 2. Asking the client to provide written documentation such as pay stubs or school schedules, and
 - 3. Conducting a computer data match through other Department programs' computer systems.
- C. The client is responsible for providing all required verification. The Department shall offer to assist a client who has difficulty in obtaining the verification and requests help.

- D. A client shall provide the Department with all requested verification within 10 calendar days from the notice date of a written request for such information. When a client does not timely comply with a request for information, the Department shall deny the application as provided in R6-5-4908(B).

Historical Note

Adopted effective July 31, 1997, under an exemption from the provisions of A.R.S. Title 41, Chapter 6 (Supp. 97-3).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1997, Ch. 300, § 74(A). Exemption from A.R.S. Title 41, Chapter 6 means the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review and approval; and the Department was not required to hold public hearings on this Section.

R6-5-4907. Withdrawal of an Application

- A. An applicant may withdraw an application at any time prior to its disposition by providing the Department with a written request for withdrawal signed by the applicant.
- B. If an applicant makes an oral request to withdraw an application:
 - 1. The Department shall accept the oral request, provide the applicant with a written withdrawal form, and request that the applicant complete the form and return it to the Department. The Department shall inform the applicant of the consequences of not returning the withdrawal form within 10 days of the notice date.
 - 2. If the applicant fails to return the completed withdrawal form, the Department shall deny the application for failure to provide information unless the applicant rescinds the oral withdrawal request within 10 days of the date the Department provides the applicant a withdrawal form.
- C. A withdrawal is effective as of the application file date unless the applicant specifies a different date on the withdrawal form.
- D. An application that has been withdrawn shall not be reinstated; an applicant who has withdrawn an application shall reapply anew.

Historical Note

Adopted effective July 31, 1997, under an exemption from the provisions of A.R.S. Title 41, Chapter 6 (Supp. 97-3).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1997, Ch. 300, § 74(A). Exemption from A.R.S. Title 41, Chapter 6 means the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review and approval; and the Department was not required to hold public hearings on this Section.

R6-5-4908. Child Care Assistance Approvals and Denials

- A. The Department shall complete the eligibility determination within 30 calendar days of the application file date or referral receipt date, unless:
 - 1. The application or referral is withdrawn,
 - 2. The application or referral is rendered moot because the applicant has died or cannot be located, or
 - 3. There is a delay resulting from a Department request for additional verification information as provided in R6-5-4906(D).

- B. The Department shall deny Child Care Assistance when the applicant fails to:
1. Complete the application and an eligibility interview, as described in R6-5-4905;
 2. Submit all required verification information within 10 days of the notice date of a written request for verification, or within 30 days of the application file date which-ever is later; or
 3. Cooperate during the eligibility determination process as required by R6-5-4911(A).
- C. When an applicant satisfies all eligibility criteria, the Department shall determine the service authorization amount, the fee level and copayment amount (if applicable), approve Child Care Assistance, and send the applicant an approval notice. The approval notice shall include the amount of assistance, fee level and copayment information, and an explanation of the applicant's appeal rights.

Historical Note

Adopted effective July 31, 1997, under an exemption from the provisions of A.R.S. Title 41, Chapter 6 (Supp. 97-3).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1997, Ch. 300, § 74(A). Exemption from A.R.S. Title 41, Chapter 6 means the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review and approval; and the Department was not required to hold public hearings on this Section.

R6-5-4909. 12-month Review

- A. The Department shall complete a review of all eligibility factors for each client at least once every 12 months, beginning with the 12th month following the first month of Child Care Assistance eligibility.
- B. The Department may elect to review eligibility factors more frequently than every 12 months.
- C. At least 30 days prior to the 12-month review date, the Department shall mail the client a notice advising of the need for a review, and the requirement to submit a completed review application and verification of income and other eligibility factors for the most recent calendar month.
- D. In response to such notice, the client shall mail or deliver to the Department a completed review application and verification by the date on the notice.
- E. The Department shall verify the client's income and any eligibility factors that have changed or are subject to change.
- F. The Department shall terminate Child Care Assistance effective the review date and deny the review application if the client:
1. Fails to submit the review application by the review date, or
 2. Fails to submit requested verification by the review date as required by the Department for a redetermination of eligibility.
- G. If the client submits the review application and required verification within 30 days after the review date, the Department shall not require the client to appear for an intake interview and shall approve Child Care Assistance effective the date that the application and verification were received if other eligibility criteria are met.

Historical Note

Adopted effective July 31, 1997, under an exemption from the provisions of A.R.S. Title 41, Chapter 6 (Supp.

97-3). Amended by exempt rulemaking at 13 A.A.R. 92, effective December 31, 2006 (Supp. 06-4).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1997, Ch. 300, § 74(A). Exemption from A.R.S. Title 41, Chapter 6 means the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review and approval; and the Department was not required to hold public hearings on this Section.

R6-5-4910. Reinstatement of Assistance

- A. If the Department has terminated Child Care Assistance, the Department shall not reinstate assistance unless the client files a new application.
- B. Notwithstanding subsection (A), the Department shall reinstate assistance within 10 calendar days when:
1. Termination was due to Department error; the Department shall reinstate assistance effective the date following the date of termination;
 2. The Department receives a court order or administrative hearing decision mandating reinstatement; the Department shall reinstate assistance effective the date prescribed by the court order or hearing decision; or
 3. The recipient files a request for a fair hearing within 10 days of the notice date of the termination notice and requests that assistance be continued pending the outcome of an appeal; the Department shall reinstate assistance effective the date following the date of termination.

Historical Note

Adopted effective July 31, 1997, under an exemption from the provisions of A.R.S. Title 41, Chapter 6 (Supp. 97-3).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1997, Ch. 300, § 74(A). Exemption from A.R.S. Title 41, Chapter 6 means the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review and approval; and the Department was not required to hold public hearings on this Section.

R6-5-4911. General Eligibility Criteria

- A. Applicant and Recipient Responsibility.
1. An applicant for or recipient of Child Care Assistance shall cooperate with the Department as a condition of initial and continuing eligibility. The client shall:
 - a. Give the Department complete and truthful information;
 - b. Within two business days from the date the change becomes known, inform the Department of all changes in:
 - i. Income;
 - ii. Eligible activities as described in R6-5-4912;
 - iii. Work or school schedules;
 - iv. Persons moving in or out of the household;
 - v. Tax claimants moving in or out of the household;
 - vi. Other circumstances affecting eligibility or the amount of assistance authorized; and
 - c. Comply with all the Department's procedural requirements.

2. The Department may deny an application for or reduce or terminate assistance, if the client fails or refuses to cooperate with the Department to determine eligibility.
- B. Eligible Applicants.**
1. In order to be considered an eligible applicant for Child Care Assistance, a client shall reside with the child needing care and shall be:
 - a. The parent of the child for whom assistance is being requested; or
 - b. The caretaker relative related by blood, adoption, or marriage to the child for whom assistance is requested, including a brother, sister, aunt, uncle, first cousin, grandmother, grandfather, and persons of preceding generations as denoted by “grand,” “great,” or “great-great.”
 - c. A court-appointed legal guardian for the child for whom assistance is requested, or a person who can provide documentation from the court that the process of legal guardianship has been initiated.
 2. When more than one applicant resides in the home, or the child resides with two different caretakers intermittently, the Department shall determine the eligible applicant for Child Care Assistance as follows:
 - a. If both the parent and a caretaker relative are in the home, the parent is the eligible applicant;
 - b. If both a legal guardian and the parent are in the home, the legal guardian is the eligible applicant;
 - c. If a caretaker relative whose legal guardianship has been terminated and the parent are both in the home, the parent is the eligible applicant;
 - d. When the child resides with a caretaker relative or legal guardian who is acting as caretaker at least 51 percent of the time, and the parent either maintains a separate residence and visits the child intermittently, or resides outside of the child’s home for an indefinite period of time, the caretaker relative or legal guardian of the child is the eligible applicant for the child.
 - i. An eligible applicant cannot be the noncertified relative provider or certified provider of the child for whom he or she is applying for assistance.
 - ii. The Department shall not consider the tax claimant status of the caretaker relative or legal guardian under R6-5-4914(D) with respect to any member of the eligible family.
 - e. When the child resides with two or more caretaker relatives, the caretaker relative who will be claiming the child as a dependent for income tax purposes is the eligible applicant for Child Care Assistance.
 3. Acceptable verification of guardianship shall include the following court documents:
 - a. Petition for Temporary Appointment of Guardian (date stamped as received by the court);
 - b. Petition for Permanent Appointment of Guardian (date stamped as received by the court);
 - c. Order of Appointment of a Temporary Guardian;
 - d. Order of Appointment of a Permanent Guardian;
 - e. Letters and Acceptance of Permanent Guardianship.
 4. If the client has not been appointed as a guardian when the Department authorizes Child Care Assistance, the client shall to continue the legal process for appointment in order to retain eligibility for Child Care Assistance.
 5. The client shall verify relationship or guardianship status as requested by the Department.
- C. Arizona Residency.** The client and the child for whom assistance is requested shall be Arizona residents and shall be physically present within Arizona.
- D. Age of the Child.** An eligible child is birth through 12 years of age only; a child aged 13 or older is ineligible for Child Care Assistance.
- E. Citizenship and Legal Residency Requirements.**
1. The client shall be a United States citizen or shall be a legal resident of the United States.
 2. The client shall verify citizenship or legal residency status as requested by the Department by providing a birth certificate, naturalization documentation, or alien or immigration registration documentation from the U.S. Immigration and Naturalization Service (INS).
- F. Eligible Activity or Need.**
1. The client, and any other parent or responsible person in the household shall be engaged in an eligible activity, or have an eligible need for Child Care Assistance as prescribed in R6-5-4912 that causes each client, parent, or responsible person to be unavailable to provide care to the child for whom assistance is requested.
 2. The Department does not require a tax claimant to be engaged in an eligible activity, unless the tax claimant is the other parent of a child receiving Child Care Assistance.
- G. Availability of the Client, Parent, and Responsible Person.**
1. The Department shall consider the availability of the client, and any other parent or responsible person in the household in determining eligibility and the amount of Child Care Assistance authorized for each individual child needing care.
 2. The client, parent, and any other responsible person in the household shall be unavailable to provide care to the child for whom assistance is being requested for a portion of a 24-hour day due to an eligible activity or need.
 3. In a family with more than one parent or responsible person, the Department shall authorize Child Care Assistance for the period of time that neither the parent nor the responsible person is available due to an eligible activity or need.
 4. The Department shall not consider the availability of a tax claimant in determining eligibility or amount of Child Care Assistance authorized for the client’s children, unless the tax claimant is the other parent of a child receiving Child Care Assistance.
- H. Provider Selection and Arrangements.**
1. The Department shall not authorize Child Care Assistance until the applicant has selected a child care provider. An allowable child care provider for DES Child Care Assistance:
 - a. Shall be one of the following:
 - i. A DHS-licensed child care center;
 - ii. A DHS-certified group home;
 - iii. A DES-certified family child care home;
 - iv. A DES-certified in home care provider;
 - v. A DES-noncertified relative provider;
 - vi. A regulated provider meeting requirements established by military installations or federally recognized Indian Tribes.
 - b. Shall have a registration agreement with the Department.
 2. The Department shall not authorize Child Care Assistance with a noncertified relative provider when Child Care Assistance is requested for a CPS referred family, or a CPS or DDD foster family;

3. The Department shall not authorize Child Care Assistance with a noncertified relative or certified provider when:
 - a. The relative or certified provider is the natural, step, or adoptive parent of the child for whom assistance is requested;
 - b. Child Care Assistance is requested by a Cash Assistance participant and the relative or certified provider is included in the same Cash Assistance grant as the child care applicant; or
 - c. The relative or certified provider is included in family size as prescribed in R6-5-4914(D), is the applicant for Child Care Assistance, or is the applicant's spouse.

Historical Note

Adopted effective July 31, 1997, under an exemption from the provisions of A.R.S. Title 41, Chapter 6 (Supp. 97-3). Amended by exempt rulemaking at 13 A.A.R. 92, effective December 31, 2006 (Supp. 06-4).

Editor's Note: *The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1997, Ch. 300, § 74(A). Exemption from A.R.S. Title 41, Chapter 6 means the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review and approval; and the Department was not required to hold public hearings on this Section.*

R6-5-4912. Eligible Activity or Need

- A. Eligible activities and needs for Child Care Assistance are described in this subsection:
 1. Employment. Full or part-time employment for monetary compensation;
 2. Self Employment. Full or part time self employment for monetary compensation.
 3. Education and Training Activities with Minimum Work Requirement. A client who is employed shall be eligible to receive Child Care Assistance for education and training activities as prescribed in subsections (A)(3)(a), (b), and (c).
 - a. Post-secondary education in a college or trade school.
 - i. The client is employed an average of at least 20 hours per week, per calendar month.
 - ii. A self-employed client meets the 20-hour work requirement if the client's monthly net profit, divided by the current minimum wage standard, equates to the average 20-hour weekly work requirement.
 - iii. The education or training activity is related to the client's employment goal.
 - iv. The client's educational level is freshman or sophomore as defined by the educational institution, or the educational activities are in pursuit of an Associate Degree, or the client is in training at a vocational or trade school.
 - v. The client shall maintain satisfactory progress in the educational activity and remain in good standing, as defined by the educational institution.
 - vi. The client has not received more than the lifetime limit of 24 months of Child Care Assistance for education and training activities. Child Care Assistance authorized for educa-

- tional activities before August 1, 1997, does not count toward the 24-month limit.
- vii. Countable months toward the 24-month limit are those calendar months in which the Department authorized additional child care services for education and training needs; the Department shall not calculate the 24-month limit based on monthly usage.
- viii. The client assumes full responsibility for employment goals and educational choices made; the Department is under no obligation to provide Child Care Assistance until educational or employment goals are attained.
- ix. The Department shall authorize Child Care Assistance for actual class time, time between classes as determined by the Department, and travel time to and from school only.
- x. Correspondence courses, home study courses, and study time are not eligible educational activities for Child Care Assistance.
- b. High School, G.E.D., E.S.O.L., and Remedial Educational Activities for Adults age 20 and Older.
 - i. The client is employed an average of at least 20 hours per week, per month.
 - ii. A self-employed client meets the 20-hour work requirement if the person's monthly net profit, divided by the current minimum wage standard, equates to the average 20-hour weekly work requirement.
 - iii. The educational or training activity is related to the client's employment goal.
 - iv. The client shall maintain satisfactory progress in the educational activity and remain in good standing, as defined by the educational institution.
 - v. The client has not received more than the lifetime limit of 12 months of Child Care Assistance for education and training activities described in this Section. Child Care Assistance authorized for educational activities before August 1, 1997, does not count toward the 12-month limit.
 - vi. Countable months toward the 12-month limit are those calendar months in which the Department authorized additional child care services for education and training needs. The Department shall not calculate the 12-month limit based on monthly usage.
 - vii. The client assumes full responsibility for employment goals and educational choices made; the Department is under no obligation to provide Child Care Assistance until educational and employment goals are attained.
 - viii. Allowable educational activities are: attendance at high school, G.E.D. or E.S.O.L. classes, or remedial educational activities as determined allowable by the Department.
 - ix. The Department shall authorize Child Care Assistance for actual class time, time between classes as determined by the Department, and travel time to and from school only.
 - x. Correspondence courses, home study courses, and study time are not allowable educational activities for DES Child Care Assistance.
- c. Cash Assistance participants who are sanctioned due to Jobs noncompliance are ineligible for Child Care

- Assistance for education and training activities in any month when a Jobs sanction is applied to the Cash Assistance case, unless the education and training activities are Jobs approved.
4. Teen Parents in Education and Training Activities. Teen parents are eligible for Child Care Assistance for education and training activities according to the following criteria:
 - a. The teen parent is under age 20.
 - b. The teen parent is attending high school, G.E.D., or E.S.O.L. classes, or remedial educational activities in pursuit of a high school diploma.
 - c. Child Care Assistance for teen parents for the educational activities described in this Section is not time-limited. The teen parent shall continue to receive assistance for the educational activity if eligibility criteria are met and until the teen parent:
 - i. Receives a diploma or certificate; or
 - ii. Attains the age of 20 years, whichever occurs first.
 - d. If the teen parent attends post-secondary educational activities, the eligibility criteria outlined under "Post- Secondary Education" in subsection (A)(3)(a) shall apply.
 - e. The Department shall authorize Child Care Assistance for actual class time, time between classes as determined by the Department, and travel time to and from school only.
 - f. Correspondence courses, home study courses, and study time are not allowable educational activities for Child Care Assistance.
 - g. Cash Assistance participants who have been sanctioned due to Jobs noncompliance are ineligible for Child Care Assistance for education and training activities in any month that a Jobs noncompliance sanction is applied to the Cash Assistance case, unless the education and training activities are Jobs approved.
 5. Participation in Jobs Approved Activities. Individuals participating in the Jobs Program and who receive Cash Assistance shall be eligible for Child Care Assistance if the following criteria are met.
 - a. The individual is referred by a Jobs Program Specialist to CCA for Child Care Assistance.
 - b. The individual is required to contact a local DES Child Care Office to notify CCA of the selection of a provider, and to cooperate with CCA to arrange child care services.
 - c. The Child Care service authorization shall be based on the days and hours of the approved Jobs activity as specified by the Jobs Program Specialist in the Jobs referral.
 - d. Jobs participants shall receive Child Care Assistance for Jobs approved educational and training activities only. Educational and training activities that are not Jobs approved are not eligible activities for Child Care Assistance for Jobs participants.
 6. Unable or Unavailable to Provide Care. Clients who are unable or unavailable to care for their own children for a portion of a 24-hour day are eligible for Child Care Assistance according to the following criteria.
 - a. Clients who are unable to care for their own children due to a physical, mental, or emotional disability are eligible for Child Care Assistance when the diagnosis, inability to care for the children, and anticipated recovery date (or the date of the next medical evaluation) have been verified by a licensed physician, certified psychologist, or certified behavioral health specialist.
 - b. The Department shall authorize Child Care Assistance to cover:
 - i. The amount of time the client is unable to care for the child; and
 - ii. The amount of time needed for ongoing treatment for the specified condition as verified by the physician, certified psychologist, or certified behavioral health specialist.
 - c. Child Care Assistance shall not cover intermittent and routine appointments that are not part of an ongoing treatment plan.
 - d. Clients participating in a drug rehabilitation program are eligible for Child Care Assistance to participate in activities as specified by the drug rehabilitation program.
 - e. Clients participating in a court-ordered community service program are eligible for Child Care Assistance to support required community service participation as specified by the court.
 - f. Clients who are residents of a homeless or domestic violence shelter are eligible for Child Care Assistance based on shelter residency, and on verification provided by an authorized representative at the shelter. Child Care Assistance shall cover:
 - i. The days and hours that the client is unavailable to provide care to their own child due to participation in shelter-directed activities as verified by an authorized representative of the shelter; and
 - ii. The days and hours that the client is unable to provide care to the client's own child due to a physical, mental, or emotional disability as verified by a licensed physician, certified psychologist, or a certified behavioral health specialist.
 - B. Gaps In Employment.** Clients receiving Child Care Assistance are eligible for continued assistance during gaps in employment.
 1. The Department shall continue Child Care Assistance for each parent, legal guardian, or relative caretaker in the eligible family during no more than two gaps in employment of 30 days in each 12-month period.
 2. The Department shall authorize Child Care Assistance during a 30-day gap in employment beginning the day after the last day worked, after the client provides verification of his or her job termination date.
 3. Gaps in employment may be consecutive (if requested).
 - a. The Department shall continue Child Care Assistance for an additional 30 days upon request of the client, if the client has not already used Child Care Assistance during two gaps in employment in the most recent 12-month period immediately preceding the job termination date.
 - b. The second gap in employment shall begin the day after the last day of the first gap in employment.
 4. The Department shall continue to authorize the same number of units of Child Care Assistance as previously authorized for the employment activity.
 5. The Department shall decrease the client's fee level and copayment under Appendix A, based on the loss of earned income effective the date that terminated employment has been verified, or the day after the last day worked, whichever is the later date.

6. The Department shall end Child Care Assistance during a gap in employment on the 30th day after the client's last day worked, or on the 60th day after the client's last day worked if two consecutive gaps were authorized, unless the client can verify participation in a new eligible activity.
7. When a client fails to report job loss timely as described under R6-5-4911(A)(1), and continues to use Child Care Assistance, the Department shall automatically reduce the overpayment period by subtracting any unused gaps in employment in lieu of the corresponding months of overpayment.
8. Child care utilized during a gap in employment shall count toward the 60 month per child time limit for Child Care Assistance under R6-5-4919.
9. CPS Referred Families and CPS and DDD Foster Families.
 - a. Child Care Assistance shall be provided to families requiring assistance as documented in a CPS case plan, or to children who are in the care, custody, and control of the Department, and who need Child Care Assistance as documented in a foster care case plan.
 - b. Eligibility for Child Care Assistance under this provision shall be determined by CPS and DDD on a case by case basis.
- C. Verification of Eligible Activity or Need. The client shall verify eligible activities and needs as requested by the Department. Acceptable verification shall include:
 1. Pay stubs for the most recent 30-day period;
 2. Employer's statement verifying start date, hourly rate of pay, work schedule, and frequency of pay including:
 - a. The date of receipt of the first full paycheck if the client is newly employed; and
 - b. The last day worked, if the client's employment has terminated.
 3. Quarterly or annual tax statement for the most recent calendar quarter or year to verify self-employment activities;
 4. Self-employment log to document self-employment activities and income accompanied by receipts for gross sales and business expenses for the most recent calendar month or quarter;
 5. Written verification from an educational institution to verify days and hours of attendance, start and end dates of the activity, educational level, and satisfactory progress;
 6. Written verification from a licensed physician, certified psychologist, or certified behavioral health specialist indicating the diagnosis, inability to care for the child, days and hours that child care is needed, and the anticipated recovery date;
 7. Written verification from a homeless or domestic violence shelter indicating the days, hours, and duration that child care is needed as prescribed in subsection (A)(6)(f).

Historical Note

Adopted effective July 31, 1997, under an exemption from the provisions of A.R.S. Title 41, Chapter 6 (Supp. 97-3).

Amended by exempt rulemaking at 13 A.A.R. 92, effective December 31, 2006 (Supp. 06-4).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1997, Ch. 300, § 74(A). Exemption from A.R.S. Title 41, Chapter 6 means the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for

review and approval; and the Department was not required to hold public hearings on this Section.

R6-5-4913. Applicants and Recipients as Child Care Providers

- A. The client for Child Care Assistance may also be the child care provider for any child for whom assistance is requested when:
 1. The client works for but is not the DES contracted party for the provision of Child Care Assistance;
 2. The client receives monetary compensation for work performed as a child care provider;
 3. The client cares for other unrelated children, for whom client does not receive Child Care Assistance, as well as for the child for whom the client has applied for Child Care Assistance; and
 4. The client is unavailable to provide care to the child for whom assistance is requested. When the client is also the child care provider, this is defined as:
 - a. There is no "not for compensation" slot available for the child; and
 - b. Caring for the child as well as for the other children for whom the child care provider receives compensation, would exceed the ratio per state certification or licensing standards pursuant to A.R.S. § 36-897.01 and 6 A.A.C. 5, Article 52.
- B. If there is no "not for compensation" slot available for the child, and other eligibility criteria described in this Article are met, the client for Child Care Assistance may also be the child care provider for the child for whom assistance is requested.

Historical Note

Adopted effective July 31, 1997, under an exemption from the provisions of A.R.S. Title 41, Chapter 6 (Supp. 97-3).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1997, Ch. 300, § 74(A). Exemption from A.R.S. Title 41, Chapter 6 means the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review and approval; and the Department was not required to hold public hearings on this Section.

R6-5-4914. Income Eligibility Criteria

- A. Child Care Assistance Without Regard to Income. The Department shall not determine income eligibility for Child Care Assistance for the following:
 1. Jobs participants who need Child Care Assistance to participate in the Jobs Program, and who are referred to CCA as prescribed in R6-5-4904(B).
 2. Cash Assistance participants who need Child Care Assistance to maintain employment.
 3. CPS referred families, and CPS or DDD foster families who need Child Care Assistance as documented in a CPS or foster care case plan, and who are referred to CCA as prescribed in R6-5-4904(B).
- B. Child Care Assistance With Regard to Income. The Department shall determine income eligibility for Child Care Assistance for the following:
 1. Former Cash Assistance participants who need Child Care Assistance to maintain employment as prescribed in R6-5-4916(A).
 2. Clients who are not Cash Assistance participants but who need Child Care Assistance to maintain employment.
 3. Teen parents who need Child Care Assistance for educational activities as prescribed in R6-5-4912(A)(4).
 4. Clients who need Child Care Assistance because they are unable or unavailable to care for their own children due to

physical, mental or emotional disability, participation in a drug treatment or court-ordered community service program, or residency in a homeless or domestic violence shelter as prescribed in R6-5-4912(A)(6).

C. Income Maximum for Child Care Assistance. The Department shall determine income eligibility by calculating the gross monthly income of all family members included in family size unless otherwise excluded as prescribed in subsections (D), (E), (F), and (H).

1. If the gross monthly income for the family is equal to or less than 165% FPL, the family meets the income eligibility requirements for Child Care Assistance.
2. If the gross monthly income for the family exceeds 165% FPL, the family does not meet the income eligibility requirements for Child Care Assistance.

D. Family Size Determination. The Department shall include the countable income of every person included in family size for the purpose of determining income eligibility as prescribed in this subsection.

1. Family size shall consist of:
 - a. The applicant for Child Care Assistance;
 - b. The applicant's natural, adoptive, and step children;
 - c. Any other parent or responsible person living in the household who is legally and financially responsible for either the applicant, or for the children needing care;
 - d. The children of the other parent or responsible person residing in the same household; and
 - e. The tax claimant under subsection R6-5-4914(D)(3).
2. When a parent applies for Child Care Assistance for a natural, adoptive, or step child, the Department shall:
 - a. If the applicant and other adult in the household are married, or have children in common who need child care, make one family size determination for the family.
 - b. Count the income of both parents.
3. When a tax claimant resides in the household with a parent who is applying for or receiving Child Care Assistance, the Department shall include the tax claimant in family size if:
 - a. The tax claimant states an intention to claim any of the following members of the eligible family residing in the same household as a dependent on the tax claimant's federal or state income tax return for the current calendar year:
 - i. The parent who is the applicant;
 - ii. The parent's natural, adoptive, or step children less than 18 years of age;
 - iii. The parent's spouse;
 - iv. The other parent of the children for whom assistance is requested, or who are receiving Child Care Assistance; or
 - v. The dependent children of the other parent residing in the household, and who are included in family size.
 - b. The tax claimant signs a declaration stating the intention to claim specific members of the eligible family as tax dependents for the current calendar year.
4. The Department shall include the tax claimant's dependent children under age 18 and spouse residing in the same household in family size.
5. When the applicant and his or her spouse are legally married and do not reside in the same household, but have the intention of remaining a family, the Department shall

include the spouse in family size if the absent spouse is engaged in an eligible activity under R6-5-4912.

6. When a caretaker relative applies for Child Care Assistance for another related child only:
 - a. Family size shall consist of the other related child or children only; and
 - b. The Department shall exclude both the caretaker relative and his or her spouse from the family size determination.
7. When the applicant applies for Child Care Assistance for natural, adoptive, or step children, and also for another related child, the Department shall make one family size determination for the family:
 - a. Family size shall consist of the applicant, the applicant's child, any other related eligible children who need care, and any other parent or responsible person in the household.
 - b. Any income received by or for an "other related" child less than 13 years of age shall be counted.
 - c. If there is another relative in the household who states an intention to claim an other related child as a dependent for income tax purposes, this tax claimant must be the applicant for the child. The Department shall determine family size separately for this child under R6-5-4914(D)(6).
8. When an unwed minor parent applies for Child Care Assistance for his or her own child, and resides with his or her parents:
 - a. The Department shall include the following in family size, unless the minor parent or the minor parent's children are tax dependents as described under subsection (d) below:
 - i. The minor parent; and
 - ii. The minor parent's child.
 - b. The Department shall not include the parents and siblings of the unwed minor parent in family size.
 - c. The Department shall deem a portion of the monthly gross countable income received by the parent of the minor parent to be available to meet the needs of the unwed minor parent and his or her children as described in this subsection, unless the parent of the minor parent is a tax claimant, under subsection (d) below.
 - i. The Department shall calculate the monthly gross countable income of the parents of the unwed minor parent;
 - ii. The Department shall subtract the amount of monthly gross countable income that equates to 165% FPL as specified in Appendix A, for the number of parents and siblings of the unwed minor parent residing in the same household only; and
 - iii. The Department shall count the remaining monthly gross countable income received by the parents of the unwed minor parent as available to meet the needs of the unwed minor parent and his or her children in the income eligibility determination.
 - d. If a parent of the minor parent is a tax claimant who intends to claim the minor parent or the minor parent's child as a tax dependent, the Department shall determine family size as follows:
 - i. The Department shall include the tax claimant, the tax claimant's spouse, and the tax claimant's dependent children residing in the same

- household in family size with the minor parent, and his or her child; and
 - ii. The Department shall count all countable income received by the tax claimant and the tax claimant's spouse in the income eligibility determination.
 9. When a married, separated, widowed, or divorced minor parent applies for Child Care Assistance for his or her own children:
 - a. The Department shall include the minor parent and his or her own dependent children in family size;
 - b. The Department shall include monthly gross countable income received by the minor parent and the other parent or responsible person residing in the home in the income eligibility determination;
 - c. The Department shall not consider income received by the parent of the minor parent in the income eligibility determination, unless the parent of the minor parent is a tax claimant, under subsection (8)(d); and
 - d. The Department shall not include parents and siblings of the minor parent in family size, unless the parent of the minor parent is a tax claimant, under subsection (8)(d).
 10. If a tax claimant included in family size is also a parent who needs Child Care Assistance for his or her own child, the tax claimant shall submit a separate application.
 - a. The Department shall make a separate eligibility and family size determination for the tax claimant's dependent children less than age 18.
 - b. The Department shall include the parent, spouse or other parent or responsible person, and their dependent children in family size.
 11. When a guardian applies for Child Care Assistance for a child in guardianship only, the Department shall:
 - a. Make one family-size determination for the child in guardianship.
 - b. Include all children in guardianship in family size.
 - c. Exclude the guardian and the guardian's spouse from family size.
 - d. Count the income received by or for the children in guardianship.
 - e. If the parent of the child needing care is also in the household, the Department shall not include the parent in family size; and shall not count his or her income.
 12. When the applicant applies for Child Care Assistance for natural, step, or adoptive children in addition to the children in guardianship, the Department shall:
 - a. Make one family-size determination.
 - b. Include in family size the applicant, the applicant's children, the children in guardianship less than 13 years of age who need care, and any other parent or responsible person in the household.
 - c. Count the applicant's and other parent's or responsible person's income.
 - d. Count the income received by or for the children in guardianship less than 13 years of age.
 13. When a foster parent applies for Child Care Assistance for his or her own children:
 - a. The Department shall include the applicant, other parent or responsible person, and their children in family size; and
 - b. The Department shall not include the foster child in family size unless the foster child is a relative.
- E. Verification of Tax Claimant Status**
1. The Department shall verify tax claimant status as described in R6-5-4914(D) by requiring:
 - a. The client to submit a signed and dated declaration stating that no relative 18 years of age or older residing in the same household intends to claim any member of the eligible family as a tax dependent for the current calendar year; or,
 - b. The client and the relative 18 years of age or older residing in the same household who intends to claim a member of the eligible family as a tax dependent for the current calendar year to:
 - i. Submit a signed and dated declaration stating that fact; and,
 - ii. State the name of the family member whom the relative intends to claim as a tax dependent.
 2. The Department shall include the tax claimant, his or her spouse, and dependent children in family size upon receipt of the signed declaration.
 3. If the tax claimant no longer intends to claim a member of the eligible family as a tax dependent, the client must sign and date a new declaration.
 - a. The new declaration shall specify that the tax claimant no longer intends to claim a member of the eligible family as a tax dependent.
 - b. The Department shall remove the tax claimant, tax claimant's spouse, and his or her dependent children from family size after receipt of the signed declaration.
- F. Countable Income.** The Department shall count the gross monthly income of a family as prescribed in subsection (D); countable income shall include:
1. Gross earnings received for work including wages, salary, armed forces pay (with the exception of specifically designated allotments for food and shelter costs), commissions, tips, overtime, piece-rate payments, and cash bonuses earned, before any deductions.
 2. Net income from non-farm self employment including gross receipts minus business expenses. Gross receipts include the value of all goods sold and services rendered. Business expenses include costs of goods and services purchased or produced, rent, heat, light, power, depreciation charges, wages, and salaries paid, business taxes, and other expenses incurred in operating the business. The value of salable merchandise consumed by the proprietors of retail stores is not included as part of net income. Payments on loans or mortgages obtained to increase capital investments in property or equipment are not allowed as deductible expenses.
 3. Net income from farm self employment which includes gross receipts minus operating expenses. Gross receipts include the value of all products sold, government crop loans, money received from the rental of farm equipment to others, and incidental receipts from the sale of wood, sand, gravel, and similar items. Operating expenses include costs of feed, fertilizer, seed, and other farming supplies, wages paid to farmhands, depreciation charges, cash rent, interest on farm mortgages, farm building repairs, farm taxes, and other expenses incurred in operation of the farm. The value of fuel, food, or other farm products used for family living is not included as part of net income. Payments on loans or mortgages obtained to increase capital investments in property or equipment are not allowed as deductible expenses.
 4. Social Security payments prior to deductions for medical insurance including Social Security benefits and "survi-

- vors” benefits, and permanent disability insurance payments made by the Social Security Administration.
5. Railroad retirement insurance income.
 6. Dividends including interest on savings, stocks and bonds, income and receipts from estates or trusts, net rental income or royalties, receipts from boarders or lodgers (net income received from furnishing room and board shall be 1/3 of the total amount charged). Interest on Series H. United States Government Savings bonds.
 7. Mortgage payments received shall be prorated on a monthly basis.
 8. Public assistance payments including payments from the following programs: Cash Assistance, Supplemental Security Income (SSI), State Supplementary Payments (SSP), General Assistance (GA), Bureau of Indian Affairs General Assistance (BIAGA), and Tuberculosis Control (TC).
 9. Pensions and annuities including pensions or retirement benefits paid to a retired person or their survivors by a former employer or by a union, or distributions or withdrawals from an individual retirement account.
 10. Unemployment Insurance payments including compensation received from government unemployment insurance agencies or private companies during periods of unemployment, and any strike benefits received from union funds.
 11. Workers’ compensation payments.
 12. Money received from the Domestic Volunteer Act when the adjusted hourly payment is equal to or greater than minimum wage; Action Volunteer Programs include VISTA, Foster Grandparent Program (FGP), Retired Senior Volunteer Program (RSVP), and Senior Companion Program (SCP).
 13. Alimony or spousal maintenance which shall be counted the month received.
 14. Child support which shall be counted the month received.
 15. Veterans’ pensions including benefits and disability payments paid periodically by the Veterans Administration to members of the Armed Forces or to a survivor of deceased veterans.
 16. Cash gifts received on a monthly basis from relatives, other individuals, and private organizations, as a direct payment in the form of money.
 17. Money received through the lottery, sweepstakes, contests, or through gambling ventures whether received on an annuity or lump sum basis.
 18. Any other source of income not specifically excluded in subsection (F).
- G. Excluded Income.** The Department shall exclude the items listed in this subsection when determining a family’s gross monthly income.
1. Per capita payments to or funds held in trust for any individual in satisfaction of a judgment of the Indian Claims Commission or the Court of Claims;
 2. Payments made pursuant to the Alaska Native Claims Settlement Act to the extent such payments are exempt from taxation under Section 21(a) of the Act;
 3. Money or capital gains received as a lump sum, from the sale of personal or real property, such as stocks, bonds, or a car (unless the person was engaged in the business of selling such property, in which case the net proceeds would be counted as income from self employment);
 4. Withdrawals of bank deposits;
 5. Loans; money borrowed;
 6. Tax refunds;
 7. Any monies received through the federal Earned Income Credit (EIC);
 8. One time lump sum awards or benefits, including:
 - a. Inherited funds;
 - b. Insurance awards;
 - c. Damages recovered in a civil suit;
 - d. Monies contributed by a client to a retirement fund that are later withdrawn prior to actual retirement; and
 - e. Retroactive public assistance payments;
 9. The value of U.S. Department of Agriculture (USDA) Food Stamps;
 10. The value of USDA-donated food;
 11. The value of any supplemental food assistance received under the Child Nutrition Act of 1966 and special food service program for children under the National School Lunch Act, the Women, Infant, and Children Program (WIC), Child and Adult Care Food Program (C.A.C.F.P.), and the School Lunch Program;
 12. Any payment received under the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (for example, Navajo/Hopi Relocation Act);
 13. Earnings of a child who is under the age of 18 and attending high school or other training program, and who is not a minor parent who needs Child Care Assistance for his or her own child;
 14. Home produce used for household consumption;
 15. Government-sponsored training program expenses (TRE payments) such as: training-related expenses paid to JOBS participants and Job Training Partnership Act (JTPA) training expenses paid directly to the client;
 16. The value of goods or services received in exchange for work;
 17. Interest on Series E, United States Government Savings bonds;
 18. Foster care maintenance payments received for care of foster children;
 19. Adoption subsidy payments received for the care of adopted children;
 20. Educational loans, grants, awards, and scholarships regardless of their source, including Pell Grants, Supplemental Educational Opportunity Grants (SEOG), Bureau of Indian Affairs (BIA) Student Assistance Grants, college work-study income, Carl D. Perkins Vocational and Applied Technology Education Act income, and any other state or local, public, or private educational loans, grants, awards, and scholarships;
 21. Money received from the Domestic Volunteer Act when the adjusted hourly payment is less than minimum wage; Action Volunteer Programs include VISTA, Foster Grandparent Program (FGP), Retired Senior Volunteer Program (RSVP), and Senior Companion Program (SCP);
 22. Housing and Urban Development (HUD) benefits, cash allowances and credits against rent;
 23. Vendor payments including payments made directly to a third party by friends, relatives, charities, or agencies to pay bills for the client;
 24. Vocational Rehabilitation training-related expenses (TRE) which are reimbursements for expenses paid. Subsistence and maintenance allowances, and incentive payments not designated as wages;
 25. Disaster relief funds and emergency assistance provided under the Federal Disaster Relief Act, and comparable assistance provided by a state or local government, or disaster assistance organization;

26. Energy assistance including all state or federal benefits designated as “energy assistance” or assistance from a municipal utility or non-profit agency;
 27. Agent Orange payments;
 28. Any other income specifically excluded by applicable state or federal law.
- H. Income Deduction.** Child support that is paid for dependents who do not reside in the same household with the eligible family shall be deducted from the monthly gross countable income prior to income calculation and fee level and copayment assignment as prescribed in subsection (I) and R6-5-4915.
- I. Income Calculation.** The Department shall calculate monthly income as prescribed in this subsection.
1. The Department shall include all income of all family members included in the family-size determination, other than income excluded as prescribed in R6-5-4914(F) in the determination of income eligibility.
 2. The Department shall calculate a monthly figure for each source of income separately with the appropriate method used for calculation.
 3. After calculating monthly income for each source of income, the Department shall add the monthly amounts from each source to obtain the total monthly income.
 4. The Department shall convert income received less often than monthly to a monthly figure as provided in this subsection.
 - a. The Department shall prorate the total income over the number of months that the income is intended to cover.
 - b. If the income is received on or after the date of application, a monthly share of income shall be considered beginning with its earliest possible effective date and for a number of months equal to the number of months which the income covers.
 - c. If the family receives the income prior to the date of application, the number of months that the income is intended to cover shall be equal to the number of months of coverage remaining.
 5. The Department shall anticipate income for a current or future month based on the averaged income received in the most recent 30-day period, unless the Department receives new information that indicates that the income has changed, as verified under subsection (J).
 - a. If the income received by the household has increased due to receipt of a new source of income, an increased work schedule, or a raise in salary or wages, the Department shall calculate the gross monthly countable income for the household based on the amount of income anticipated to be received on a monthly basis. The Department shall begin counting the new or increased income as described under subsection (6).
 - b. If the income received by the household has decreased due to loss of a source of income, a decreased work schedule, or a reduction in salary or wages, the Department shall cease counting the income effective the date that the client provides verification of the loss or reduction in income.
 6. When a family receives a new or increased income source that will be received monthly, weekly, bi-weekly, or semi-monthly:
 - a. The income shall not be considered available to the family until the date that the first full payment is received.
 - b. The Department shall not assess a new fee level or ineligibility to the client until the monies are available.
 - c. Once the client has already received the payment that includes the new or increased income source, and a higher fee level or ineligibility results:
 - i. The Department shall increase the fee level or terminate assistance no earlier than 10 days after the first full paycheck has been received; and
 - ii. The Department shall send a 10-day negative action notice prior to increasing the fee level or terminating assistance.
 7. The Department shall convert income received more often than monthly, for a period covering less than a month, to a monthly amount by one of the methods listed below.
 - a. If the income amount does not vary and is received monthly, weekly, bi-weekly, or semi-monthly, the conversion to a monthly amount will be obtained by multiplying the pay period amount by:
 - i. 1, if monthly;
 - ii. 4.3, if weekly;
 - iii. 2.15, if bi-weekly; or
 - iv. 2, if semi-monthly.
 - b. This amount shall be applied as income on an ongoing monthly basis until there is a change in the income.
 - c. If the monthly income received varies in amount and frequency, and exact monthly figures are unavailable, the Department shall use an average monthly figure.
 8. When the Department calculates the gross monthly income for the family, the whole dollar amount only shall be used to determine income eligibility, and fee level and copayment assignment; any amount that is a fraction of a whole dollar shall be rounded down to the next whole dollar.
- J. Verification of Income.** The client shall verify income by providing written documentation of income as requested by the Department such as:
1. Pay stubs for the most recent calendar month, or for any month of potential overpayment;
 2. Employer’s statement verifying work schedule, hourly rate of pay, and frequency of pay;
 3. Benefit award statements for the most recent benefit period;
 4. Statements of account to verify interest income;
 5. Quarterly or annual tax returns for the most recent quarter or year for self-employment income;
 6. Self-employment log accompanied by gross sales receipts and business expense receipts for the most recent calendar month or quarter; and
 7. Other written documentation from the source of the income indicating the amount of income received, source of income, frequency received, and naming the payee.

Historical Note

Adopted effective July 31, 1997, under an exemption from the provisions of A.R.S. Title 41, Chapter 6 (Supp. 97-3). Amended by exempt rulemaking at 13 A.A.R. 92, effective December 31, 2006 (Supp. 06-4).

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proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review and approval; and the Department was not required to hold public hearings on this Section.

R6-5-4915. Fee Level and Copayment Assignment

- A. The Department shall assign a fee level to the family based on family size and monthly gross countable income, as specified in Appendix A.
- B. The Department shall assign individual minimum required copayment amounts for each child in the family based on the fee level assignment, and the number of children needing care, as specified in Appendix A.
- C. The Department shall not assign a fee level or minimum required copayment to Jobs participants, Cash Assistance participants who need Child Care Assistance for employment, or families determined eligible and referred by CPS or DDD.
- D. When a client fails to pay the DES-required copayment, or fails to make satisfactory arrangements for payment of the DES-required copayment with a child care provider, the client is ineligible for Child Care Assistance.
- E. When the Department has determined that an client is ineligible for Child Care Assistance due to nonpayment of the copayment, the client is ineligible for any Child Care Assistance program that requires a copayment until past-due copayments have been paid, or until satisfactory arrangement have been made with the provider for payment.

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R6-5-4916. Special Eligibility Criteria

- A. Transitional Child Care
 1. Former Cash Assistance participants who are attempting to achieve independence from the Cash Assistance program, who need Child Care Assistance for employment, and who are otherwise eligible shall receive up to 24 months of Transitional Child Care Assistance.
 2. The former Cash Assistance participant shall have received Cash Assistance in Arizona in at least one month and shall apply for Child Care Assistance within six months after the Cash Assistance case closure date.
 3. The former Cash Assistance participant and any other parent or responsible person in the household shall need Child Care Assistance to maintain employment.
 4. The most recent Cash Assistance case closure shall not have been due to a sanction for Jobs or Child Support noncompliance, and the Cash Assistance participant shall not have been sanctioned due to intentional program violation (IPV) at the time of the most recent Cash Assistance case closure.
- B. Cash Assistance Diversion Participants.
 1. Applicants for Cash Assistance who are diverted from long-term Cash Assistance through the Cash Assistance

Diversion program shall be treated as Cash Assistance participants during the three-month period that the Cash Assistance Diversion payment covers.

2. Cash Assistance Diversion participants shall be eligible for Child Care Assistance for employment activities without regard to income as prescribed in R6-5-4914(A) during the three-month Diversion period.
3. Cash Assistance Diversion participants shall be eligible for Child Care Assistance for job search activities during the three-month Diversion period.
4. Cash Assistance Diversion participants shall be eligible for Transitional Child Care after the three-month Diversion period if the income eligibility requirements in R6-5-4914(B) and the TCC requirements in subsection (A) of this provision are met.

Historical Note

Adopted effective July 31, 1997, under an exemption from the provisions of A.R.S. Title 41, Chapter 6 (Supp. 97-3). Amended by exempt rulemaking at 13 A.A.R. 92, effective December 31, 2006 (Supp. 06-4).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1997, Ch. 300, § 74(A). Exemption from A.R.S. Title 41, Chapter 6 means the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review and approval; and the Department was not required to hold public hearings on this Section.

R6-5-4917. Waiting List for Child Care Assistance

- A. Implementation of a Waiting List for Child Care Assistance.
 1. The Department may implement a waiting list for Child Care Assistance whenever it determines that sufficient funding is not available to sustain benefits for all of the applicants requesting assistance.
 - a. The Department may implement a waiting list for all applicants under subsection (B); or,
 - b. The Department may implement a partial waiting list and prioritize access to Child Care Assistance for applicants based on income under subsection (D).
 2. When the waiting list is in effect, the Department shall place applicants determined to be eligible for Child Care Assistance on the waiting list under this subsection, and shall not authorize Child Care Assistance until the Department determines that sufficient funding is available.
- B. Applicants Who Are Subject To the Waiting List. When the waiting list is in effect, the Department shall place applicants determined to be eligible for Child Care Assistance on the waiting list, including individuals who are reapplying for Child Care Assistance following case closure. The Department shall place the following applicants on the waiting list:
 1. Applicants who are not Cash Assistance participants but who need Child Care Assistance to maintain employment under R6-5-4912(A).
 2. Teen parents who need Child Care Assistance for educational activities under R6-5-4912(D).
 3. Applicants who need Child Care Assistance because they are unable or unavailable to care for their own children due to physical, mental, or emotional disability, participation in a drug treatment or court-ordered community service program, or residency in a homeless or domestic violence shelter under R6-5-4912(F).
- C. Applicants Who Are Not Subject To the Waiting List. When the waiting list is in effect, the Department shall not place the

following applicants determined eligible for Child Care Assistance on the waiting list, and shall proceed to authorize Child Care Assistance under R6-5-4918.

1. Jobs participants who need Child Care Assistance to participate in the Jobs Program, and who are referred to CCA under R6-5-4904(B).
2. Cash Assistance participants who need Child Care Assistance to maintain employment under R6-5-4904(B).
3. CPS referred families, and CPS or DDD foster families who need Child Care Assistance as documented in a CPS or foster care case plan, and who are referred to CCA under R6-5-4904(B).
4. Former Cash Assistance participants who need Child Care Assistance to maintain employment under R6-5-4916(A).

D. Prioritization of Applicants for Child Care Assistance When the Waiting List Is In Effect. The Department shall prioritize applicants for authorization of Child Care Assistance when the waiting list is in effect under this subsection.

1. **Prioritization Based On Income.**
 - a. Families with gross monthly incomes at or below 100% of the Federal Poverty Level (FPL) receive the highest priority for assistance;
 - b. The Department shall prioritize the remainder of families applying for Child Care Assistance when the waiting list is in effect in the following order:
 - i. Families with gross monthly incomes between 101% FPL and 110% FPL;
 - ii. Families with gross monthly incomes between 111% FPL and 120% FPL;
 - iii. Families with gross monthly incomes between 121% FPL and 130% FPL;
 - iv. Families with gross monthly incomes between 131% FPL and 140% FPL;
 - v. Families with gross monthly incomes between 141% FPL and 150% FPL;
 - vi. Families with gross monthly incomes between 151% FPL and 160% FPL;
 - vii. Families with gross monthly incomes between 161% FPL and 165% FPL;
2. **Prioritization Based On Application Date.** The Department shall place clients determined eligible for Child Care Assistance on the waiting list effective the date that the Department receives an identifiable application, under R6-5-4904(A)(2).

E. Cooperation Requirement for Clients on the Waiting List.

1. Clients shall cooperate with the Department to maintain eligibility while on the waiting list, under R6-5-4911(A).
2. If the family's household income changes, the client shall notify the Department of the change in income within 2 workdays.
3. If someone moves in or out of the household, the client is required to notify the Department within 2 workdays.
4. The Department shall recalculate gross household income and notify the client of any changes in priority status described under subsection (D) based on the change in income or family size.

F. Loss of Employment While On the Waiting List.

1. If the parent or caretaker of the child loses employment while on the waiting list, the family may remain on the waiting list without an eligible activity.
2. When the Department selects the family for release from the waiting list under subsection (H), the Department shall require the parent or caretaker of the child to verify participation in an eligible activity under R6-5-4912

before the Department authorizes the family to receive Child Care Assistance.

G. Determination of Ineligibility While On the Waiting List.

1. If the family becomes ineligible for Child Care Assistance while on the waiting list, or during release from the waiting list under subsection (J), the Department shall remove the client from the waiting list and close the case.
2. The client shall submit a new application and verify eligibility for Child Care Assistance in order to be added back onto the list effective the new application date.

H. Selection from the Waiting List.

1. The Department shall select clients for release from the waiting list within each level of income priority as described under subsection (D), and in application date order.
2. When the Department notifies the client that he or she is being released from the waiting list, the Department may require the client to verify income, employment, other household circumstances or provider selection prior to being authorized for Child Care Assistance.

I. Clients Determined Eligible Upon Selection for Release from the Waiting List.

1. The Department shall authorize Child Care Assistance effective a date specified by the Department based on the availability of funding, after the client has submitted any requested verification and the Department has determined that the family remains eligible for Child Care Assistance.
2. If the client is eligible for Child Care Assistance, the Department shall authorize Child Care Assistance, and shall notify the client in writing regarding:
 - a. The start date of Child Care Assistance;
 - b. The amount of assistance authorized for each child under R6-5-4918; and
 - c. The assigned fee level and copayment for each child.

J. Clients Determined Ineligible Upon Selection for Release from the Waiting List.

1. If the client is not eligible for Child Care Assistance as described in R6-5-4920, the Department shall notify the client regarding ineligibility under R6-5-4921.
2. The Department shall require the client to submit a new application and verify eligibility for Child Care Assistance in order to be added back onto the list effective the new application date, if a waiting list remains in effect.

K. Clients Selected for Release from the Waiting List in Error.

1. If the Department determines that a client was not eligible for selection from the waiting list, and the waiting list remains in effect, the Department shall proceed as described under this subsection.
2. If the Department determines that the client is currently at a lower level of priority for assistance under subsection (D)(1) due to a previously unreported change in income or family size, the Department shall not authorize Child Care Assistance.
3. The Department shall reinstate the client on the waiting list effective the existing application date; and,
4. Notify the family in writing of reinstatement to the waiting list and the newly assigned level of priority.

Historical Note

Adopted effective July 31, 1997, under an exemption from the provisions of A.R.S. Title 41, Chapter 6 (Supp. 97-3). Former R6-5-4917 renumbered to R6-5-4918; new R6-5-4917 made by exempt rulemaking at 13 A.A.R. 92, effective December 31, 2006 (Supp. 06-4).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1997, Ch. 300, § 74(A). Exemption from A.R.S. Title 41, Chapter 6 means the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review and approval; and the Department was not required to hold public hearings on this Section.

R6-5-4918. Authorization of Child Care Assistance

- A.** Authorization Based on Eligible Activity or Need. The Department shall authorize Child Care Assistance for a portion of each 24-hour day based on the verified eligible activity or need of the parent and responsible person for the child needing care.
- B.** Authorization Based on Unavailability. The amount of Child Care Assistance authorized by the Department shall be based on the amount of time that the client and any other parent or responsible person in the household are unavailable or incapable to provide care to their own children due to an eligible activity or need as prescribed in R6-5-4911(F) and R6-5-4912. When there are two or more parents or responsible persons in the household, Child Care Assistance shall be authorized for the amount of time that neither parent or responsible person is available due to an eligible activity or need.
- C.** Authorization for Self-employment Activities.
 - 1. The Department shall authorize Child Care Assistance for self-employment activities based on monthly net income divided by the current hourly minimum wage standard.
 - 2. Authorization of Child Care Assistance for self-employment activities shall not exceed the lesser of:
 - a. The maximum number of Child Care Assistance units that can be authorized as prescribed in subsections (B) and (D), or
 - b. The number of hours calculated by dividing monthly net income from self-employment by the amount of the hourly minimum wage standard, or
 - c. The number of hours of Child Care Assistance needed by the client to perform self employment activities.
- D.** Six-child Authorization Limit.
 - 1. The Department shall authorize no more than six children in the eligible family at any given point in time.
 - a. The six-child authorization limit applies to clients under this subsection.
 - i. Clients who are not Cash Assistance participants but who need Child Care Assistance to maintain employment;
 - ii. Teen parents who need Child Care Assistance for educational activities under R6-5-4912(D); and
 - iii. Clients who need Child Care Assistance because they are unable or unavailable to care for their own children due to physical, mental, or emotional disability, participation in a drug treatment or court-ordered community service program, or residency in a homeless or domestic violence shelter under R6-5-4912(F).
 - b. The six-child authorization limit shall not apply to the following clients:
 - i. Jobs participants who need Child Care Assistance to participate in the Jobs Program, and who are referred to CCA under R6-5-4904(B);
 - ii. Cash Assistance participants who need Child Care Assistance to maintain employment;

- iii. CPS referred families, and CPS or DDD foster families who need Child Care Assistance as documented in a CPS or foster care case plan, and who are referred to CCA under R6-5-4904(B); and
 - iv. Former Cash Assistance participants who need Child Care Assistance to maintain employment under R6-5-4916(A).
 - c. For eligible families who are not subject to the six-child limit, there is no limit to the number of eligible children whom the Department can authorize to receive Child Care Assistance in the eligible family.
 - 2. If the eligible family requests Child Care Assistance for more than six children, the family shall select the six children to be authorized to receive Child Care Assistance.
 - 3. If the family fails to designate six children to receive Child Care Assistance as requested, the Department shall authorize the six youngest children.
 - 4. If the client is already receiving Child Care Assistance for six children and requests assistance for a new child, the Department shall not authorize assistance for the new child until the client notifies the Department which child will no longer receive Child Care Assistance.
- E.** Units of Child Care Assistance.
 - 1. The Department shall authorize Child Care Assistance in full- and part-day units;
 - 2. The Department shall not authorize more than 31 units for each child, per child care provider in a calendar month;
 - 3. A part-day unit of Child Care Assistance is less than six hours;
 - 4. A full-day unit of Child Care Assistance is six hours or more;
 - 5. Each child care provider determines the upper limit of what constitutes a full day of care for that provider.
 - F.** Date of Eligibility. The Department shall approve eligibility for Child Care Assistance effective the application file date or referral receipt date as described in R6-5-4904 if the client satisfies all applicable conditions of eligibility as prescribed in this Article.
 - G.** Date of Authorization.
 - 1. The Department shall authorize Child Care Assistance to begin effective the start date of the eligible activity or need, but not earlier than application file date, request date, or referral receipt date as described in R6-5-4904.
 - 2. The Department may authorize Child Care Assistance with an effective date that precedes the referral receipt date when the referral is received untimely due to administrative delay and the eligible start date of the activity or need precedes the referral receipt date for clients who are referred for Child Care Assistance as described in R6-5-4904 (B).
 - H.** Exclusion from Authorization. The Department shall not authorize Child Care for educational services for children enrolled in grades 1 through 12 when such services are provided during the regular school day.

Historical Note

Adopted effective July 31, 1997, under an exemption from the provisions of A.R.S. Title 41, Chapter 6 (Supp. 97-3). Former R6-5-4918 renumbered to R6-5-4920; new R6-5-4918 renumbered from R6-5-4917 and amended by exempt rulemaking at 13 A.R. 92, effective December 31, 2006 (Supp. 06-4).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1997, Ch. 300, § 74(A). Exemption from A.R.S. Title 41, Chapter 6 means the Department did not submit notice of

proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review and approval; and the Department was not required to hold public hearings on this Section.

R6-5-4919. Time Limit for Child Care Assistance

Under A.R.S. § 46-803(K), each child shall receive time-limited Child Care Assistance, unless the child's parents or caretakers qualify for an extension under this Section.

A. Clients Who Are Subject To the Time Limit.

1. Clients who are not Cash Assistance participants but who need Child Care Assistance to maintain employment;
2. Teen parents who need Child Care Assistance for educational activities under R6-5-4912(D); and
3. Clients who need Child Care Assistance because they are unable or unavailable to care for their own children due to physical, mental, or emotional disability, participation in a drug treatment or court-ordered community service program, or residency in a homeless or domestic violence shelter under R6-5-4912(F).

B. Clients Who Are Not Subject To the Time Limit.

1. Jobs participants who need Child Care Assistance to participate in the Jobs Program, and who are referred to CCA under R6-5-4904(B);
2. Cash Assistance participants who need Child Care Assistance to maintain employment;
3. CPS referred families, and CPS or DDD foster families who need Child Care Assistance as documented in a CPS or foster care case plan, and who are referred to CCA under R6-5-4904(B); and
4. Former Cash Assistance participants who need Child Care Assistance to maintain employment under R6-5-4916(A).

C. Effective Date of the Time Limit. The 60-month time limit shall begin:

1. For applicants of Child Care Assistance eligible under any of the categories listed in subsection (A) who file an application on or after January 1, 2007, on the date the application is received by the Department.
2. For clients receiving Child Care Assistance on January 1, 2007 under subsection (A), January 1, 2007.
3. For clients receiving Child Care Assistance on January 1, 2007 under subsection (B), the first date that the Department determines that the existing client is eligible for Child Care Assistance under one of the categories described in subsection (A).

D. Calculation of the Time Limit.

1. Each child receiving Child Care Assistance under subsection (A) shall receive time-limited assistance for:
 - a. Any combination of 1380 paid full or part day child care units; or
 - b. Child Care Assistance that spans 60 calendar months, whichever is later. A calendar month is one in which the Department pays for at least one full- or part-day unit.
2. Any unit of assistance used by the child, and later identified as a provider or agency caused overpayment shall not count toward the child's time limit.
3. Any unit of assistance used by the child, and later identified as a client-caused overpayment shall not count toward the child's time limit, if the family repays the overpayment.
4. The Department shall apply the time limit individually to each child in the family, and not to the parent or caretaker of the child.

- a. If a different caretaker applies for the child at a later point in time, each child will be entitled to the remaining portion of time-limited Child Care Assistance that has not yet been utilized.
- b. Any Child Care Assistance utilized by the child as part of an eligible family that was exempt from the time limit under subsection (B) shall not count toward the child's time limit.

E. Expiration of the Time Limit.

1. When a child exhausts time-limited of Child Care Assistance under this subsection, the Department shall stop assistance for the child unless the parents or caretakers of the child qualify for an extension under Section (F).
2. When all of the children in a family have exhausted the time limits of Child Care Assistance, the Department shall terminate assistance for the family unless the parents or caretakers:
 - a. Qualify for an extension under subsection (F); or,
 - b. Are no longer subject to the time limit as described in subsection (B).

F. Extension of the Time Limit for Child Care Assistance.

1. The Department shall grant a 6-month extension to the time limit if the parents or caretakers show efforts toward self-sufficiency during the most recent 6-month period. The Department may elect to grant extensions on a 12-month basis. In order to qualify for an extension, the parents or caretakers in the family shall:
 - a. Currently be engaged in an activity that promotes self-sufficiency, which means the parents or caretakers continue to:
 - i. Be employed a monthly average of 20 or more hours per week;
 - ii. Be employed less than 20 hours per week and earning at least minimum wage;
 - iii. Be employed a monthly average of at least 20 hours per week while attending school or training;
 - iv. Remain self-employed with a net profit equating to a monthly average of 20 hours per week times minimum wage;
 - v. Attend high school, G.E.D. classes, or remedial education for the attainment of a high school diploma for a teen parent under 20 years of age;
 - vi. Follow the treatment plan prescribed by a physician, psychiatrist, psychologist for the treatment of a specified mental, physical, or emotional condition, which precludes the parent or caretaker for caring for his or her own child for a portion of a 24-hour day;
 - vii. Participate in a drug/alcohol rehabilitation plan or court-ordered community service plan; or
 - viii. Participate in a homeless or domestic violence case plan while residing in a shelter; and,
 - b. Sign and date the "Self-Sufficiency Statement" and declare that the parents or caretakers have taken at least one of the following actions during the most recent six or 12-month period to promote self-sufficiency:
 - i. Received a job promotion, or an increase in wages, hours, or benefits;
 - ii. Remained consistently employed;
 - iii. Remained self-employed and consistently demonstrated a net profit;
 - iv. Applied for a better job;
 - v. Left one job for a better job (higher pay, more hours, better schedule, or better benefits);

- vi. Registered with DES Employment Services (e.g., One Stop Career Center or DES Job Service) or another public or private employment agency, or job searched independently;
 - vii. Not requested Cash Assistance;
 - viii. Engaged in activities to pursue or maintain child support payments from an absent parent through DES Child Support Enforcement, the county attorney's office, or a private attorney;
 - ix. Attended work-related school or training, or pursued a degree or certificate that will lead to enhanced career opportunities;
 - x. Attended high school, remedial education for the attainment of a high school diploma or G.E.D. classes;
 - xi. Attended English for Speakers of Other Languages (E.S.O.L.) classes;
 - xii. Attended a trade or vocational school, college or university and made satisfactory progress in the activity;
 - xiii. Continued with a course of treatment under the direction of a physician, psychiatrist, or psychologist;
 - xiv. Followed a shelter case plan while residing in a domestic violence/homeless shelter;
 - xv. Participated in or completed a drug/alcohol rehabilitation or court-ordered community service program;
 - xvi. Participated in other employment-related activities or career-related training activities; or
 - xvii. Any other similar action acceptable to the Department that demonstrates that the parents or caretakers are moving toward self sufficiency.
2. If the parents or caretakers do not meet the conditions specified at subsections (1)(a) and (b), the family does not qualify for an extension of the time limit.
 3. If the parents or caretakers meet the conditions specified at subsections (1)(a) and (b), and all other eligibility criteria are met, the family shall qualify for additional six or 12-calendar month extension periods if the parents or caretakers continue to meet the criteria at the end of each extension period.

G. Extension of the Time Limit after Case Closure. When a parent or caretaker applies for Child Care Assistance after the time limit for the child in care has been exhausted, the parent or caretaker of the child may qualify for an extension as follows:

1. The parent or caretaker shall be an eligible applicant under R6-5-4911(B), and shall meet the criteria for Child Care Assistance eligibility;
2. All parents or caretakers shall meet the self-sufficiency criteria prescribed at R6-5-4919(F); and
3. The parent or caretaker may qualify for successive extensions of the time limit under subsection (F).

Historical Note

Adopted effective July 31, 1997, under an exemption from the provisions of A.R.S. Title 41, Chapter 6 (Supp. 97-3). Former R6-5-4919 renumbered to R6-5-4921; new R6-5-4919 made by exempt rulemaking at 13 A.A.R. 92, effective December 31, 2006 (Supp. 06-4).

Editor's Note: *The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1997, Ch. 300, § 74(A). Exemption from A.R.S. Title 41, Chapter 6 means the Department did not submit notice of*

proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review and approval; and the Department was not required to hold public hearings on this Section.

R6-5-4920. Denial or Termination of Child Care Assistance

The Department shall deny or terminate Child Care Assistance and provide written notification as prescribed in R6-5-4921 when the client:

1. Is not an eligible applicant as prescribed in R6-5-4911(B);
2. Is not a U.S. citizen or legal resident of the U.S.;
3. Is not a resident of the state of Arizona;
4. Has no children under the age of 13;
5. Has income that exceeds the maximum allowable as prescribed in R6-5-4914(C);
6. Does not have an eligible need, and is not engaged in an eligible activity as prescribed in R6-5-4912;
7. Is available to care for the children for whom assistance is requested (or there is another parent or responsible person in the household who is not engaged in an eligible activity and is available to provide care);
8. Has not provided the information or documentation required for a determination or redetermination of eligibility;
9. Has failed to cooperate in the arrangement of child care services;
10. Has not selected a child care provider who is registered with the Department;
11. Has requested that the application be withdrawn or that assistance be terminated;
12. Is a member of a family that already has an active case or pending application on file for Child Care Assistance;
13. Cannot be located by phone or mail and mail addressed to last known address has been returned;
14. Is deceased, incarcerated, or confined to an institution; or
15. Does not satisfy one or more eligibility criteria listed in R6-5-4904 through R6-5-4916;
16. Has exhausted the 60-month lifetime limit for all children in the eligible family under R6-5-4919(D) and does not qualify for an extension.

Historical Note

Adopted effective July 31, 1997, under an exemption from the provisions of A.R.S. Title 41, Chapter 6 (Supp. 97-3). Former R6-5-4920 renumbered to R6-5-4923; new R6-5-4920 renumbered from R6-5-4918 and amended by exempt rulemaking at 13 A.A.R. 92, effective December 31, 2006 (Supp. 06-4).

Editor's Note: *The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1997, Ch. 300, § 74(A). Exemption from A.R.S. Title 41, Chapter 6 means the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review and approval; and the Department was not required to hold public hearings on this Section.*

R6-5-4921. Notification Requirements

- A. The Department shall mail or deliver written notice to the client as follows:
 1. On a decision about an application, within 30 calendar days of the date that the Department receives the completed application.

2. On a positive action, the Department shall mail adequate notice on or before the date the action will become effective.
 3. On a change in the amount of authorized units based on a change in need, the Department shall mail adequate notice on or before the date the action will become effective.
 4. On a negative action, the Department shall mail the notice at least 10 calendar days in advance of the date the action will become effective.
 5. On changes in law or policy which affect entire classes or groups and concern issues not related to individual questions of fact, the Department shall issue notice of such action at least 10 calendar days in advance of the effective date of the action.
- B.** The Department shall not provide notice on a negative action when:
1. Child Care Assistance authorized for a specified period of time is terminated and the individual was informed in writing of the termination date when the Child Care Assistance was initiated;
 2. The applicant, client, or child is deceased; and
 3. There is a loss of contact with the client and mail addressed to the last known address has been returned.
- C.** Written notice shall include a statement of the action to be taken, the reasons for the intended action, citation to the specific rule supporting the action, and an explanation of the client's rights regarding a request for a fair hearing.

Historical Note

Adopted effective July 31, 1997, under an exemption from the provisions of A.R.S. Title 41, Chapter 6 (Supp. 97-3). Former R6-5-4921 renumbered to R6-5-4924; new R6-5-4921 renumbered from R6-5-4919 by exempt rulemaking at 13 A.A.R. 92, effective December 31, 2006 (Supp. 06-4).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1997, Ch. 300, § 74(A). Exemption from A.R.S. Title 41, Chapter 6 means the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review and approval; and the Department was not required to hold public hearings on this Section.

R6-5-4922. Repealed

Historical Note

Adopted effective July 31, 1997, under an exemption from the provisions of A.R.S. Title 41, Chapter 6 (Supp. 97-3). Section repealed by exempt rulemaking at 13 A.A.R. 92, effective December 31, 2006 (Supp. 06-4).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to A.R.S. § 41-1005(A)(27). Exemption from A.R.S. Title 41, Chapter 6 means the Department did not submit these rules to the Governor's Regulatory Review Council for review and approval; and the Department was not required to hold public hearings on this Section.

R6-5-4923. Overpayments

A. Overpayments; Date of Discovery.

1. The Department shall pursue collection of all client- and provider-caused overpayments.
2. The Department discovers an overpayment on the date the Department determines that an overpayment exists.

3. The Department shall write an overpayment report within 90 days of the discovery date.
 4. If the CCA office suspects that an overpayment was caused by fraudulent activity, it shall refer the overpayment report to the Department's Office of Special Investigations for potential prosecution.
 5. The Department shall not attempt to recover an overpayment from a person who is not a current recipient when the overpayment was not the result of fraud, and the Department has exhausted reasonable efforts to collect the overpayment and has determined that it is no longer cost effective to pursue the claim.
- B.** Overpayments: Persons Liable. The Department shall pursue collection of an overpayment from:
1. The client if the overpayment was caused by the client;
 2. Any individual member of the family who was included in family size as prescribed in R6-5-4914 (D) during the overpayment period if the overpayment was caused by the client; or
 3. The child care provider if the overpayment was caused by the provider.

Historical Note

Adopted effective July 1, 1998, under an exemption from the provisions of A.R.S. Title 41, Chapter 6; filed in the Secretary of State's Office June 30, 1998 (Supp. 98-2). Former R6-5-4923 renumbered to R6-5-4925; new R6-5-4923 renumbered from R6-5-4920 by exempt rulemaking at 13 A.A.R. 92, effective December 31, 2006 (Supp. 06-4).

R6-5-4924. Appeals

A. Entitlement to a Hearing.

1. An applicant for or recipient of Child Care Assistance is entitled to a hearing to contest the following Department actions:
 - a. Denial of the right to apply for assistance;
 - b. Complete or partial denial of an application for assistance;
 - c. Failure to make an eligibility determination on an application within 30 days of the application file date;
 - d. Suspension, termination, reduction, or withholding of assistance except as provided in subsection (B);
 - e. Increase in the fee level and DES-required copayment amount; or
 - f. The existence or amount of an overpayment attributed to the family or the terms of a plan to repay the overpayment.
2. Applicants and recipients are not entitled to a hearing to challenge benefit adjustments made automatically as a result of changes in federal or state law, unless the Department has incorrectly applied such law to the individual seeking the hearing.

B. Request for Hearing; Time Limits.

1. A person who wishes to appeal a negative action shall file a written request for a fair hearing with a local CCA office, within 10 days of the negative action notice date.
2. A request for a hearing is deemed filed;
 - a. On the date it is mailed, if transmitted via the United States Postal Service or its successor. The mailing date is as follows:
 - i. As shown by the postmark;
 - ii. As shown by the postage meter mark of the envelope in which it is received, if there is no postmark; or

- iii. The date entered on the document as the date of its completion, if there is no postmark or no postage meter mark, or if the mark is illegible.
 - b. On the date actually received by the Department, if not sent through the mail as provided in subsection (B)(2)(a).
 - 3. The submission of any document is considered timely if the appellant proves that delay in submission was due to Department error or misinformation, or to delay caused by the U.S. Postal Service or its successor.
 - 4. Any document mailed by the Department is considered as having been given to the addressee on date it is mailed to the addressee's last known address. The date mailed shall be presumed to be the date shown on the document, unless otherwise indicated by the facts.
 - 5. The Office of Appeals shall deny any request that is not timely filed. A party may appeal a decision on the timeliness of an appeal.
- C. Hearing Requests; Preparation and Processing.**
- 1. Within two work days of receiving a request for appeal, the local CCA office shall notify the Office of Appeals of the hearing request.
 - 2. Within 10 days of receiving a request for appeal, the local CCA office shall prepare and forward to the Office of Appeals a prehearing summary which shall include:
 - a. The appellant's name (and case name, if different);
 - b. The appellant's SSN (or case number, if different);
 - c. The local office responsible for the appellant's case;
 - d. A brief summary of the facts surrounding, and the grounds supporting, the negative action;
 - e. Citations to the specific provisions of this Article or the Department's CCA manual which support the Department's action; and
 - f. The decision notice and any other documents relating to the appeal.
 - 3. The local office shall mail the appellant a copy of the summary. Upon receipt of a hearing request, the Office of Appeals shall schedule the hearings.
- D. Continuation of Assistance Pending Appeal; Exceptions.**
- 1. If an appellant files a request for appeal within 10 calendar days of the negative action notice date, the Department shall continue assistance at the current level unless:
 - a. The appellant waives continuation of current assistance,
 - b. The appeal results from a change in federal or state law which mandates an automatic adjustment for all classes of recipients and does not involve a misapplication of the law, or
 - c. The appellant is requesting continuation of TCC benefits for longer than the 24-month eligibility period.
 - 2. The negative action shall be stayed until receipt of an official written decision in favor of the Department, except in the following circumstances:
 - a. At the hearing and on the record, the hearing officer finds that the sole issue involves application of law, and the Department properly applied the law and computed the assistance due the appellant;
 - b. A change in eligibility or assistance amount occurs for reasons other than those being appealed, and the eligible family receives and fails to timely appeal a notice of negative action concerning such change;
 - c. Federal or state law mandates an automatic adjustment for classes of recipients;
 - d. The appellant withdraws the request for hearing; or
 - e. The appellant fails to appear for a scheduled hearing without prior notice to the Office of Appeals, and the hearing officer does not rule in favor of the appellant based upon the record.
 - 3. Upon receipt of a decision in favor of the Department, the Department shall write an overpayment for the amount of any assistance the family received in excess of the correct amount, while the stay was in effect.

Historical Note

Section R6-5-4924 renumbered from R6-5-4921 by exempt rulemaking at 13 A.A.R. 92, effective December 31, 2006 (Supp. 06-4).

R6-5-4925. Maximum Reimbursement Rates For Child Care
The Department shall pay the maximum reimbursement rates for child care as set forth in Appendix B.

Historical Note

Section R6-5-4925 renumbered from R6-5-4923 by exempt rulemaking at 13 A.A.R. 92, effective December 31, 2006 (Supp. 06-4).

Appendix A. Child Care Assistance Gross Monthly Income Eligibility Chart and Fee Schedule

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
CHILD CARE ASSISTANCE GROSS MONTHLY INCOME ELIGIBILITY CHART AND FEE SCHEDULE
 EFFECTIVE JULY 1, 2012

Family Size ↓	FEE LEVEL 1 (L1) INCOME MAXIMUM EQUAL TO OR LESS THAN 85% FPL*	FEE LEVEL 2 (L2) INCOME MAXIMUM EQUAL TO OR LESS THAN 100% FPL*	FEE LEVEL 3 (L3) INCOME MAXIMUM EQUAL TO OR LESS THAN 135% FPL*	FEE LEVEL 4 (L4) INCOME MAXIMUM EQUAL TO OR LESS THAN 145% FPL*	FEE LEVEL 5 (L5) INCOME MAXIMUM EQUAL TO OR LESS THAN 155% FPL*	FEE LEVEL 6 (L6) INCOME MAXIMUM EQUAL TO OR LESS THAN 165% FPL*
1	0 – 792	793 – 931	932 – 1,257	1,258 – 1,350	1,351 – 1,444	1,445 – 1,537
2	0 – 1,072	1,073 – 1,261	1,262 – 1,703	1,704 – 1,829	1,830 – 1,955	1,956 – 2,081
3	0 – 1,353	1,354 – 1,591	1,592 – 2,148	2,149 – 2,307	2,308 – 2,467	2,468 – 2,626
4	0 – 1,633	1,634 – 1,921	1,922 – 2,594	2,595 – 2,786	2,787 – 2,978	2,979 – 3,170
5	0 – 1,914	1,915 – 2,251	2,252 – 3,039	3,040 – 3,264	3,265 – 3,490	3,491 – 3,715
6	0 – 2,194	2,195 – 2,581	2,582 – 3,485	3,486 – 3,743	3,744 – 4,001	4,002 – 4,259
7	0 – 2,475	2,476 – 2,911	2,912 – 3,930	3,931 – 4,221	4,222 – 4,513	4,514 – 4,804
8	0 – 2,755	2,756 – 3,241	3,242 – 4,376	4,377 – 4,700	4,701 – 5,024	5,025 – 5,348
9	0 – 3,036	3,037 – 3,571	3,572 – 4,821	4,822 – 5,178	5,179 – 5,536	5,537 – 5,893
10	0 – 3,316	3,317 – 3,901	3,902 – 5,267	5,268 – 5,657	5,658 – 6,047	6,048 – 6,437
11	0 – 3,597	3,598 – 4,231	4,232 – 5,712	5,713 – 6,135	6,136 – 6,559	6,560 – 6,909**
12	0 – 3,877	3,878 – 4,561	4,562 – 6,158	6,159 – 6,614	6,615 – 7,050**	

MINIMUM REQUIRED CO-PAYMENTS

Per child in care	full day = \$1.00 part day = \$.50	full day = \$2.00 part day = \$1.00	full day = \$3.00 part day = \$1.50	full day = \$5.00 part day = \$2.50	full day = \$7.00 part day = \$3.50	full day = \$10.00 part day = \$5.00
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For families receiving Transitional Child Care (TCC) there is no co-pay assigned beyond the third child in the family.

Full day = Six or more hours; Part day = Less than six hours.

Families receiving Child Care Assistance based on Child Protective Services/Foster Care, the Jobs Program or those who are receiving Cash Assistance (CA) and are employed, may not have an assigned fee level and may not have a minimum required co-payment. However, all families may be responsible for charges above the minimum required co-payments if a provider's rates exceed allowable state reimbursement maximums and/or the provider has other additional charges.

*Federal Poverty Level (FPL) = US DHHS 2012 poverty guidelines. The Arizona state statutory limit for child care assistance is 165% of the Federal Poverty Level.

**The Federal Child Care & Development Funds statutory limit (for eligibility for child care assistance) is 85% of the state median income.

Historical Note

Appendix A adopted effective July 31, 1997, under an exemption from the provisions of A.R.S. Title 41, Chapter 6 (Supp. 97-3). Appendix A repealed; new Appendix A adopted effective July 1, 1998, under an exemption from the provisions of A.R.S. Title 41, Chapter 6; filed with the Office of the Secretary of State June 30, 1998 (Supp. 98-2). Appendix A repealed; new Appendix A adopted by exempt rulemaking at 5 A.A.R. 2379, effective July 1, 1999 (Supp. 99-3). Amended by exempt rulemaking at 6 A.A.R. 2726, effective July 1, 2000 (Supp. 00-2). Amended by exempt rulemaking at 7 A.A.R. 3111, effective July 1, 2001 (Supp. 01-2). Amended by exempt rulemaking at 8 A.A.R. 2952, effective July 1, 2002 (Supp. 02-2). Amended by exempt rulemaking at 9 A.A.R. 3207, effective July 1, 2003 (Supp. 03-3). Amended by exempt rulemaking at 10 A.A.R. 2938, effective July 1, 2004 (Supp. 04-3). Appendix A repealed; new Appendix A made by exempt rulemaking at 11 A.A.R. 2731, effective July 1, 2005 (Supp. 05-2). Appendix A repealed; new Appendix A made by exempt rulemaking at 11 A.A.R. 4137, effective October 1, 2005 (Supp. 05-3). Appendix A repealed; new Appendix A made by exempt rulemaking at 12 A.A.R. 2700, effective July 1, 2006 (Supp. 06-3). Appendix A amended by exempt rulemaking at 13 A.A.R. 2583, effective July 1, 2007 (Supp. 07-2). Appendix A amended by exempt rulemaking at 14 A.A.R. 2859, effective July 1, 2008 (Supp. 08-2). Appendix A amended by exempt rulemaking at 15 A.A.R. 702, effective April 1, 2009 (Supp. 09-1). Appendix A repealed; new Appendix A made by exempt rulemaking at 15 A.A.R. 1222, effective July 1, 2009 (Supp. 09-2). Appendix A repealed; new Appendix A made by exempt rulemaking at 17 A.A.R. 1334, effective July 1, 2011 (Supp. 11-2). Appendix A repealed; new Appendix A made by exempt rulemaking at 18 A.A.R. 2070, effective July 1, 2012 (Supp. 12-3).

Editor's Note: The following Appendix was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to A.R.S. § 41-1005(A)(27). Exemption from A.R.S. Title 41, Chapter 6 means the Department did not submit this Appendix to the Governor's Regulatory Review Council for review and approval; and the Department was not required to hold public hearings on this Appendix.

Appendix B. Maximum Reimbursement Rates for Child Care

ARIZONA DEPARTMENT OF ECONOMIC SECURITY DIVISION OF EMPLOYMENT AND REHABILITATION SERVICES CHILD CARE ADMINISTRATION

MAXIMUM REIMBURSEMENT RATES FOR CHILD CARE (effective for services provided on or after 7/1/2007)

CENTERS

Age Group	District I	District II	District III	District IV	District V	District VI
Birth < 1 yr:						
Full day	31.71	28.35	23.52	22.05	31.50	33.60
Part day	23.52	20.79	19.32	19.95	26.25	26.25
1 yr < 3 yrs:						
Full day	27.93	26.25	21.84	19.95	29.40	21.84
Part day	21.00	19.07	18.90	18.90	15.75	18.48
3 yrs < 6 yrs:						
Full day	24.99	23.19	21.00	18.90	21.00	19.95
Part day	17.85	16.80	15.75	16.80	13.02	13.65
6 yrs < 13 yrs:						
Full day	24.57	23.10	17.85	17.85	20.10	19.95
Part day	16.80	15.75	14.70	15.75	14.00	13.65

GROUP HOMES

Age Group	District I	District II	District III	District IV	District V	District VI
Birth < 1 yr:						
Full day	25.20	23.10	24.15	21.00	19.95	22.26
Part day	16.80	16.80	24.15	14.70	13.13	18.90
1 yr < 3 yrs:						
Full day	23.10	23.10	23.10	18.90	19.95	22.31
Part day	15.75	16.80	15.75	12.60	12.60	17.85
3 yrs < 6 yrs:						
Full day	21.00	21.00	23.10	18.90	19.95	19.43
Part day	15.75	16.80	14.65	12.60	12.60	16.80
6 yrs < 13 yrs:						
Full day	18.90	21.00	17.85	18.90	19.95	19.42
Part day	14.70	16.60	14.65	12.60	12.60	17.85

CERTIFIED FAMILY HOMES AND CERTIFIED IN-HOME PROVIDERS

Age Group	District I	District II	District III	District IV	District V	District VI
Birth < 1 yr:						
Full day	21.00	19.95	18.90	18.90	21.00	18.90
Part day	14.70	12.60	10.50	11.03	12.60	10.50
1 yr < 3 yrs:						
Full day	21.00	18.90	17.85	17.85	20.10	17.85
Part day	13.65	12.60	10.50	11.03	11.55	10.50
3 yrs < 6 yrs:						
Full day	18.90	18.90	16.80	17.85	18.90	16.80
Part day	12.60	12.60	10.50	11.03	10.50	10.50
6 yrs < 13 yrs:						
Full day	17.85	18.90	16.80	16.80	18.90	16.80
Part day	12.60	11.55	10.50	10.50	10.50	10.50

The actual reimbursement amount is equal to the reimbursement rate minus any DES designated co-payment. However, in no event shall the amount reimbursed exceed the lesser of the provider's actual charges or the maximum reimbursement rate minus any DES designated co-payment.

Payment Rates for Non-Certified Relative Providers (NCRPs) will be \$11.03 for Full day and \$6.30 for Part day, minus any DES designated co-payment. This rate will be paid to NCRPs statewide for care provided to children of all ages.

The maximum reimbursement rates may be increased by up to ten percent for child care providers who are nationally accredited.

Full day = six or more hours per day. Part day = less than six hours per day.

Historical Note

Appendix B adopted effective July 1, 1998, under an exemption from the provisions of A.R.S. Title 41, Chapter 6; filed with the Office of the Secretary of State June 30, 1998 (Supp. 98-2). Appendix B repealed; new Appendix B adopted by exempt rulemaking at 5 A.A.R. 2379, effective July 1, 1999 (Supp. 99-3). "Non-Certified Relative Providers" section amended by exempt rulemaking at 6 A.A.R. 2726, effective July 1, 2000 (Supp. 00-2). "Centers," "Group Homes," and "Certified Family Homes and Certified In-home Providers" sections amended by exempt rulemaking at 7 A.A.R. 4884, effective October 1, 2001 (Supp. 01-4). Amended by exempt rulemaking at 9 A.A.R. 3207, effective July 1, 2003 (Supp. 03-3). Appendix B amended by exempt rulemaking at 13 A.A.R. 2443, effective July 1, 2006 (Supp. 07-1). Appendix B amended by exempt rulemaking at 13 A.A.R. 2586, effective July 1, 2007 (Supp. 07-2).

ARTICLE 50. CHILD CARE RESOURCE AND REFERRAL SYSTEM

R6-5-5001. Definitions

The following definitions apply in this Article.

1. "ADE" means the Arizona Department of Education, which administers the CACFP at the state level.
2. "Alternate approval" means a status the ADE confers on an uncertified, unlicensed provider that demonstrates compliance with CACFP child care standards to the ADE.
3. "Caregiver state licensing ratio requirements" means Arizona Department of Health Services (DHS) regulations that mandate DHS oversight of child care facilities with five or more children in care for compensation where child care is provided for periods of less than 24 hours per day.
4. "Child care" means a compensated service that is provided to a child unaccompanied by a parent or guardian during a portion of a 24-hour day. The service includes supervised and planned care, training, recreation, and socialization.
5. "CACFP" means the Child and Adult Care Food Program, funded and administered at the federal level by the Food and Consumer Services, a program of the U.S. Department of Agriculture.
6. "CCR&R" means child care resource and referral, a service the Department administers under A.R.S. § 41-1967.
7. "Center" means the same as "child care facility" in A.R.S. § 36-881(3).
8. "Certified" or "licensed" means a provider holds a license as prescribed in A.R.S. § 36-882, or is certified under A.R.S. § 46-807 or A.R.S. § 36-897.
9. "Child with special needs" means a child who needs increased supervision, modified equipment, modified activities, or a modified facility, within a child care setting, due to any physical, mental, sensory, or emotional delay, or medical condition, and includes a child with a disability.
10. "Compensation" means something given or received in return for child care, such as money, goods, or services.
11. "Contractor" means an agency with which the Department contracts for provision of CCR&R services.
12. "Customer" means a person who is requesting information from a CCR&R contractor.
13. "Database" means a computerized collection of CCR&R facts, figures, and information for licensed, certified, and registered providers and customers arranged for ease and speed of retrieval.
14. "Department" or DES means the Arizona Department of Economic Security.
15. "Dropped for cause" means an ADE Sponsoring Organization has terminated a family child care provider from participation in the CACFP.
16. "Exclude" means to refuse to include a particular provider in or to remove a provider from the CCR&R database.
17. "Family child care" means child care provided by a certified or registered provider in the provider's own home.
18. "In-home child care" means child care provided in a child's own home.
19. "Information only listing" means a provider listed on the CCR&R who will receive training information and other information about child care issues and activities, but who will not receive any referrals.
20. "Listing status" means the condition under which a provider may receive a referral (referral listing) or is restricted from receiving a referral (information only listing).
21. "Over-Ratio Referral Form" means a communication tool used to relay to the Department of Health Services (DHS) information concerning a potential violation of caregiver state licensing ratio requirements.
22. "Personally identifiable information" means any information about a person other than a provider, that, when considered alone, or in combination with other information, identifies or permits another person to readily identify the person who is the subject of the information. Personally identifiable information includes:
 - a. Name, address, and telephone number;
 - b. Date of birth or age;
 - c. Physical description;
 - d. School;
 - e. Place of employment; and
 - f. Any unique identifying number, such as driver's license number, a social security number, or regulatory license number.
23. "Program Administrator" means the person who oversees the Child Care Administration, a unit of the Department.
24. "Provider" means an adult who, or a facility that, provides child care services.
25. "Provider type" means a category of provider or program such as a center, family child care, and in-home child care.
26. "Referral" means the information listed in R6-5-5005(C), (D), and (E), that a Contractor gives to a customer.

27. "Referral listing" means that a contractor may refer a provider listed on the CCR&R registry or database to customers, and the provider may receive training and other information about child care issues and activities.
28. "Registered provider" means a family child care provider who is an adult and is not licensed or certified by any government agency, but who meets the requirements to be listed in the CCR&R registry.
29. "Registry" means the list of providers that:
 - a. Are not licensed or certified by a government agency,
 - b. Voluntarily list with CCR&R, and
 - c. Meet the requirements under A.R.S. § 41-1967 to receive referrals and training information.
30. "Regulated" means a provider who is required to meet licensing or certification standards set by a government agency, including a federal, state, or tribal government agency.
31. "Revocation" means the permanent removal of a child care provider's license or certificate by a government agency.
32. "SDA" means service delivery area, which is a specific geographic area where CCR&R services are offered.
33. "Sponsoring organization" means a public or non-profit private organization that administers the CACFP on behalf of ADE.
34. "Suspension" means that a regulatory agency has temporarily removed a provider's certificate or license.
35. "Work day" means Monday through Friday, excluding Arizona state holidays.

Historical Note

Adopted effective August 11, 1976 (Supp. 76-4). Section repealed effective November 8, 1982 (Supp. 82-6). New Section adopted effective November 19, 1996 (Supp. 96-4). Amended by exempt rulemaking at 8 A.A.R. 2956, effective July 1, 2002 (Supp. 02-2).

R6-5-5002. Provider Participation Requirements

- A. To be considered for inclusion in the CCR&R database, a provider shall submit the following information to the Contractor for the provider's SDA:
 1. Provider's name;
 2. Address;
 3. Phone number;
 4. Days and times the facility is open;
 5. Ages of children accepted;
 6. Capacity;
 7. Regulatory affiliation, if any;
 8. Meals provided to children in care;
 9. Training and experience;
 10. Accreditation;
 11. Fees;
 12. School transportation;
 13. DES Provider ID, if applicable;
 14. The provider's choice of listing status; and
 15. DHS Child Development Center (CDC) or Small Group Home (SGH) number.
- B. Regulated Providers: Before adding a regulated provider to the CCR&R database, the Contractor shall confirm the provider's regulatory affiliation with the appropriate regulatory agency. For the purpose of this subsection, confirmation of the regulatory affiliation is based solely on the accuracy of the information obtained from the regulatory agency.
- C. Registered Providers: The provisions in this subsection govern provider participation requirements for registered family child care providers.

1. In addition to the information listed in subsection (A), a registered family child care provider shall complete and submit to the Contractor, on Department-approved forms, a notarized sworn statement and a notarized certification statement attesting that the provider is not subject to exclusion or removal from the CCR&R database under any of the grounds specified in A.R.S. § 41-1967(E).
2. Before adding a registered family child care provider to the CCR&R registry and database, a Contractor shall review the provider's sworn statement and certification statement described in subsection (C)(1) and include on the registry only those providers who affirm that they are not subject to exclusion or removal under A.R.S. § 41-1967(E).
3. Before adding a registered family child care provider to the CCR&R registry and database, a Contractor shall receive clearance from the Department that neither a provider nor anyone providing care in the provider's home has had a child abuse or neglect investigation that has been substantiated by Child Protective Services (CPS) in this state.

Historical Note

Adopted effective August 11, 1976 (Supp. 76-4). Section repealed effective November 8, 1982 (Supp. 82-6). New Section adopted effective November 19, 1996 (Supp. 96-4). Amended by exempt rulemaking at 8 A.A.R. 2956, effective July 1, 2002 (Supp. 02-2).

R6-5-5003. Notification of Changes

- A. A provider listed on the CCR&R database shall notify the Contractor of any changes to the information or statement given under R6-5-5002(A) or (C)(1).
- B. A provider may modify self-initiated changes in listing status at any time by notifying the Contractor.

Historical Note

Adopted effective August 11, 1976 (Supp. 76-4). Section repealed effective November 8, 1982 (Supp. 82-6). New Section adopted effective November 19, 1996 (Supp. 96-4). Amended by exempt rulemaking at 8 A.A.R. 2956, effective July 1, 2002 (Supp. 02-2).

R6-5-5004. Referrals Not Guaranteed

- A. A Contractor shall make referrals to participating providers on a random basis based on a family's self-reported needs.
- B. A Contractor shall not:
 1. Guarantee the number or frequency of referrals to a participating provider; or
 2. Guarantee that listing on the CCR&R will result in economic benefit or gain to a participating provider.

Historical Note

Adopted effective August 11, 1976 (Supp. 76-4). Section repealed effective November 8, 1982 (Supp. 82-6). New Section adopted effective November 19, 1996 (Supp. 96-4). Amended by exempt rulemaking at 8 A.A.R. 2956, effective July 1, 2002 (Supp. 02-2).

R6-5-5005. Referral Process

- A. To obtain a referral, a customer shall give the contractor the following information, if available, about the customer's child care needs:
 1. Customer name;
 2. Address;
 3. Phone number;
 4. Days and times child care is needed;
 5. Preferred type of child care provider;
 6. Location where care is needed or preferred, and

7. Age of child.
- B.** A Contractor shall give a customer a referral that is consistent with the customer's stated preferences.
1. The Contractor shall not make a referral unless the Contractor can give the customer the names of at least three potential providers within the customer's search parameters.
 2. If the Contractor cannot name at least three potential providers meeting the customer's stated preferences, the Contractor shall ask the customer to expand the search parameters until the Contractor can name at least three potential providers.
- C.** The Contractor shall provide the customer with provider profile information on each referred provider, including the following:
1. Provider's name;
 2. Address or major cross streets;
 3. Phone number;
 4. Days and hours of operation;
 5. Ages of children accepted;
 6. Ratio and capacity;
 7. Regulatory affiliation, if any;
 8. Meal information;
 9. Training and experience;
 10. Accreditation;
 11. Fees and available subsidies;
 12. School transportation.
- D.** As part of a referral, a Contractor shall give each customer written information that includes the following:
1. That the Contractor selects providers based on the customer's stated preferences;
 2. That the Contractor provides referrals and does not recommend, endorse, or guarantee any particular child care provider;
 3. That the Contractor does not regulate, monitor, or verify information supplied by a provider;
 4. That a child's parent or guardian is solely responsible for choosing an appropriate child care provider to meet a family's needs; and
 5. That a provider's listing status may change after their initial placement on the registry or database and that customers are encouraged to call back periodically for updated information.
- E.** As part of a referral, a Contractor shall provide the customer with the following Department-approved educational information:
1. A list of criteria to consider when selecting quality child care;
 2. A description of the types of child care providers in Arizona;
 3. A description of CCR&R services and a list of office locations and phone numbers statewide; and
 4. An explanation of the process for filing a child care related complaint.
- Historical Note**
- Adopted effective August 11, 1976 (Supp. 76-4). Section repealed effective November 8, 1982 (Supp. 82-6). New Section adopted effective November 19, 1996 (Supp. 96-4). Amended by exempt rulemaking at 8 A.A.R. 2956, effective July 1, 2002 (Supp. 02-2).
- or investigate any complaint about a provider, except as otherwise prescribed by law for a family child care provider.
- B.** Regulated Providers: Upon receipt of a complaint about a regulated provider, a Contractor shall refer the complainant to the appropriate regulatory agency, law enforcement agency, or Child Protective Services.
- C.** Registered Providers: The provisions in this subsection govern complaints about a registered provider.
1. Any person may complain about a registered family child care provider on the registry by notifying a Contractor. Upon receipt of a complaint on a registered family child care provider, a Contractor shall:
 - a. Refer the complainant to the appropriate investigative agency (law enforcement or child protective services), if the issue raised in the complaint is suspected child abuse or neglect. The contractor shall forward a complaint involving law enforcement or child protective services to the DES Child Care Administration for resolution;
 - b. Refer the complainant to DHS and forward an over-ratio referral form to DHS if the complaint alleges that the provider is caring for more children than the law allows; or
 - c. Take a complaint made in reference to a CACFP home provider not regulated by any other agency and forward the complaint to ADE for resolution by its sponsoring agencies.
 - d. Take the complaint if it raises an issue other than those described in subsections (C)(1)(a), (b) or (c).
 2. If the Contractor takes the complaint as under subsection (C)(1)(c) or (d), the Contractor shall obtain and record, on a Department approved form, the following information, if available:
 - a. Provider name and address;
 - b. Summary of the complaint, including date and time of incident;
 - c. Name, address, and phone number of the person making the complaint, unless the complainant indicates that the complainant or someone else may come to substantial harm. The Contractor shall document a complainant's claim that substantial harm may result as a result of disclosure of the complainant's name, as prescribed in A.R.S. § 41-1010; and
 - d. If applicable, witness information, such as name, address, and phone number.
 3. The person recording the information shall sign and date the form.
 4. After redacting personally identifiable information, the Contractor shall send the complaint form to the provider for response within three work days.
 5. The provider shall respond to the complaint by completing the provider response portion of the complaint form within 30 days of the complaint mailing date;
 6. The Contractor shall allow the public to inspect the complaint, and the provider's response, if given, with all personally identifiable information redacted. After the 30-day provider response period has expired, the Contractor shall make a complaint available for public inspection at the Contractor's office or the Contractor may mail a copy of the complaint.

Historical Note

Adopted effective August 11, 1976 (Supp. 76-4). Section repealed effective November 8, 1982 (Supp. 82-6). New Section adopted effective November 19, 1996 (Supp. 96-

R6-5-5006. Monitoring; Complaint Recording and Reporting Requirements

- A.** Monitoring and Investigation: Neither the Department nor its Contractors monitor or investigate the activities of a provider,

- 4). Amended by exempt rulemaking at 8 A.A.R. 2956, effective July 1, 2002 (Supp. 02-2).

R6-5-5007. Provider Listing Status

A. Regulated Providers:

1. When the Department learns that a regulatory agency has suspended a regulated provider's license, certificate, or alternate approval, the Department shall direct a Contractor to change the provider's listing status from referral listing to information only listing, using the process in R6-5-5009.
2. If a Contractor has changed a provider to information only listing status under subsection (A)(1), the Department shall direct the Contractor to return the provider to referral listing status if the regulatory agency removes the provider's suspension status.
3. The Department shall notify the provider in writing when the Department returns the provider to referral status. The Department shall send the notice within 10 work days of the change in status, and shall include the effective date of the change.

B. Registered Providers:

1. When the Department receives a complaint or is notified that a registered provider may have failed or may be unable to meet the needs of a family due to one of the following circumstances, the Department shall direct a Contractor to change a registered provider's listing status from referral listing to information listing using the process in R6-5-5009:
 - a. A child has allegedly been abused, neglected, exploited, or abandoned while in the registered provider's care;
 - b. A registered provider has allegedly been involved in activities or circumstances that may threaten the health, safety, or emotional well-being of a child, including, acts of physical violence, domestic disputes, or incidents involving deadly weapons or dangerous or narcotic drugs; or
 - c. As determined by DHS, a registered provider has allegedly violated state law by providing care to more than four children at any one time for compensation.
2. If a Contractor has changed a registered provider to information only listing status, as prescribed in subsection (B)(1), the Department shall direct the Contractor to return the registered provider to referral listing status if one of the following occurs:
 - a. Child Protective Services or a law enforcement agency determines that the allegation cannot be substantiated;
 - b. Child Protective Services or a law enforcement agency determines that the threat to a child has been eliminated; or
 - c. DHS determines that the registered provider may continue child care activities without obtaining a certificate or license.
3. As used in subsection (B)(2), substantiation by a law enforcement agency means that law enforcement has referred a case to a prosecutorial agency with a recommendation to file charges.
4. The Department shall notify the registered provider in writing when the provider is returned to referral status. The Department shall send the notice within 10 work days of the change in status, and shall include the effective date of the change.

Historical Note

Adopted effective August 11, 1976 (Supp. 76-4). Section repealed effective November 8, 1982 (Supp. 82-6). New Section adopted effective November 19, 1996 (Supp. 96-4). Amended by exempt rulemaking at 8 A.A.R. 2956, effective July 1, 2002 (Supp. 02-2).

R6-5-5008. Provider Exclusion or Removal

- A.** The Department may direct a Contractor to exclude or remove a provider from the database according to the process in R6-5-5009, for the following reasons:
1. The provider fails or refuses to provide information as requested by the Department or a Contractor;
 2. A regulatory agency or sponsoring organization verifies that the provider's license, certificate, or alternate approval has been denied, revoked, terminated, or dropped for cause;
 3. The Department learns that information in the written, sworn, and notarized statements submitted by the provider under R6-5-5002(C) is false;
 4. The provider is subject to removal or exclusion for any reason listed in A.R.S. § 41-1967(E); or,
 5. The provider fails to comply with these rules.
- B.** A Contractor may summarily and without notice remove a provider from the CCR&R database for the following reasons:
1. The Contractor is unable to contact the provider because:
 - a. The provider's phone is disconnected;
 - b. The provider is no longer at the last known address and has given no forwarding address; or
 - c. The provider has died; or
 2. The provider requests removal.
- C.** A provider removed under subsection (B) may request reinstatement by calling the Contractor for the provider's SDA and providing current information.
- D.** Upon receipt of a request for reinstatement, the Contractor shall update the information listed in R6-5-5002 and, if applicable, confirm that the provider has submitted information requested by the Department or Contractor.
- E.** The Contractor shall reinstate the provider unless there are grounds for removal under subsections (A)(1) through (5).

Historical Note

Adopted effective November 19, 1996 (Supp. 96-4). Amended by exempt rulemaking at 8 A.A.R. 2956, effective July 1, 2002 (Supp. 02-2).

R6-5-5009. Administrative Review Process

- A.** When the Department receives information indicating that the Department may need to change a provider's listing status or remove or exclude a provider, the Department Program Administrator or designee shall review the information and decide whether grounds exist as listed in R6-5-5007 or R6-5-5008(A).
- B.** If the Department decides to change a provider's listing status or to remove or exclude a provider, the Department shall:
1. Notify the Contractor to change the listing status or to remove or exclude the provider; and
 2. Within 10 work days of the effective date of the change of listing status, removal or exclusion, send the provider written notice via certified mail of the action taken.
- C.** The notice shall include the following information:
1. The effective date of the change in listing status or the removal or exclusion;
 2. The reason for the change in listing status or the removal or exclusion;
 3. The statutory provision requiring the provider's change in listing status or the removal or exclusion;

4. An explanation of the provider's right to an administrative review; and,
 5. A statement explaining where the provider may file a written request for an administrative review and the time period for doing so.
- D.** The Department shall mail the notice to the provider's last known address. The mailing date is presumed to be the date appearing on the notice.
- E.** A provider may request an administrative review by filing a written request for review with the Department, within 15 work days after the mailing date of the Department's notice.
- F.** The provider shall mail the written request for administrative review to:
Department of Economic Security
Child Care Administration
Program Administrator
P.O. Box 6123 S.C. 801A
Phoenix, Arizona 85005
- G.** In the written request, the provider shall include the reason for requesting an administrative review and any documentation supporting the reinstatement request.
- H.** A request for an administrative review is timely if:
1. The Department receives it within the 15-day appeal period in subsection (E); or
 2. The envelope in which the request was mailed is post-marked or postage-meter marked within the period in subsection (E).
- I.** The Program Administrator or designee shall review the Department's decision and all documentation submitted by the provider.
- J.** The Program Administrator or designee shall notify the provider and the Contractor of the results of the administrative review within 15 work days from the date the Department receives the request for review.
1. The decision shall be in writing and mailed to the provider's last known address. The date on the decision is presumed to be the mailing date.
 2. The decision shall include information about the provider's right to further appeal.
- K.** The provider may appeal the Department's decision under R6-5-5010.

Historical Note

Adopted effective November 19, 1996 (Supp. 96-4).
Amended by exempt rulemaking at 8 A.A.R. 2956, effective July 1, 2002 (Supp. 02-2).

R6-5-5010. Administrative Appeal Process

- A.** A provider may appeal the Department's administrative review decision under 6 A.A.C. 5, Article 75 by filing a request for an appeal with the Department within 15 work days after the mailing date of the Department's administrative review decision described in R6-5-5009(J).
- B.** A provider shall mail the written request for an appeal to:
Department of Economic Security
Child Care Administration
Program Administrator
P.O. Box 6123 S.C. 801A
Phoenix, Arizona 85005
- C.** In the written request, the provider shall include the reason for requesting an appeal and any documentation supporting the request.
- D.** The Department's actions in reference to removal or exclusion from the database or changes in listing status are not appealable under this Article if the action is based on:
1. Failure to clear a fingerprint or criminal background check; or

2. Failure to clear a Child Protective Services background check

E. A request for an appeal is timely if:

1. The Department receives it within the 15-day appeal period in subsection (A); or
2. The envelope in which the request is mailed is post-marked or postage-meter marked within the 15-day period prescribed in subsection (A).

Historical Note

Adopted effective November 19, 1996 (Supp. 96-4).
Amended effective June 4, 1998 (Supp. 98-2). Amended by exempt rulemaking at 8 A.A.R. 2956, effective July 1, 2002 (Supp. 02-2).

ARTICLE 51. EXPIRED**R6-5-5101. Expired****Historical Note**

Adopted effective July 6, 1976 (Supp. 76-4). Former Section R6-5-5101 repealed, new Section R6-5-5101 adopted effective September 30, 1977 (Supp. 77-5). Former Section R6-5-5101 repealed, new Section R6-5-5101 adopted effective June 17, 1985 (Supp. 85-3). Section expired under A.R.S. § 41-1056(E) at 7 A.A.R. 5257, effective October 31, 2001 (Supp. 01-4).

R6-5-5102. Expired**Historical Note**

Adopted effective July 6, 1976 (Supp. 76-4). Former Section R6-5-5102 repealed, new Section R6-5-5102 adopted effective September 30, 1977 (Supp. 77-5). Amended effective March 17, 1981 (Supp. 81-2). Former Section R6-5-5102 repealed, new Section R6-5-5102 adopted effective June 17, 1985 (Supp. 85-3). Section expired under A.R.S. § 41-1056(E) at 7 A.A.R. 5257, effective October 31, 2001 (Supp. 01-4).

R6-5-5103. Expired**Historical Note**

Adopted effective July 6, 1976 (Supp. 76-4). Former Section R6-5-5103 repealed, new Section R6-5-5103 adopted effective September 30, 1977 (Supp. 77-5). Former Section R6-5-5103 repealed, new Section R6-5-5103 adopted effective June 17, 1985 (Supp. 85-3). Section expired under A.R.S. § 41-1056(E) at 7 A.A.R. 5257, effective October 31, 2001 (Supp. 01-4).

R6-5-5104. Expired**Historical Note**

Adopted effective July 6, 1976 (Supp. 76-4). Former Section R6-5-5104 repealed, new Section R6-5-5104 adopted effective September 30, 1977 (Supp. 77-5). Amended effective April 25, 1978 (Supp. 78-2). Amended effective March 26, 1979 (Supp. 79-2). Amended effective March 17, 1981 (Supp. 81-2). Former Section R6-5-5104 repealed, new Section R6-5-5104 adopted effective June 17, 1985 (Supp. 85-3). Section expired under A.R.S. § 41-1056(E) at 7 A.A.R. 5257, effective October 31, 2001 (Supp. 01-4).

R6-5-5105. Expired**Historical Note**

Adopted effective July 6, 1976 (Supp. 76-4). Former Section R6-5-5105 repealed, new Section R6-5-5105 adopted effective September 30, 1977 (Supp. 77-5). Amended effective April 25, 1978 (Supp. 78-2).

Amended paragraph (3) effective March 17, 1981 (Supp. 81-2). Former Section R6-5-5105 repealed, new Section R6-5-5105 adopted effective June 17, 1985 (Supp. 85-3). Section expired under A.R.S. § 41-1056(E) at 7 A.A.R. 5257, effective October 31, 2001 (Supp. 01-4).

R6-5-5106. Expired

Historical Note

Adopted effective July 6, 1976 (Supp. 76-4). Former Section R6-5-5106 repealed, new Section R6-5-5106 adopted effective September 30, 1977 (Supp. 77-5). Former Section R6-5-5106 repealed, new Section R6-5-5106 adopted effective June 17, 1985 (Supp. 85-3). Section expired under A.R.S. § 41-1056(E) at 7 A.A.R. 5257, effective October 31, 2001 (Supp. 01-4).

R6-5-5107. Expired

Historical Note

Adopted effective July 6, 1976 (Supp. 76-4). Former Section R6-5-5107 repealed, new Section R6-5-5107 adopted effective September 30, 1977 (Supp. 77-5). Amended effective March 17, 1981 (Supp. 81-2). Former Section R6-5-5107 repealed, new Section R6-5-5107 adopted effective June 17, 1985 (Supp. 85-3). Section expired under A.R.S. § 41-1056(E) at 7 A.A.R. 5257, effective October 31, 2001 (Supp. 01-4).

ARTICLE 52. CERTIFICATION AND SUPERVISION OF FAMILY CHILD CARE HOME PROVIDERS

R6-5-5201. Definitions

The following definitions apply in this Article:

1. "Abandonment" has the meaning ascribed to "abandoned" in A.R.S. § 8-201 (1).
2. "Abuse" has the meaning ascribed in A.R.S. § 8-201 (2).
3. "Age" means years of a person's lifetime when used in reference to a number, unless the term "months" is used.
4. "Adult" means a person age 18 or older.
5. "Applicant" means a person who submits a written application to the Department to become certified as a child care provider.
6. "Backup provider" means an adult who, or an entity that, provides child care when a provider is not available.
7. "CACFP" means the Child and Adult Care Food Program.
8. "Certificate" means a document the Department issues to a provider as evidence that the provider has met the child care standards of this Article.
9. "Child" means a person younger than age 18.
10. "Child care" means the compensated care, supervision, recreation, socialization, guidance, and protection of a child who is unaccompanied by a parent.
11. "Child care personnel" means all adults residing in a home facility, an in-home provider, and any backup provider.
12. "Child care registration agreement" means a written contract between a provider and the Department; that establishes the rights and duties of the provider and the Department for provision of child care.
13. "Child care specialist" means a Department child care eligibility and/or certification staff person.
14. "CHILDS" means the Children's Information Library and Data Source, which is a comprehensive, automated system to support child welfare policies and procedures, and includes information on investigations, ongoing case management, and payments.
15. "CHILDS Central Registry" means the Child Protective Services Central Registry, a confidential, computerized database within CHILDS, which the Department maintains according to A.R.S. § 8-804.
16. "Child with special needs" means a child who needs increased supervision, modified equipment, modified activities, or a modified facility, due to any physical, mental, sensory, or emotional delay, or medical condition, and includes a child who has a physical or mental impairment that substantially limits one or more major life activities; has a record of having a physical or mental impairment that substantially limits one or more of the child's major life activities; or who is regarded as having an impairment, regardless of whether the child has the impairment.
17. "Client" means a person who applies for and meets the eligibility criteria for a child care service program administered by the Department.
18. "Compensation" means something given or received, such as money, goods, or services, as payment for child care services.
19. "Corporal punishment" means any act that is administered as a form of discipline and that either is intended to cause bodily pain, or may result in physical damage or injury.
20. "CPS" means Child Protective Services, a Department administration that operates a program to investigate allegations of child maltreatment and provide protective services.
21. "Department" means the Arizona Department of Economic Security.
22. "Developmentally appropriate" means an action that takes into account:
 - a. A child's age and family background;
 - b. The predictable changes that occur in a child's physical, emotional, social, cultural, and cognitive development; and
 - c. The individual child's pattern and timing of growth, personality, and learning style.
23. "DHS" means the Arizona Department of Health Services.
24. "Direct supervision" means within sight and sound.
25. "Exploitation" means an act of taking advantage of, or making use of a child selfishly, unethically, or unjustly for one's own advantage or profit, in a manner contrary to the best interests of the child, such as having a child panhandle, steal, or perform other illegal activities.
26. "Evening care" means child care provided at any time between 6:30 p.m. and midnight.
27. "Heating device" means an instrument designed to produce heat for a room or inside area and includes a non-electric stove, fireplace, freestanding stove, or space heater.
28. "Home facility" means a provider's residence that the Department has certified as a location where child care services may be provided.
29. "Household member" means a person who does not provide child care services and who resides in the home facility of a provider for 21 consecutive days or longer or who resides periodically throughout the year for a total of at least 21 days.
30. "Infant" means:
 - a. A child who is younger than 12 months old; and
 - b. A child who is younger than 18 months old and not walking.

31. "In-home provider" means a provider who cares for a child in the child's home.
32. "Maltreatment" means abuse, neglect, exploitation, or abandonment of a child.
33. "Medication" means any prescribed or over-the-counter drug or medicine.
34. "Mechanical restraint" means a device to restrict a child's movement.
35. "Neglect" has the same meaning ascribed in A.R.S. § 8-201(21).
36. "Night-time care" means child care provided at any time between midnight and 6:00 a.m.
37. "Non-parent relative" means a caretaker relative who exercises responsibility for the day-to-day physical care, guidance, and support of a child who physically resides with the relative and who is by affinity, consanguinity, or court decree, a grandparent, great grandparent, sibling of the whole or half-blood, stepbrother, stepsister, aunt, uncle, great aunt, great uncle, or first cousin of the child.
38. "Parent" means the biological or adoptive parent of a child, a court-appointed guardian, or a non-parent relative.
39. "Provider" means an adult who is not the parent or guardian of a child needing care, and to whom the Department has issued a certificate, and includes a backup provider who performs the provider's duties when the provider is unavailable.
40. "Physical restraint" means the use of bodily force to restrict a child's freedom of movement.
41. "Safeguard" means to use reasonable efforts and developmentally appropriate measures to eliminate the risk of harm to a child in care and ensure that a child in care will not be harmed by a particular object, substance, or activity. Safeguarding may include:
 - a. Locking up a particular substance or item;
 - b. Putting a substance or item beyond the reach of a child who is not mobile;
 - c. Erecting a barrier that prevents a child from reaching a particular place, item, or substance;
 - d. Mandating the use of a protective safety device; or
 - e. Providing direct supervision.
42. "Sanitize" means treatment by a heating or chemical process that reduces the bacterial count, including pathogens, to a safe level.
43. "Time out" means removing a child from a situation by directing the child to remain in a specific chair or place identified as the time out place, for no more than one minute for each year of a child's age, but no more than 10 minutes.
44. "Undue hardship" means significant difficulty or substantial expense concerning the operation of a provider's program. In this subsection, "significant" and "substantial" are measured relative to the level of net income the provider earns from child care services.
45. "Unusual incident" means any accident, injury, behavior problem, or other extraordinary situation involving a provider or a child in care, including suspected child maltreatment.

Historical Note

Adopted effective July 6, 1976 (Supp. 76-4). Section repealed, new Section adopted effective May 11, 1994 (Supp. 94-2). Amended by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5202. Initial Application for Certification

- A. To become a certified child care provider, an applicant shall comply with all requirements of this Article and other applicable requirements of federal, state, or local law.
- B. An applicant shall be at least age 18.
- C. An applicant shall submit a complete, signed application form to the Department.
- D. An applicant shall designate one or more backup providers from the following list:
 1. An individual who is age 18 or older and who satisfies the requirements for backup providers outlined in this Article;
 2. A DHS-licensed child care center;
 3. A DHS-certified child care group home; or
 4. A DES-certified family child care home.
- E. An applicant shall participate in any orientation and training and shall cooperate in conducting any pre-certification interviews and inspections the Department may require.
- F. An applicant shall give the Department the names of three references who:
 1. Have known the applicant at least one year,
 2. Are unrelated by blood or marriage to the applicant, and
 3. Can furnish information regarding the applicant's character and ability to care for a child.
- G. An applicant and any designated individual backup provider shall furnish a self-statement of physical and mental health on a form provided by the Department.
- H. An applicant and each designated individual backup provider shall have the physical, mental, and emotional health necessary to perform the duties and meet the responsibilities established by this Article. If the Department has questions about the applicant's health that the applicant cannot satisfactorily answer or explain, the applicant, upon request by the Department, shall submit to a physical or psychological examination by a licensed physician, psychologist, or psychiatrist, and shall provide the Department with a professional opinion addressing the Department's questions. The applicant shall bear the cost of any professional examinations that the Department needs to determine whether the individual is qualified.
- I. The Department may require an applicant to furnish at least the following information about the applicant, the applicant's spouse, members of the applicant's household, children residing outside of the applicant's home, and the individual backup provider:
 1. Name;
 2. Current address;
 3. Telephone number;
 4. Date of birth;
 5. Social security number;
 6. Maiden name, aliases, and nicknames;
 7. Relationship to the applicant or backup provider;
 8. Marital status and marital history;
 9. Educational background;
 10. Ethnicity;
 11. Gender;
 12. Birthplace;
 13. Physical characteristics; and
 14. Citizenship status.
- J. Child care personnel shall submit the notarized criminal history certification form required by A.R.S. § 41-1964, and disclose whether they have committed any acts of child maltreatment or have been the subject of a Child Protective Service investigation.
- K. On a Department form, an applicant, all adult household members, and all individual backup providers shall provide employment histories for the five-year period immediately

preceding the application date, beginning with the individual's present or most recent job.

- L.** An applicant shall furnish proof that the applicant, the individual backup provider, and members of the applicant's household who are age 13 or younger are immune from measles, rubella, diphtheria, tetanus, pertusis, polio, and any other diseases for which routine immunizations are readily and safely available.
 - 1. The Department may waive the requirements of this subsection for a household member if the applicant will be certified as an in-home provider only and submits an affidavit attesting that household members will not be present when child care services are provided.
 - 2. The Department shall waive the requirements of this subsection if the applicant:
 - a. Submits an affidavit stating that household members are being raised in a religion whose teachings oppose immunization; and
 - b. Affirms, in writing, that families will be notified of the religious exemption before child care services are provided.
- M.** An applicant shall submit evidence of current freedom from pulmonary tuberculosis for the applicant, all household members, and all individual backup providers. If the application is approved, this evidence shall be submitted each succeeding calendar year.
 - 1. Evidence required under this subsection is limited to:
 - a. A report of a negative Mantoux skin test performed within three months of the date or anniversary date of initial certification.
 - b. A physician's written statement based on an examination performed within three months of the date or anniversary date of initial certification.
 - 2. The Department shall waive the requirements of this subsection for household members if the applicant will be certified as an in-home provider only and submits an affidavit that household members will not be present when child care services are provided.
- N.** An applicant shall provide a statement of services on a Department form. The statement shall describe:
 - 1. The home at which services will be provided, location, and hours of operation;
 - 2. The applicant's daily rates and fees;
 - 3. The ages of children the applicant will accept;
 - 4. The equipment, materials, daily activities, and play areas available to children in care;
 - 5. Any special child care skills, knowledge, or training the applicant has; and
 - 6. The behavior, guidance, and discipline methods the applicant uses.
- O.** During an interview with the child care specialist, an applicant shall complete a Department questionnaire describing:
 - 1. The applicant's child rearing philosophy;
 - 2. The home environment, including intra-family relationships and attitudes toward child care;
 - 3. The parenting and discipline methods employed by the applicant and the applicant's parents; and
 - 4. The applicant's child care training and experience.
- P.** Upon Department request, an applicant, all members of the applicant's household, and all individual backup providers shall comply with any additional requirements and requests for interviews, inspections, or information necessary to determine the applicant's fitness to serve as a certified child care provider.
- Q.** A complete application package consists of an applicant's completed application form and evidence that the applicant, all

members of the applicant's household, and all individual backup providers have met all requirements and submitted all information and documentation listed in this Section.

- R.** The Department shall send an applicant a notice of administrative completeness or deficiency, as described in A.R.S. § 41-1074, indicating the additional information, if any, that the applicant must provide for a complete application package. The Department shall send the notice after receiving the application and before expiration of the administrative review time-frame described in R6-5-5204. If the applicant does not supply the missing information listed in the notice, the Department may close the file.
- S.** An applicant whose file is closed may reapply for certification.
- T.** After an applicant submits a complete application for initial certification, the Department shall inspect the applicant's home to determine whether the home meets the regulations of this Article.

Historical Note

Adopted effective July 6, 1976 (Supp. 76-4). Section repealed, new Section adopted effective May 11, 1994 (Supp. 94-2). Amended by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5203. Initial Certification: The Home Facility

A provider's home facility shall meet the requirements of this Section.

- 1. A provider shall maintain the indoor and outdoor premises of the home facility in a safe and sanitary condition, free from hazards and vermin, and in good repair. A mobile home shall have skirting to ensure that a child in care cannot go beneath the mobile home.
- 2. Any area to be occupied by a child in care shall have heat, light, ventilation, and screening. The provider shall maintain the home facility between 68° and 85° F.
- 3. A provider shall vent and safeguard all heating devices to protect each child from burns and harmful fumes.
- 4. A provider shall safeguard all potentially dangerous objects from children, including:
 - a. Household and automotive tools;
 - b. Sharp objects, such as knives, glass objects, and pieces of metal;
 - c. Fireplace tools, butane lighters and igniters, and matches;
 - d. Machinery;
 - e. Electrical boxes;
 - f. Electrical outlets;
 - g. Electrical wires; and
 - h. Chemicals, cleaners, and toxic substances.
- 5. A provider shall store firearms and ammunition separately from one another, under lock and key or combination lock.
- 6. A home facility shall have adequate space and equipment to accommodate each child in care, and other household members who are in the home facility at the same time as children in care. In this subsection, "adequate" means sufficient space and equipment to:
 - a. Permit all persons in the dwelling to have safe freedom of movement;
 - b. Permit children in care to be seated together for meals and snacks; and
 - c. Permit all children in care to be engaged in developmentally appropriate activities at the same time and in a room where the provider can keep all children within sight.
- 7. A provider shall keep outside play areas clean and safe and shall fence the play area if there are conditions that

may pose a danger to any child playing outside. The fence shall be at least 4 feet high and free of hazards, including splinters and protruding nails or wires. The fence shall have only self-closing, self-latching, lockable gates.

8. A home facility shall have the following equipment:
 - a. A charged, readily accessible, operable, multi-purpose (ABC class) fire extinguisher that the applicant knows how to operate;
 - b. At least one UL-approved, working smoke detector, properly mounted on each level of the dwelling;
 - c. At least two usable outdoor exits;
 - d. A posted written plan or diagram for emergency evacuation;
 - e. A working telephone or other two-way communication device acceptable to the Department; and
 - f. An easily accessible life-saving device if the home facility has a pool or other body of water more than 12 inches deep. A “life-saving device” means a ring buoy with at least 25 feet of 1/2-inch rope attached or a shepherd’s crook.
9. If a home facility has a swimming pool or other body of water more than 12 inches deep, the pool or body of water shall be enclosed by a permanent fence that separates it from all other outdoor areas and from doors and windows into the home facility. The fence shall be at least 5 feet high and shall have only self-closing, self-latching, lockable gates. Open spaces between upright or parallel posts and poles on fences and gates shall be no more than 4 inches apart. When the pool or body of water is not in use, the provider shall lock the gates.
10. A provider shall enclose spas and hot tubs with fencing as described in subsection (9), or with a hard, locked cover that prevents access and can support at least 100 pounds.

Historical Note

Adopted effective July 6, 1976 (Supp. 76-4). Amended effective March 5, 1979 (Supp. 79-2). Section repealed, new Section adopted effective May 11, 1994 (Supp. 94-2). Amended by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5204. Initial Certification: Department Responsibilities

- A. Before issuing a certificate, the Department shall:
 1. Conduct at least one face-to-face interview with an applicant;
 2. Contact any other person necessary to determine an applicant’s fitness to be a certified provider;
 3. Ensure that an applicant and all individual backup providers have complied with and satisfy the requirements of R6-5-5202;
 4. Inspect the home where an applicant will provide child care, unless it is the child’s own home, and ensure that it meets the requirements of R6-5-5203;
 5. Conduct a CHILDS Central Registry check for:
 - a. An applicant;
 - b. The applicant’s household members;
 - c. The applicant’s emancipated children who live outside the applicant’s home, if any; and
 - d. Any individual backup provider.
 6. Find that an applicant has the intent and ability to provide child care that is safe, developmentally appropriate, and in compliance with the requirements of this Article.
- B. The Department shall objectively determine whether to certify an applicant based on the applicant’s entire application package, and the information the Department has acquired during the course of the application process.

Historical Note

Adopted effective July 6, 1976 (Supp. 76-4). Section repealed, new Section adopted effective May 11, 1994 (Supp. 94-2). Amended by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5205. Certification Time-frames

For the purpose of A.R.S. § 41-1073, the Department established the following certification time-frames:

1. Administrative completeness review time-frame: 60 days,
2. Substantive review time-frame: 30 days, and
3. Overall time-frame: 90 days.

Historical Note

Adopted effective July 6, 1976 (Supp. 76-4). Section repealed, new Section adopted effective May 11, 1994 (Supp. 94-2). Former Section R6-5-5205 renumbered to R6-5-5206 and new Section adopted by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5206. Certificates: Issuance; Non-transferability

- A. A certificate is valid for three years from the date of issuance. The Department may revoke a certificate before expiration as provided in this Article and by law.
- B. A certificate is not transferable and is valid only for the provider and location identified on the certificate.
- C. A provider shall post the certificate in a conspicuous location in the home facility.
- D. A certificate is the property of the state of Arizona. Upon revocation or voluntary closure, a provider shall surrender the certificate issued to the provider to the Department within seven days.
- E. The Department shall designate on the certificate issued to the provider the total number of children to be allowed in child care at any one time. The total shall not exceed the limits set in R6-5-5220.

Historical Note

Adopted effective July 6, 1976 (Supp. 76-4). Amended effective February 24, 1977 (Supp. 77-1). Section repealed, new Section adopted effective May 11, 1994 (Supp. 94-2). Former Section R6-5-5206 renumbered to R6-5-5207; new Section R6-5-5206 renumbered from R6-5-5205 and amended by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5207. Maintenance of Certification: General Requirements; Training

- A. Child care personnel and all individual backup providers shall be fingerprinted and pay all required fingerprint fees within the time prescribed in A.R.S. § 41-1964.
- B. A provider and all individual backup providers shall maintain the physical, mental, and emotional health necessary to fulfill all legal requirements for child care providers.
- C. No later than 60 days after the date of provider certification, a provider and individual backup providers shall furnish the Department with proof of acceptable first aid training and certification in infant/child cardiopulmonary resuscitation (“CPR”). As used in this Section, “acceptable training” means a course approved by the American Red Cross or the American Heart Association. The Department may extend the time for completing this requirement and children may remain in care during an extension, if:
 1. The class was not available within the 60-day time period; or
 2. The provider, individual backup provider, or a dependent was ill, and the provider or backup provider was unable to attend a scheduled class due to the illness.

- D. A provider and individual backup providers shall maintain current training and certification in first aid and infant/child CPR through acceptable training courses.
- E. A certified provider shall attend at least six hours of training each calendar year in any of the following subjects:
 1. The Department's child care program, policies, and procedures;
 2. Child health and safety, including recognition, control, and prevention of illness and disease;
 3. Child growth and development;
 4. Child abuse prevention, detection, and reporting;
 5. Positive guidance and discipline;
 6. Child nutrition;
 7. Communication with families; family involvement;
 8. Developmentally appropriate practices; and
 9. Other similar subjects designed to improve the provider's ability to provide child care.
- F. A provider shall maintain a record of all training, and annually furnish the Department with proof of attendance.
- G. A provider shall maintain a safe and clean home facility, including furnishings, equipment, supplies, materials, utensils, toys, and grounds, that meets the standards in this Article.
- H. At all times, a provider shall allow the Department access to all parts of the home facility. The Department shall make at least two onsite visits each year to each home facility and in-home provider. At least one visit shall be unannounced.
- I. A provider shall allow a parent or a designated representative access to the home facility at all times when the parent's child is present, and shall give parents and designated representatives written notice explaining this right.
- J. A provider shall directly supervise a visitor to the home facility while the visitor is in an area with a child in care.
- K. A provider shall not expose a child in care to tobacco products or smoke.
- L. A provider shall not care for a child while under the influence of alcoholic beverages, medication, or any other substance, that may or does impair the provider's ability to care for a child.
- M. A provider shall not consume alcoholic beverages while caring for a child.
- N. A provider shall not refuse to provide care to any child on the basis of color, sex, religion, disability, or national origin.
- O. If a provider is notified that a child or household member has a communicable disease, the provider shall ensure that a child who lacks written evidence of immunity to the communicable disease is not permitted to be present in the home facility until:
 1. A parent provides written evidence of the child's immunity to the disease; or
 2. A local health department notifies the provider that the child may return to the home facility
- B. A provider shall demonstrate the continued physical, mental, and emotional health necessary to perform the duties and fulfill the responsibilities in this Article.
- C. Before recertification, a provider and designated individual backup provider shall furnish a self statement of physical and mental health and freedom from communicable diseases on a form furnished by the Department.
- D. The Department shall renew a certificate only after a provider demonstrates the intent and ability to provide child care that is safe, developmentally appropriate, and in compliance with the requirements of this Article.
- E. Unless the Department, in its sole discretion, accepts a provider's written assurance of future compliance with the requirements of this subsection, the Department shall deny recertification or take other enforcement action when the provider does not accept Department-referred children on three separate occasions unless the refusal is for:
 1. Illness, accident, or incapacity of the provider;
 2. Illness, accident, or incapacity of any household member, if the existing condition will pose a risk to children in care, or limit the provider's ability to provide child care in accordance with the law;
 3. The provider is not equipped or trained to provide care to the referred child, and the provider cannot acquire the equipment or training without undue hardship;
 4. The provider has no available slots;
 5. The situations listed in R6-5-5222 and a backup provider is unavailable;
 6. A child has not been immunized, and the parent or guardian is unwilling to obtain appropriate immunization, in accordance with R6-5-5219(F); or
 7. The home facility is in temporary disrepair or under construction.
- F. The Department may obtain any supplemental information needed to determine continuing fitness to serve as a certified child care provider.
- G. A provider, all household members, and an individual backup provider shall cooperate with the Department in providing all information required for recertification.
- H. The Department shall determine whether to recertify a provider based on the provider's original application package, all previous monitoring reports, and all additional information the Department receives during the recertification process.

Historical Note

Adopted effective July 6, 1976 (Supp. 76-4). Section repealed, new Section adopted effective May 11, 1994 (Supp. 94-2). Former Section R6-5-5208 renumbered to R6-5-5209; new Section R6-5-5208 renumbered from R6-5-5207 and amended by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5209. Program and Equipment

R6-5-5208. Recertification Requirements

- A. Before recertifying a provider, the Department shall interview the provider at the location where child care will be provided. The Department Representative may interview an in-home provider at the in-home provider's residence. The interview shall include a discussion and review of the provider's experiences in the provision of child care services during the current certification period.
- B. A provider shall incorporate into the program each child's daily routine activities, such as diapering, toileting, eating,

dressing, resting, and sleeping, in accordance with the developmental needs of each child.

- C. A provider shall develop a flexible, developmentally appropriate program that the provider can adjust to accommodate unanticipated events such as the illness of a child or changes in the weather.
- D. A provider shall have play equipment and materials sufficient to meet the program requirements described in subsections (A) through (C), and to ensure that all children in care can be occupied in developmentally appropriate play at the same time.
- E. A provider who cares for a child who is younger than age 2 shall have a variety of developmentally appropriate play equipment and supplies available for the child, such as:
 1. Touch boards;
 2. Soft puppets;
 3. Soft or plastic blocks;
 4. Simple musical instruments;
 5. Push-pull toys for beginning walkers;
 6. Picture and texture books;
 7. Developmentally appropriate art materials, including crayons, paints, finger paints, watercolors, and paper;
 8. Simple, 2-3 piece puzzles and peg boards; and
 9. Large beads to string or snap.
- F. A provider who cares for a child age 2 or older shall have a variety of developmentally appropriate play equipment and supplies available for the child, such as:
 1. Art supplies;
 2. Blocks and block accessories;
 3. Books and posters;
 4. Dramatic play areas with toys and dress-up clothes;
 5. Large muscle equipment;
 6. Manipulative toys;
 7. Science materials; and
 8. Musical instruments.
- G. A provider shall have a bed, cot, mat, crib, or playpen for each child in care who requires a daily nap or rest period. Each infant in care shall have a safe crib, port-a crib, bassinet, or playpen.

Historical Note

Adopted effective July 6, 1976 (Supp. 76-4). Section repealed, new Section adopted effective May 11, 1994 (Supp. 94-2). Former Section R6-5-5209 renumbered to R6-5-5210; new Section R6-5-5209 renumbered from R6-5-5208 and amended by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5210. Safety; Supervision

- A. When a provider is unavailable to care for a child for a reason described in R6-5-5222(B), the provider may use only the backup provider designated under R6-5-5202 or R6-5-5222(E).
- B. A provider shall give parents and guardians written notice of the provider's backup care plan.
- C. A provider shall not engage in activities that interfere with the ability to supervise and care for children, including other employment, and volunteer or recreational activities. An in-home provider shall not perform housekeeping duties unrelated to the care of the child.
- D. A provider shall directly supervise each child who is awake.
- E. A provider shall have unobstructed access to and shall be able to hear each child who is sleeping.
- F. A provider shall not permit a child in care to use a spa or hot tub.
- G. A provider shall have written permission from a parent or guardian before allowing a child to engage in water play. In this subsection, "water play" means any activity in which water is likely to get into a child's ears.
- H. A provider shall directly supervise any child who is in a pool area.
- I. A provider shall accompany a child who is using a public or semi-public swimming place.
- J. A provider shall have written permission from a child's parent or designated representative to bathe or shower the child, or to allow the child to bathe or shower independently.
- K. A provider shall not permit a child younger than age 6 to bathe or shower unsupervised.
- L. A provider shall report suspected child abuse or neglect to CPS or the local law enforcement department as required by A.R.S. § 13-3620.
- M. A provider shall use developmentally appropriate precautions to separate a child in care from hazardous areas, including locked doors and safe portable folding gates.
- N. A provider shall release a child only to the child's parent or to an adult who has been designated in writing by the parent.
- O. A provider shall not allow a person addicted to or under the influence of illegal drugs or alcohol in the home facility while children in care are present.
- P. A provider shall not permit a person who is abusive to children, or who uses unacceptable disciplinary methods as described in R6-5-5212, into the home facility when children in care are present.

Historical Note

Adopted effective July 6, 1976 (Supp. 76-4). Amended effective March 5, 1979 (Supp. 79-2). Section repealed, new Section adopted effective May 11, 1994 (Supp. 94-2). Former Section R6-5-5210 renumbered to R6-5-5211; new Section R6-5-5210 renumbered from R6-5-5209 and amended by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5211. Sanitation

- A. A provider and each child in care shall wash their hands with soap and running water after playing with animals or using the toilet, and before and after handling, serving, or eating food. If a child cannot reach a sink with running water, due to the child's age or some limiting condition, the provider shall clean that child's hands with an individual, clean, washcloth.
- B. A provider shall wash, in hot soapy water, and sanitize, all utensils used for eating, drinking, and food preparation.
- C. A provider shall have a garbage can with a close-fitting lid.
- D. A provider shall dispose of garbage in the home facility at least once a day.
- E. A provider shall empty and sanitize wading pools measuring 12 inches deep or less, after each use.
- F. A provider shall maintain, in a sanitary condition, a swimming pool or other area or container, which is more than 12 inches deep and used for water play.
- G. A provider shall frequently check the diaper of each child in care and shall immediately change a soiled diaper.
- H. A provider shall have sanitary arrangements for diaper changing and disposal of soiled diapers, including the following:
 1. The diaper changing area shall not be in an area where food is prepared or consumed;
 2. The diapering surface shall be cleaned, sanitized, and dried after each diaper change;
 3. Following bulk stool disposal into a toilet, soiled cloth diapers shall not be rinsed, but shall be bagged in plastic, individually labeled with child's name, stored in a covered container out of reach of children, and returned to the child's parent each day; and

4. Soiled disposable diapers shall be discarded in a tightly covered, lined container out of reach of children.
- I. Before and after each diaper change, a provider shall wash hands with soap and running water in a sink not used for food preparation.
- J. A provider shall sanitize a bathtub before bathing each child in care.

Historical Note

Adopted effective July 6, 1976 (Supp. 76-4). Section repealed, new Section adopted effective May 11, 1994 (Supp. 94-2). Former Section R6-5-5211 renumbered to R6-5-5212; new Section R6-5-5211 renumbered from R6-5-5210 and amended by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5212. Discipline

- A. A certified provider and all individual backup providers shall sign a written agreement to abide by the Department's policy on developmentally appropriate discipline.
- B. Only a provider may discipline a child in care;
- C. A provider may physically restrain a child whose behavior is uncontrolled, only when the physical restraint:
 1. Is necessary to prevent harm to the child or others;
 2. Occurs simultaneously with the uncontrolled behavior;
 3. Does not impair the child's breathing; and
 4. Cannot harm the child.

A provider shall use the minimum amount of restraint necessary to bring the child's behavior under control.
- D. A provider shall not use the following disciplinary measures:
 1. Corporal punishment, including shaking, biting, hitting, or putting anything in a child's mouth;
 2. Placing a child in isolation or in a closet, laundry room, garage, shed, basement, or attic;
 3. Locking a child out of the home facility;
 4. Placing a child in any area where the provider cannot directly supervise the child;
 5. Methods detrimental to the health or emotional needs of a child;
 6. Administering medications;
 7. Mechanical restraints of any kind;
 8. Techniques intended to humiliate or frighten a child;
 9. Discipline associated with eating, sleeping, or toileting; or
 10. Abusive or profane language.
- E. As a disciplinary measure, a provider may place a child in time out. During the time out period, the provider shall keep the child in full view. Time out shall not be used for children less than age 3.
- F. A provider shall maintain consistent, reasonable rules that define acceptable behavior for a child in care.
- G. A provider shall use discipline only to teach acceptable behavior and to promote self-discipline, not for punishment or retribution.

Historical Note

Adopted effective May 11, 1994 (Supp. 94-2). Former Section R6-5-5212 renumbered to R6-5-5213; new Section R6-5-5212 renumbered from R6-5-5211 and amended by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5213. Evening And Nighttime Care

- A. A provider who offers evening or nighttime care shall remain awake until each child in care is asleep.
- B. A provider who offers nighttime care shall have a safe and sturdy crib for each infant, and a safe and sturdy bed or cot with mattress for each child. Crib bars or slats shall be no more

than 2 3/8 inches apart, and the crib mattress shall fit snugly into the crib frame so that no space remains between the mattress and frame.

- C. A provider may allow siblings to share a bed only if the provider has received written parental permission.

Historical Note

Adopted effective May 11, 1994 (Supp. 94-2). Former Section R6-5-5213 renumbered to R6-5-5214; new Section R6-5-5213 renumbered from R6-5-5212 and amended by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5214. Children Younger than Age 2

A provider who cares for a child younger than age 2 shall comply with the following requirements:

1. A provider shall frequently hold a child and give each infant and toddler physical contact and attention throughout the day.
2. A provider shall respond promptly to a child's distress signals and need for comfort.
3. A provider shall get written permission from a parent or guardian to give a child a bedtime or nap-time bottle. If the provider receives permission, the provider shall use only water in the bottles, unless otherwise directed by the child's physician.
4. A provider shall not confine a child in a crib, high chair, swing, or playpen, for more than one consecutive waking hour.
5. A provider shall not feed cereal by bottle, except with the written instruction of a physician.
6. A provider shall hold an infant younger than age 1 for any bottle feeding, and shall not prop bottles with a child in care.

Historical Note

Adopted effective May 11, 1994 (Supp. 94-2). Former Section R6-5-5214 renumbered to R6-5-5215; new Section R6-5-5214 renumbered from R6-5-5213 and amended by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5215. Children with Special Needs

- A. When enrolling a child with special needs, a provider shall comply with the requirements of this Section:
 1. A provider shall consult with parents to establish a mutually agreed upon plan regarding services for a child with special needs;
 2. A provider shall have the physical ability and appropriate training to provide the care required by a child with special needs;
 3. A provider shall use best efforts to integrate a child with special needs into the daily activities of the home facility in a manner that is the least restrictive, and that meets the child's individual needs;
 4. If a provider regularly cares for a child with special needs older than age 3 who requires diapering, the home facility shall have a diaper changing area that permits the child to have privacy. Proper sanitation shall be maintained as described in R6-5-5211.
- B. A provider shall make reasonable accommodations in the home facility, equipment, and materials for a child with special needs.

Historical Note

Adopted effective May 11, 1994 (Supp. 94-2). Former Section R6-5-5215 renumbered to R6-5-5216; new Section R6-5-5215 renumbered from R6-5-5214 and amended by final rulemaking at 5 A.A.R. 1983, effective

May 20, 1999 (Supp. 99-2).

R6-5-5216. Transportation

- A.** A provider shall obtain prior written permission from a child's parent before transporting a child in a privately owned vehicle or on public transportation.
- B.** A provider shall ensure that a child in care is transported in a private vehicle by a person who has:
 - 1. A valid Arizona driver's license;
 - 2. Automobile insurance that meets the financial responsibility requirement of Arizona law; and
 - 3. No convictions for driving while intoxicated within three years before the date of transportation.
- C.** A provider shall transport a child only in a mechanically safe vehicle. "Mechanically safe" means a vehicle with:
 - 1. Functioning brakes, signal lights, and headlights;
 - 2. Tires with tread; and
 - 3. Structural integrity.
- D.** A provider shall not transport a child on a motorcycle or in a vehicle that is not constructed for the purpose of transporting people, such as a truck bed, camper, or any trailered attachment to a motor vehicle.
- E.** A provider shall transport a child in a separate car seat, seat belt, or child-restraint device in compliance with A.R.S. § 28-907.
- F.** A provider shall never leave a child unattended in a vehicle.
- G.** A provider shall maintain first-aid supplies in a privately owned vehicle used to transport children in care.
- H.** A provider shall carry a child's emergency-information card when transporting a child in care.
- I.** A provider shall sign a form that states that the provider will abide by R6-5-5216.

Historical Note

Adopted effective May 11, 1994 (Supp. 94-2). Former Section R6-5-5216 renumbered to R6-5-5217; new Section R6-5-5216 renumbered from R6-5-5215 and amended by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5217. Meals and Nutrition

- A.** A provider shall serve a child in care wholesome and nutritious foods and beverages. In this Section, "wholesome and nutritious" means foods and beverages consistent with the requirements of 7 CFR 226.20 (January 1, 1998), which is incorporated by reference and available for inspection at the Department's Authority Library, 1789 West Jefferson, Phoenix, Arizona 85007 and in the office of the Secretary of State at 1700 West Washington, Phoenix, Arizona. The incorporated material contains no later amendments or editions.
- B.** A provider shall supplement meals and snacks supplied by a parent when the supplied food does not provide a child with a wholesome and nutritious diet.
- C.** A provider shall make available to a child in care meals and snacks that satisfy the child's appetite and dietary needs.
- D.** A provider shall consult with a parent to identify, in writing, any special dietary needs or instructions for a child in care.
- E.** A provider shall give a child any necessary assistance in feeding and shall teach self-feeding skills, but shall not force a child to eat.
- F.** A provider shall monitor all perishable foods, including infant formulas and sack lunches. The provider shall ensure that food is individually labeled with a child's name, dated, covered, and properly stored to prevent spoilage at temperatures of 45°F or less.

Historical Note

Adopted effective May 11, 1994 (Supp. 94-2). Former

Section R6-5-5217 renumbered to R6-5-5218; new Section R6-5-5217 renumbered from R6-5-5216 and amended by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5218. Health Care; Medications

- A.** When a provider enrolls a child for care, the provider shall make written arrangements with the child's parent for emergency medical care of the child.
- B.** If a child becomes ill while in care, a provider shall:
 - 1. Make the child comfortable and keep the child in full view; and
 - 2. Notify the parent or other designated person that the child is ill and must be immediately removed from care.
- C.** A provider shall notify the parent of other children in care when a child in care contracts an infectious illness.
- D.** A provider shall not provide care while knowingly infected with or presenting symptoms of an infectious disease.
- E.** If a child exhibits symptoms of an infectious disease, the child may return to care when fever free and symptom free, or with written permission from the child's medical practitioner that returning will not endanger the health of the child or other children in care.
- F.** A provider shall not admit a child in need of professional medical attention to the home facility and shall direct the parent to obtain medical attention for the child.
- G.** Only a provider shall administer medication with signed written instructions for administering the medication from the child's parent.
- H.** A provider shall not administer:
 - 1. Medication that is date expired or in something other than its original container; or
 - 2. Prescription medication that does not bear the date of issue, the child's name, the amount and frequency of dosage, and the doctor's name.
- I.** A provider shall maintain a written log of all medications administered. The log shall include:
 - 1. The name of the child receiving the medication;
 - 2. The name of the medication;
 - 3. The date and time of administration; and
 - 4. The dosage administered.

A provider shall use a sanitary medication measure for accurate dosage.
- J.** A provider shall keep all medication in a locked storage container, and refrigerate if necessary.
- K.** A provider shall have first-aid supplies available at the home facility, which shall be administered only by the provider.
- L.** A provider is responsible for obtaining only emergency medical treatment for a child in care.

Historical Note

Adopted effective May 11, 1994 (Supp. 94-2). Former Section R6-5-5218 renumbered to R6-5-5219; new Section R6-5-5218 renumbered from R6-5-5217 and amended by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5219. Recordkeeping; Unusual incidents; Immunizations

- A.** A provider shall maintain a daily attendance log on a Department-approved form and shall require that each child be signed in and out on the log by the parent or other individual designated in writing by the parent.
- B.** On a form approved by the Department, a provider shall promptly log all accidents, injuries, behavior problems, or other unusual incidents at the home facility, including any suspected child abuse or neglect.

- C. A provider shall immediately report all unusual incidents to a parent or guardian of the child involved and shall report the incidents to the Department within 24 hours of the time of occurrence.
- D. A provider shall maintain records in accordance with the requirements of the provider's child care registration agreement. The provider shall make the following records readily available for inspection by the Department and shall keep them separate from household and other personal records:
 1. Information listed in subsection (E);
 2. Immunization records identified in subsection (F) and R6-5-5202 (L);
 3. Documentary evidence of freedom from communicable tuberculosis as required by R6-5-5202 (M);
 4. The provider's certification, re-certification, and monitoring records;
 5. Health records of child care personnel;
 6. The provider's training records;
 7. Unusual incident reports; and
 8. Daily logs of attendance, accidents, injuries, medications administered, behavior problems, or other unusual incidents.
- E. A provider shall maintain at least the following information for each child in care:
 1. The child's name, home address, telephone number, gender, and date of birth;
 2. The name, home and business addresses, and telephone numbers of the child's parent;
 3. The name, address and telephone number of the child's physician or health care provider and hospital;
 4. Authorization and instructions for emergency medical care when the parent cannot be located; and
 5. Written authorization to release a child to any individual other than the parent and the name, home and work addresses, and telephone numbers of that individual.
- F. A provider shall maintain an immunization record or exemption affidavit for each child in care.
 1. Documentation required under this subsection is limited to:
 - a. An immunization record prepared by the child's health care provider stating that child has received current, age-appropriate immunizations specified in R9-6-701, including Immunizations for Diphtheria, homophiles influenza type b, Hepatitis B, Measles, Mumps, Pertusis, Poliomyelitis, Rubella, and Tetanus;
 - b. An affidavit signed by the child's health care provider stating that the child has a medical condition that causes the required immunizations to endanger the child's health; or
 - c. An affidavit signed by the child's parent stating that the child is being raised in a religion whose teachings oppose immunization.
 2. If a child has received all current immunizations but requires further inoculations to be fully immunized, the provider shall require the parent to verify that the parent will have the child complete all immunizations in accordance with the DHS recommended schedule identified in R9-6-701. The provider shall:
 - a. Require the parent to produce documented records from the child's health care provider of the immunizations as they are completed; and
 - b. Maintain the records as required by subsection (F)(1).
 3. The provider shall not permit a child in care to remain enrolled for more than 15 days if the parent does not pro-

vide proof of current, age-appropriate immunizations, a statement of timely completion of further inoculations, or exemption from immunization.

- G. Children exempted from immunizations for religious or medical reasons shall be excluded from the home facility if there is an outbreak of an immunizable disease at the home facility.

Historical Note

Adopted effective May 11, 1994 (Supp. 94-2). Former Section R6-5-5219 renumbered to R6-5-52020; new Section R6-5-5219 renumbered from R6-5-5218 and amended by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5220. Provider/Child Ratios

- A. The Department may certify a provider in a home facility to care for a maximum of four children at a time, from birth through age 12, for compensation. A provider in a home facility may care for a maximum of six children at a time, from birth through age 12, or a child age 13 or older who is a child with special needs, when all of the following conditions are met:
 1. No more than four children in care are for compensation; and
 2. No more than two of the children in care are younger than age 1, unless a sibling group.
- B. The Department may certify an in-home provider to provide the following care:
 1. An in-home provider may care for a sibling group of no more than six children.
 2. An in-home provider shall care only for the children who live in that home.
 3. An in-home provider may bring the in-home provider's own children to the in-home location with the written permission of the client, and so long as the total number of children at the in-home location does not exceed six children.
- C. The Department may further limit the ratios allowed in subsections (A) and (B) to protect the well-being of children in care. The Department may impose additional restrictions when:
 1. There are more than two children residing in the home facility who are counted in the ratio;
 2. The Department determines that the home facility and the furnishings are inadequate to accommodate four children at a time for compensation, as provided in Section R6-5-5203(6);
 3. The Department has determined that a provider is physically unable to care for four children at a time; for compensation or
 4. A provider requests certification for fewer than four children at a time for compensation.
- D. For the sole purpose of establishing and monitoring ratios, the Department shall not count any child who is age 13 or older, except as provided in subsection (A) for a child with special needs.

Historical Note

Adopted effective May 11, 1994 (Supp. 94-2). Former Section R6-5-5220 renumbered to R6-5-5221; new Section R6-5-5220 renumbered from R6-5-5219 and amended by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5221. Change Reporting Requirements

At least 15 days before the effective date of any scheduled change, or within 24 hours after an unscheduled change, which significantly affects the provision of child care services, a provider shall furnish

the Department with written notice of the change. Significant changes include, but are not limited to:

1. Home remodeling;
2. Home repair;
3. Pool installation;
4. Relocating to a new residence;
5. Change in household composition;
6. Telephone number change;
7. Change of backup provider;
8. Voluntarily relinquishing the certificate; and
9. Any other change in the home facility or the provider's personal circumstances that affect the provider's ability to provide stable child care services.

Historical Note

Adopted effective May 11, 1994 (Supp. 94-2). Former Section R6-5-5221 renumbered to R6-5-5222; new Section R6-5-5221 renumbered from R6-5-5220 and amended by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5222. Use of A Backup Provider

- A. A provider shall maintain a backup provider, and shall keep clients and the Department apprised of the backup provider's identity and location.
- B. A provider may use a backup provider only in the following circumstances:
 1. When the provider is ill;
 2. When the provider is attending to an emergency related to the provision of child care;
 3. When the provider has an emergency involving the provider or the provider's dependent family members;
 4. When the provider needs to attend a non-emergency appointment for the provider or the provider's dependent family members, and the provider cannot schedule the appointment outside of normal child care hours;
 5. When the provider is attending classes to meet training requirements listed in this Article; or
 6. When the provider is taking a vacation.
- C. At the time of enrollment of a child in care, a provider shall advise the parent of the possible use of a backup provider.
- D. A provider shall notify the Department within 24 hours of the onset of the use of a backup provider.
- E. When a provider designates a new backup provider, the provider shall ensure that the backup provider meets the requirements for backup providers in R6-5-5202.
- F. A provider shall execute a backup provider agreement form furnished by the Department, which identifies the backup provider and contains assurances that the backup provider will be used in accordance with the requirement of this Section.

Historical Note

Adopted effective May 11, 1994 (Supp. 94-2). Former Section R6-5-5222 renumbered to R6-5-5223; new Section R6-5-5222 renumbered from R6-5-5221 and amended by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5223. Claims For Payment

- A. A provider shall submit claims for payment in the manner prescribed in the child care registration agreement with the Department.
- B. A provider shall make all financial arrangements with a backup provider. The Department shall not make direct payments to the backup provider.

Historical Note

Adopted effective May 11, 1994 (Supp. 94-2). Former Section R6-5-5223 renumbered to R6-5-5224; new Sec-

tion R6-5-5223 renumbered from R6-5-5222 and amended by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5224. Complaints; Investigations

- A. Any person may register, with the Department, a written or verbal complaint about a provider or the operation of a home facility. Upon receipt of a complaint, or in response to the observations of Department staff, the Department shall investigate the allegations made and any matters related to certification and compliance with the child care registration agreement.
- B. A provider who is the subject of a complaint shall cooperate with the Department in conducting an investigation. The provider shall allow a Department representative to inspect the home facility and all records, and to interview any child care personnel, or household member.
- C. The Department shall maintain a file on all complaints against a provider and shall make information on valid complaints available to parents and to the general public upon request and as permitted by law.
- D. Following an investigation, the Department shall take appropriate administrative action as described in this Article.

Historical Note

Adopted effective May 11, 1994 (Supp. 94-2). Former Section R6-5-5224 renumbered to R6-5-5225; new Section R6-5-5224 renumbered from R6-5-5223 and amended by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5225. Probation

- A. The Department may place a provider on probation when a Department representative observes a problem or the Department receives and validates a complaint in an area of noncompliance that does not endanger a child in care.
- B. The Department shall set a term of probation that does not exceed 30 days.
- C. The Department may suspend a provider's child care certificate if the same infraction that resulted in probation is repeated during a provider's current certification period and the Department determines that the provider has not demonstrated either the intent or ability to comply with the requirements of this Article.
- D. The Department shall not authorize any new child for payment to a provider who is on probation. Children already in that provider's care may remain authorized.
- E. Probationary status is not appealable.

Historical Note

Adopted effective May 11, 1994 (Supp. 94-2). Former Section R6-5-5225 renumbered to R6-5-5226; new Section R6-5-5225 renumbered from R6-5-5224 and amended by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5226. Certification, Denial, Suspension, and Revocation

- A. The Department may deny, suspend, or revoke certification when:
 1. An applicant or provider violates or fails to comply with any statute or rule applicable to the provision of Child Care Services.
 2. An applicant or provider has a certificate or license to operate a child care home or facility denied, revoked, or suspended in any state or jurisdiction.
 3. An applicant or provider fails to disclose requested information or provides false or misleading information to the Department.

4. A provider's contract with the Department to furnish child care services expires or is terminated.
 5. Child care personnel fail or refuse to comply with or meet the requirements of A.R.S. § 41-1964.
 6. A provider fails or refuses to correct or repeats a violation that resulted in probation or suspension.
 7. The Department, through its CPS hotline, receives a report of alleged child maltreatment by an applicant, provider, or household member who is under investigation by CPS or a law enforcement agency or is being reviewed in a civil, criminal, or administrative hearing.
 8. An applicant or provider fails or refuses to cooperate with the Department in providing information required by these rules or any information necessary to determine compliance with these rules.
 9. An applicant, provider, or household member engages in any activity or circumstance that may threaten or adversely affect the health, safety, or welfare of children, including inadequate supervision or failure to protect from actual or potential harm.
 10. An applicant or provider is unable or unwilling to meet the physical, emotional, social, educational, or psychological needs of children.
 11. The Department, through its CPS hotline, receives a report of alleged child maltreatment in a home facility that is under investigation by CPS or a law enforcement agency or is being reviewed in a civil, criminal, or administrative proceeding.
 12. An applicant, provider, or household member is the subject of a substantiated or undetermined report of child maltreatment in any state or jurisdiction. Substantiated child maltreatment includes, but is not limited to, a probable cause finding by CPS or a law enforcement agency.
 13. CPS or a law enforcement agency substantiates a report of child maltreatment in a home facility.
- B.** In determining whether to take disciplinary action against a provider, or to grant or renew a certificate, the Department may evaluate the provider's history from other certification periods, both in Arizona and in other jurisdictions, and shall consider multiple violations of statutes or rules applicable to the provision of child care services as evidence that the applicant or provider is unable or unwilling to meet the needs of children.

Historical Note

Adopted effective May 11, 1994 (Supp. 94-2). Former Section R6-5-5226 repealed; new Section renumbered from R6-5-5225 and amended by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5227. Adverse Action; Notice Effective Date

- A.** When the Department denies, suspends, or revokes certification, it shall mail a written, dated notice of the adverse action to the applicant or the provider at the applicant's or provider's last known address.
- B.** A notice of adverse action shall specify:
1. The adverse action taken and date the action will be effective;
 2. The reasons supporting the adverse action; and
 3. The procedures by which the applicant or provider may contest the action taken and the time period in which to do so.
- C.** Except as provided in subsection (D), a revocation, suspension, or denial of recertification is effective 20 calendar days from the date on the notice or letter advising the provider of the adverse action.

- D.** A suspension, revocation, or denial of recertification is effective on the date of the notice or letter advising the person of the adverse action if:
1. The adverse action is based on the failure of child care personnel to comply with or meet the requirements of A.R.S. § 41-1964; or
 2. The Department bases the adverse action on a determination that the health, safety, or welfare of a child in care is in jeopardy.
- E.** The Department shall stop payment authorization for all subsidized children in care on the effective date of a suspension, revocation, or denial of recertification.
- F.** The Department shall not authorize the referral of additional children to a provider after mailing a notice of adverse action to the provider's last known address.

Historical Note

Adopted effective May 11, 1994 (Supp. 94-2). Amended effective June 4, 1998 (Supp. 98-2). Former Section R6-5-5227 renumbered to R6-5-5228 and new Section adopted by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5228. Appeals

- A.** An applicant or provider may appeal the following Department decisions:
1. Denial of certification or re-certification;
 2. Suspension of a certificate; and
 3. Revocation of a certificate.
- B.** A person who wishes to appeal an adverse action shall file a written request for a hearing with the Department within 15 calendar days of the date on the notice or letter advising the provider of the adverse action.
- C.** The Department shall conduct a hearing as prescribed in 6 A.A.C. 5, Article 75. Decisions based on failure to clear a fingerprint check or criminal history check are not appealable under this Article.
- D.** Matters relating to contractual agreements with the Department, including payment rates and amounts, are not appealable under this Article.
- E.** When an adverse action based on R6-5-5226(A)(7) is appealed under this Article, allegations of child maltreatment are not at issue and shall not be adjudicated in an administrative proceeding conducted under subsection (C).

Historical Note

New Section R6-5-5228 renumbered from R6-5-5227 and amended by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

ARTICLE 53. REPEALED

Former Article 53 consisting of Sections R6-5-5301 through R6-5-5305 repealed effective April 9, 1981.

ARTICLE 54. REPEALED

Former Article 54 consisting of Sections R6-5-5401 through R6-5-5411 repealed effective November 8, 1982.

ARTICLE 55. CHILD PROTECTIVE SERVICES

R6-5-5501. Definitions

The definitions in A.R.S. §§ 8-531, 8-201, and 8-801, and the following definitions apply in this Article:

1. "Abandonment" has the same meaning ascribed to "abandoned" in A.R.S. § 8-201(1).
2. "Abuse" means the same as A.R.S. § 8-201(2).
3. "Aggravating factor" means a specific circumstance that increases the risk of harm to a child and may result in a shorter investigation response time.

4. “Alleged abuser” means a child’s parent, guardian, or custodian accused of child maltreatment.
5. “Alternative investigation” means, under R6-5-5507, a method to determine that a report of child maltreatment is unsubstantiated without a field investigation.
6. “Alternative response” means a report referred to Family Builders for assessment and services and not investigated by CPS according to Laws 1997, Chapter 223, § 2.
7. “Caregiver” means a child’s parent, guardian, or custodian.
8. “Child” means a person less than age 18.
9. “Child Abuse Hotline,” or “the Hotline,” means a state-wide, toll-free telephone service, including TDD service, that the Department operates 24 hours per day, seven days per week, to receive calls about child maltreatment.
10. “CHILDS” means the Children’s Information Library and Data Source, which is a comprehensive automated system to support child welfare policies and procedures and includes information on investigations, ongoing case management, and payments.
11. “CHILDS Central Registry” means the Child Protective Services Central Registry, a confidential computerized database within CHILDS, that the Department maintains according to A.R.S. § 8-804.
12. “Child welfare agency” has the same meaning as in A.R.S. § 8-501(A)(1).
13. “CPS” means Child Protective Services, a program within the Administration for Children, Youth and Families (ACYF), a division of the Department designated to receive and investigate allegations of child maltreatment and provide protective services as described in subsection (40).
14. “CPS Administrator” means the DES Administrator responsible for operation of CPS, or that person’s designee, which may include the Field Operations Manager, the CPS District Program Manager (“DPM”), the CPS Assistant District Program Manager (“APM”), or the CPS Local Office Manager.
15. “CPS Specialist” has the same meaning ascribed to “protective services worker” in A.R.S. § 8-801(2).
16. “CPS-CIU” means the Child Protective Services Central Intake Unit that operates the Child Abuse Hotline, screens incoming communications, and transmits reports to a CPS unit.
17. “Custodian” means a person defined in A.R.S. § 8-201(8). For CPS reporting purposes, a custodian is also any person with whom the child resides at the time of a maltreatment and includes a:
 - a. Friend,
 - b. Relative,
 - c. Foster parent, and
 - d. Child welfare agency.
18. “DCYF” means the Department’s Division of Children, Youth and Families, an administrative unit that includes CPS.
19. “DDD” means the Department’s Division of Developmental Disabilities.
20. “Delinquent act” has the same meaning prescribed in A.R.S. § 8-201(9).
21. “Department” means the Arizona Department of Economic Security.
22. “Exploitation” means use of a child by a parent, guardian, or custodian for material gain, which may include forcing a child to panhandle, steal, or perform other illegal activities.
23. “Family” means persons, including at least one child, who are related by blood or law, who are legal guardians of a child, or who reside in the same household.
24. “Family assessment” means a process that:
 - a. CPS uses to evaluate a family’s strengths, weaknesses, and problems;
 - b. Is based on the family’s history, observations about the family, professional opinions, and other information; and
 - c. Includes a child safety assessment to determine the probability of risk to a child under R6-5-5512.
25. “Family Builders” means a program that allows CPS to refer selected reports to community-based providers for a family assessment and services according to Laws 1997, Chapter 223, § 2.
26. “Guardian” means the same as A.R.S. § 8-531(9).
27. “Incoming communication” means a telephonic, written, or in-person contact to CPS that is received by or ultimately directed to the Child Abuse Hotline.
28. “Licensing specialist” means a person who is:
 - a. Designated by the Department or another state licensing agency; and
 - b. Responsible for licensing, supervision, support, and monitoring of foster homes or child welfare agencies.
29. “Lifestyle” means a way of life or pattern of conduct that reflects the values and attitudes of a child’s parent, guardian, or custodian.
30. “Maltreatment” means abuse, neglect, abandonment, or exploitation of a child. When used in reference to CPS activities, maltreatment means that a parent, guardian, or custodian:
 - a. Has committed an act of maltreatment,
 - b. May commit an act of maltreatment,
 - c. Has permitted another person to commit an act of maltreatment, or
 - d. Had reason to know that another person might commit an act of maltreatment and did not act to prevent the potential maltreatment.
31. “Mandated reporter” means a person who is required to report suspected child maltreatment under A.R.S. § 13-3620.
32. “Minor hygienic problem” means a body condition that does not pose a risk of serious or immediate harm, such as body odor, dirty hair, matted hair, dirty clothing, and treated chronic head lice.
33. “Mitigating factor” means a specific circumstance that reduces the risk of harm to a child and may permit a longer investigation response time.
34. “Neglect” or “neglected” means the same as A.R.S. § 8-201(21).
35. “Non-abusive caregiver” means a parent, guardian, or custodian who is not the subject of a CPS report or an investigation of alleged maltreatment.
36. “Notice of removal” means a form of notification that CPS gives to a person other than a caregiver when CPS removes a child and places the child in temporary custody.
37. “Ongoing protective services” are voluntary or involuntary social services designed to help a family resolve problems that contribute to child abuse and may include counseling, parenting classes, parent aide services, and voluntary foster care placement.
38. “Out-of-home placement” means a place where a child resides when the child is unable to reside at home because of maltreatment and includes:

- a. A relative home,
 - b. A foster home,
 - c. A licensed child welfare agency,
 - d. A behavioral health facility,
 - e. An unlicensed nonrelative,
 - f. An independent living program, and
 - g. A group home for persons with developmental disabilities.
39. "Probable cause" means that the Department has some evidence that an allegation is more likely to be true than not true.
40. "Protective services" means the same as A.R.S. § 8-801(1).
41. "PSRT" means the DCYF Protective Services Review Team that administers the process described in A.R.S. § 8-811 for appeal of proposed substantiated findings of abuse or neglect.
42. "Report" means a classification assigned to an incoming communication after the Child Abuse Hotline has screened the communication and found it to include:
- a. An allegation of maltreatment about a person who is currently a child, and
 - b. Sufficient information for CPS to locate the child who is the subject of the maltreatment.
43. "Screening" means an initial process of determining whether an incoming communication contains an allegation of child maltreatment and should be classified as a report.
44. "Standard response time" means the period between the time a local CPS office receives a report from the Hotline and an action is taken to determine that a child victim is safe, in the absence of aggravating or mitigating factors.
45. "Substantiated" means that a CPS Specialist has concluded, after an investigation, that there is probable cause to believe an alleged abuser committed an act of child maltreatment.
46. "TDD" means a telecommunication device for the deaf.
47. "Unsubstantiated" means that a CPS Specialist has concluded, after an investigation, that there is no probable cause to believe an alleged abuser committed an act of child maltreatment.

Historical Note

Adopted effective June 2, 1976 (Supp. 76-3). Former Section R6-5-5501 repealed, new Section R6-5-5501 adopted effective December 8, 1983 (Supp. 83-6). Amended by final rulemaking at 5 A.A.R. 444, effective January 15, 1999 (Supp. 99-1).

R6-5-5502. Receipt and Screening of Information; Child Abuse Hotline

- A. The Department operates a Child Abuse Hotline to receive and screen incoming communications. If a person calls, visits, or writes a Department office other than the Child Abuse Hotline to report child maltreatment, the Department shall refer the person or written communication to the Hotline.
- B. The Department accepts anonymous calls of alleged maltreatment.
- C. When the Hotline receives a communication, the Hotline staff shall:
 - 1. Ask a caller's identity;
 - 2. Use the standardized questions listed in Appendix 1 to this Article, to determine:
 - a. The type of maltreatment alleged, and
 - b. Whether to classify the communication as a report, and

- 3. Check the CHILDS Central Registry and other DES computer databases for prior reports on the same persons.
- D. When the Department receives an oral report from a mandated reporter, the Department shall ask the mandated reporter to file a written statement confirming the oral report.

Historical Note

Adopted effective June 2, 1976 (Supp. 76-3). Former Section R6-5-5502 repealed, new Section R6-5-5502 adopted effective December 8, 1983 (Supp. 83-6). Section repealed, new Section adopted at 5 A.A.R. 444, effective January 15, 1999 (Supp. 99-1). Numbering of subsection (C)(3) amended to correct typographical error (Supp. 00-2).

R6-5-5503. Non-Reports

Unless a communication includes an allegation of child maltreatment, the Department shall not classify as a report statements concerning the following matters:

- 1. A child's absence from school;
- 2. A child age 8 or older who allegedly committed a delinquent act;
- 3. Siblings of a child age 8 or older who allegedly committed a delinquent act;
- 4. A child whose parents are absent but made arrangements for the child's care;
- 5. A child who is receiving treatment from an accredited Christian Science practitioner, or other religious or spiritual healer, unless the child's health is:
 - a. In imminent harm, under R6-5-5512(B); or
 - b. Endangered by lack of medical care;
- 6. A child with minor hygienic problems;
- 7. The lifestyle of a child's parent, guardian, or custodian;
- 8. Custody disputes, including:
 - a. A noncustodial parent who is denied visitation by the custodial parent, and
 - b. A relative or other person who wants legal custody of a child; and
- 9. Spiritual neglect of a child or the religious practices or beliefs to which a child is exposed.

Historical Note

Adopted effective June 2, 1976 (Supp. 76-3). Former Section R6-5-5503 repealed, new Section R6-5-5503 adopted effective December 8, 1983 (Supp. 83-6). Section repealed, new Section adopted at 5 A.A.R. 444, effective January 15, 1999 (Supp. 99-1).

R6-5-5504. Preliminary Screening Classifications

- A. Screening Classifications. After preliminary screening, Child Abuse Hotline staff shall classify a communication into one of the following categories:
 - 1. A communication that is a non-report, or
 - 2. A report for investigation.
- B. Communication that is a non-report.
 - 1. If a caller describes a problem that does not involve child maltreatment, the Hotline staff shall refer the caller to a community resource that can help with the problem.
 - 2. If a communication involves a child who is already in the Department's care, custody, and control, the Hotline staff shall record the information and send it to the child's case manager for action. If a communication involves a licensed out-of-home care provider, the Hotline shall also notify the provider's licensing specialist or the appropriate licensing authority.
 - 3. If a communication involves suicidal or homicidal behavior, or presents a danger to self or others, the Hotline staff

shall refer the caller to law enforcement or behavioral health services.

4. If a communication involves an incorrigible or delinquent child who is age 8 or older, the Hotline staff shall refer the caller to the local county juvenile probation office.
5. If a communication involves child maltreatment by a person other than a child's caregiver, without the caregiver's knowledge, the Hotline staff shall notify, and direct the caller to notify, local law enforcement.

C. Review of non-reports.

1. If the information provided by a caller is not a report, the CPS Hotline staff shall:
 - a. Record the information;
 - b. Inform a caller that the information is not a report; and
 - c. If a caller disagrees with the decision not to take a report, advise the caller that a request may be made for a supervisory review.
2. If a caller requests a supervisory review, the Hotline staff shall transfer the caller to an available supervisor. The caller may request further review by the Child Abuse Hotline Assistant Program Manager, Hotline Program Manager, and ultimately, the ACYF Field Operations Manager.
3. A Child Abuse Hotline supervisor or a CPS quality assurance specialist shall review all communications not classified as a report within 48 hours of receipt to verify that the communication was properly classified.

D. Communication that is a report for investigation.

1. If a communication contains the information required for a report, the Hotline staff shall gather additional information using the standardized questions listed in Appendix 2.
2. The Hotline staff shall assign each report a priority code and may assign a tracking code.
3. The Hotline staff may shorten or lengthen the response time based on aggravating or mitigating factors received during the screening.
4. The Hotline staff shall give the caller the name and phone number of the local office supervisor receiving the report.
5. The Hotline staff shall enter the report information into CHILDS.
6. The Hotline staff shall immediately transmit the report to a local office for disposition.

Historical Note

Adopted effective June 2, 1976 (Supp. 76-3). Former Section R6-5-5504 repealed, new Section R6-5-5504 adopted effective December 8, 1983 (Supp. 83-6). Section repealed, new Section adopted at 5 A.A.R. 444, effective January 15, 1999 (Supp. 99-1).

R6-5-5505. Priority Codes; Initial Response Time

A. Priority codes and initial response times are:

1. Priority 1: High Risk;
 - a. Standard Response Time: two hours;
 - b. Mitigated Response Time: 24 hours.
2. Priority 2: Moderate Risk;
 - a. Standard Response Time: 48 hours;
 - b. Aggravated Response Time: 24 hours;
 - c. Mitigated Response Time: 72 hours.
3. Priority 3: Low Risk;
 - a. Standard Response Time: 72 hours;
 - b. Aggravated Response Time: 48 hours;
 - c. Mitigated Response Time: 72 hours excluding weekends and Arizona state holidays.
4. Priority 4: Potential Risk;

- a. Standard Response Time: seven days;
- b. Aggravated Response Time: 72 hours excluding weekends and Arizona state holidays.

- B.** All response times are measured from the time that the CPS local office receives the report from the Child Abuse Hotline to the time action is taken to determine the current safety of the alleged victim.
- C.** To comply with the priority response time, entities other than CPS, such as law enforcement personnel, emergency personnel, or paramedics, may initially respond to a report.
- D.** If law enforcement or emergency personnel initially respond to a report, CPS shall respond and investigate the report no later than the mitigated response time for the designated priority.

Historical Note

Former Section R6-5-5505 repealed effective December 8, 1983 (Supp. 83-6). New Section adopted by final rulemaking at 5 A.A.R. 444, effective January 15, 1999 (Supp. 99-1).

R6-5-5506. Methods for Investigation of Reports

- A.** Upon receipt of a report, a CPS unit supervisor:
 1. May aggravate or mitigate the response time, if the Child Abuse Hotline has not assigned a mitigating or aggravating factor, but shall not change any aggravating or mitigating factors assigned by the Hotline; and
 2. Shall assign one of the following dispositions:
 - a. Field investigation;
 - b. Alternative investigation under R6-5-5507;
 - c. Legally prohibited investigation. A federal, state statute, or court order prohibits CPS from investigating if, for example:
 - i. The alleged maltreatment occurs on a United States military base or Tribal reservation land, or
 - ii. A court orders CPS not to investigate; or
 - d. Alternative response, such as reports referred to Family Builders.
- B.** The CPS unit supervisor shall document the action taken and the disposition.

Historical Note

Former Section R6-5-5506 repealed effective December 8, 1983 (Supp. 83-6). New Section adopted by final rulemaking at 5 A.A.R. 444, effective January 15, 1999 (Supp. 99-1).

R6-5-5507. Alternative Investigation

- A.** Upon receipt of a report, a CPS unit supervisor may conduct an alternative investigation.
- B.** To conduct an alternative investigation, CPS shall contact a mandatory reporting source who is currently involved with the family and can provide information that:
 1. The child and other children residing in the home are not:
 - a. Current victims of maltreatment, or
 - b. At risk of imminent harm; and
 2. The allegations are unsubstantiated.
- C.** A CPS administrator shall review and approve any decision to conduct an alternative investigation.
- D.** If information gathered during an alternative investigation indicates that an alleged victim may be at risk of harm, the CPS Supervisor shall immediately assign the case for field investigation.
- E.** CPS shall not conduct an alternative investigation if an allegation involves an alleged victim who is:
 1. Already in Department custody,
 2. Currently the subject of an open CPS case,

3. In a DES- or DHS-licensed or certified facility, or
4. In a DES-licensed family foster home.

Historical Note

Former Section R6-5-5507 repealed effective December 8, 1983 (Supp. 83-6). New Section adopted by final rulemaking at 5 A.A.R. 444, effective January 15, 1999 (Supp. 99-1).

R6-5-5508. Conduct of a Field Investigation

- A.** When conducting a field investigation, a CPS Specialist shall determine:
 1. The name, age, location, and current physical and mental condition of all children in the home of the alleged victim;
 2. Whether any child in the home has suffered maltreatment; and
 3. Whether any child in the home is at risk of maltreatment in the future.
- B.** A CPS Specialist shall investigate allegations using the following methods:
 1. Interview the alleged victim;
 2. Interview the alleged victim's caregiver who allegedly committed the abuse;
 3. Interview other adults and children residing in the home;
 4. Interview other persons who may have relevant information, including the reporting source, medical personnel, relatives, neighbors, and school personnel;
 5. Review available documentation including medical and psychiatric reports, police reports, school records, and prior CPS files; or
 6. Consult with law enforcement.
- C.** A CPS Specialist may interview a child without prior parental consent under A.R.S. § 8-802(C)(2).
- D.** A CPS Specialist may exclude the alleged abuser from participating in an interview with the alleged victim, the alleged victim's siblings, or other children residing in the alleged victim's household.
- E.** Before interviewing a caregiver, a CPS Specialist shall:
 1. Orally inform the caregiver of the rights and duties under A.R.S. § 8-803(B);
 2. Give the caregiver a written statement summarizing the same information; and
 3. Ask the caregiver to sign a written acknowledgment of receipt of the information.
- F.** A CPS Specialist may take temporary custody of a child under A.R.S. §§ 8-821(A) and (B) and 8-802(C)(4). The CPS Specialist shall take temporary custody of an alleged victim if the alleged victim needs to be examined and the caregiver will not consent to the examination.
- G.** If a CPS Specialist finds more allegations of maltreatment during the investigation, the CPS Specialist shall incorporate the allegations into the report and investigate under this Article.

Historical Note

Former Section R6-5-5508 repealed effective December 8, 1983 (Supp. 83-6). New Section adopted by final rulemaking at 5 A.A.R. 444, effective January 15, 1999 (Supp. 99-1).

R6-5-5509. Establishing Probable Cause of Child Maltreatment

To determine whether to recommend a substantiated allegation of maltreatment, the CPS Specialist shall consider all information gathered during the investigation, including:

1. Whether the alleged abuser or non-abusive caregiver admitted the maltreatment;

2. Whether a child provided a developmentally appropriate description of maltreatment;
3. Witness statements from persons other than the caregivers and the alleged victim;
4. Physical or behavioral signs of maltreatment or damage;
5. Medical opinions and opinions from treating professionals, including any conflict of opinion;
6. The consistency of the information provided; and
7. History of child maltreatment.

Historical Note

Former Section R6-5-5509 repealed effective December 8, 1983 (Supp. 83-6). New Section adopted by final rulemaking at 5 A.A.R. 444, effective January 15, 1999 (Supp. 99-1).

R6-5-5510. Investigation Findings; Required Documentation

After completing an investigation, a CPS Specialist shall:

1. Unsubstantiate the allegations or make a proposed finding that the allegation is substantiated based on whether the CPS Specialist finds probable cause to believe maltreatment occurred, and after considering the information listed in R6-5-5509;
2. Determine whether the family has any unresolved problems involving child maltreatment and needs further services;
3. Document in the case record the reason for the finding;
4. Include in the case record any oral and written statements or other documentation provided by a caregiver;
5. Notify the PSRT of a proposed substantiated allegation finding under A.R.S. § 8-811;
6. Enter an unsubstantiated allegation finding into the CHILDS Central Registry and send the caregiver written notice of the unsubstantiated allegation finding.

Historical Note

Former Section R6-5-5510 repealed effective December 8, 1983 (Supp. 83-6). New Section adopted by final rulemaking at 5 A.A.R. 444, effective January 15, 1999 (Supp. 99-1).

R6-5-5511. Ongoing Services; Imminent Harm Not Identified; Case Closure

- A.** If a finding is unsubstantiated or substantiated without unresolved problems, the CPS Specialist shall close the case.
- B.** If a finding is unsubstantiated or substantiated, and there is no risk of imminent harm to a child, but the family has unresolved problems that create a potential for maltreatment, CPS shall determine whether to open the case for ongoing protective services if:
 1. A family requests ongoing protective services, or
 2. A dependency action is pending.
- C.** CPS shall offer a family voluntary protective services before filing a dependency action.
- D.** When CPS offers a family voluntary protective services, CPS shall:
 1. Document the family's acceptance or refusal of services,
 2. Document any services provided, and
 3. Document any action that CPS has taken to ensure that a child is safe.
- E.** To determine how to proceed for ongoing services, CPS shall consider the following criteria:
 1. Whether a family acknowledges past maltreatment or potential for future maltreatment,
 2. Whether the services are available to help a family address risk factors, and
 3. Whether a family is willing to cooperate with the provision of services.

Historical Note

Former Section R6-5-5511 repealed effective December 8, 1983 (Supp. 83-6). New Section adopted by final rulemaking at 5 A.A.R. 444, effective January 15, 1999 (Supp. 99-1).

R6-5-5512. Procedures for Substantiated Reports; Removal; Imminent Harm

- A.** If CPS recommends a substantiated finding of maltreatment, CPS shall determine whether the child can safely remain in the home or needs to be removed.
- B.** The following situations indicate imminent harm and require CPS to intervene as provided in R6-5-5513:
 1. No caregiver is present and a child cannot care for himself or herself or for other children in the household;
 2. A child has severe or serious nonaccidental injuries that require immediate medical treatment, such as:
 - a. Head injury, with risk of damage to the central nervous system;
 - b. Internal injuries;
 - c. An injury resulting in coma;
 - d. Multiple plane injuries indicative of battering;
 - e. Facial bruises;
 - f. Fractures or bruises in a nonambulatory child;
 - g. Instrumentation injury with risk of impairment; or
 - h. Immersion burns;
 3. A child requires immediate medical treatment for a life-threatening medical condition or a condition likely to result in impairment of bodily functions or disfigurement, and the child's caregiver is not willing or able to obtain treatment;
 4. A child is suffering from nutritional deprivation that has resulted in malnourishment or dehydration to the extent that the child is at risk of death or permanent physical impairment;
 5. A doctor or psychologist determines that a child's caregiver is unable or unwilling to provide minimally adequate care;
 6. The physical or mental condition of a child's caregiver endangers a child's health or safety, such as a caregiver who:
 - a. Exhibits psychotic behavior and fails to take prescribed medications,
 - b. Suffers from a deteriorating physical condition or illness, or
 - c. Takes prescribed or nonprescribed drugs that result in a child being neglected;
 7. The home environment has conditions that endanger a child's health or safety, such as human or animal feces, undisposed-of garbage, exposed wiring, access to dangerous objects, or harmful substances that present a substantial risk of harm to the child;
 8. A doctor or psychologist has determined that:
 - a. A child's caregiver has emotionally damaged the child;
 - b. The child is exhibiting severe anxiety, depression, withdrawal, or aggressive behavior due to the emotional damage; and
 - c. The caregiver is unwilling or unable to seek treatment for the child; or
 9. A CPS Specialist has probable cause to believe that a caregiver has engaged in sexual conduct with a child or has allowed the child to participate in sexual activity with others.
- C.** In situations not listed in subsection (B), a CPS specialist shall determine the risk of imminent harm and need for removal by:

1. Doing a family assessment to identify family strengths and risk factors; and
2. Evaluating all facts and circumstances surrounding a child and family situation, including the following:
 - a. Whether a law enforcement official or medical professional expresses concern about risk to the child victim if the child victim returns to or remains in the home;
 - b. The alleged abuser's behavior towards the child victim;
 - c. Other adults in the household's behavior towards the child victim;
 - d. Whether the child victim resides with a parent or other adult who is willing and able to protect the child;
 - e. The conditions of the home environment and whether those conditions threaten the child victim's safety or physical health;
 - f. Whether there has been a pattern of maltreatment, particularly a pattern of incidents of increasing severity;
 - g. The nature and severity of the alleged maltreatment;
 - h. Whether DES is able to provide services to the child or family to alleviate conditions or problems that pose a risk of maltreatment, without the need for removal;
 - i. Whether the child's caregiver refuses access to a child or declined an offer of in-home services;
 - j. The family's strengths and risk factors;
 - k. The child's current physical and mental condition; and
 - l. Whether the child victim has injuries that require immediate medical treatment.

Historical Note

Former Section R6-5-5512 repealed effective December 8, 1983 (Supp. 83-6). New Section adopted by final rulemaking at 5 A.A.R. 444, effective January 15, 1999 (Supp. 99-1).

R6-5-5513. Alternatives to Involuntary Removal; Voluntary Placement; Removal

- A.** Before removing a child from home without the consent of the child's caregiver, CPS shall consider whether:
 1. CPS may help the family obtain resources such as emergency food, shelter, clothing, or utilities, so that the child can safely remain in the home;
 2. CPS may enter into an agreement with the child's caregivers that provides for the alleged abuser to leave the home and for remaining family members to protect the child;
 3. The caregiver identifies a relative or friend who can temporarily care for the child without court intervention or orders;
 4. CPS may help the protective caregiver and the child leave the home of the alleged abuser;
 5. CPS may place the child in voluntary foster care under A.R.S. § 8-806.
- B.** If a child is at risk of imminent harm and the alternative methods identified in subsection (A) will not eliminate the risk of harm, CPS shall take temporary custody of the child as provided in A.R.S. § 8-821.
- C.** CPS shall document the placement alternatives considered and the reasons for not selecting the options listed in subsection (A).

Historical Note

Former Section R6-5-5513 repealed effective December 8, 1983 (Supp. 83-6). New Section adopted by final rulemaking at 5 A.A.R. 444, effective January 15, 1999 (Supp. 99-1).

R6-5-5514. Removal Review

- A. Under A.R.S. § 8-822(3), within 48 hours of removing a child and before filing a dependency petition, CPS shall have a removal review team assess alternatives to continued out-of-home placement and the need for CPS to file a dependency petition.
- B. The removal review team shall include the CPS specialist who conducted the investigation and removed the child and the CPS specialist's supervisor. The removal review team shall also include at least one other qualified professional such as a psychologist or counselor.
- C. The removal review team shall consider the factors listed in R6-5-5512 and R6-5-5513(A) to determine whether to return a child, pursue a voluntary placement option, or file a dependency petition.
- D. The team shall document, in the child's case record, alternatives considered and the reason for the action taken.
- E. Within 48 hours of removing a child, DES shall either file a dependency petition or return the child, as required by A.R.S. § 8-821.

Historical Note

Former Section R6-5-5514 repealed effective December 8, 1983 (Supp. 83-6). New Section adopted by final rulemaking at 5 A.A.R. 444, effective January 15, 1999 (Supp. 99-1).

R6-5-5515. Procedures for Investigations of Maltreatment in a Licensed Child Welfare Agency

- A. Before CPS investigates an allegation of maltreatment in a licensed child welfare agency ("agency"), the CPS Specialist shall advise the agency's chief executive officer, or that person's designee, of the following:
 1. The nature of the allegation,
 2. How CPS will conduct the investigation,
 3. The names of the agency staff members and children that the CPS Specialist plans to interview, and
 4. The rights listed in subsection (C).
- B. Notwithstanding subsection (A), CPS may conduct an unannounced investigation if:
 1. The agency's chief executive officer is the subject of a maltreatment allegation, or
 2. Prior notice of the investigation may jeopardize the safety of a child in the agency's care.
- C. When CPS investigates an allegation of maltreatment at an agency, the agency may:
 1. Seek legal counsel at any time during the investigation;
 2. Present information about the allegation before CPS issues a finding; and
 3. Receive:
 - a. An oral status report on the progress of an investigation not completed within 21 days,
 - b. A copy of the report with personally identifiable information redacted, and
 - c. Written notice of the investigation finding.
- D. The Department shall document the investigation and findings in an agency's licensing file.

Historical Note

Former Section R6-5-5515 repealed effective December 8, 1983 (Supp. 83-6). New Section adopted by final

rulemaking at 5 A.A.R. 444, effective January 15, 1999 (Supp. 99-1).

R6-5-5516. Procedures for Investigations of Out-of-Home Care Providers

- A. In this Section, an "out-of-home care provider" means:
 1. A child in the custody of the Department by court order or voluntary foster care under A.R.S. § 8-806 and placed with:
 - a. An unlicensed nonrelative,
 - b. An unlicensed relative,
 - c. A licensed family foster home,
 - d. A certified adoptive home; and
 2. A family child care home provider certified by the Department under A.R.S. § 46-807.
- B. A CPS Specialist shall notify the following of an investigation of an allegation of abuse or neglect by an out-of-home care provider:
 1. The parent or legal guardian of each child in the home,
 2. The case manager or supervisor for each child in the home,
 3. The attorney and guardian ad litem for each child in the home, and
 4. The provider's licensing or certification specialist.
- C. When CPS investigates an allegation of sexual abuse, a CPS Specialist shall audiotape or videotape all interviews.
- D. Unless a situation jeopardizes the safety of a child, a CPS Specialist shall consult with the following individuals before removing a child from an out-of-home care provider:
 1. The child's case manager or supervisor,
 2. The foster home licensing specialist or supervisor,
 3. The ACYF District Program Manager, and
 4. The Assistant Attorney General if the child is in the physical custody of the provider.
- E. CPS shall notify the parent or legal guardian of each child in the provider's care, the out-of-home care provider, and each child's case manager of the investigation findings.
- F. CPS shall hold a case conference in three days, if CPS intends to substantiate a report to discuss the investigation findings and to determine the Department's recommendations regarding licensing.
- G. An out-of-home care provider may bring a person representing the provider's interests to the case conference after waiving the provider's right to confidentiality.
- H. The Department shall document the investigation and findings in the case record.

Historical Note

Former Section R6-5-5516 repealed effective December 8, 1983 (Supp. 83-6). New Section adopted by final rulemaking at 5 A.A.R. 444, effective January 15, 1999 (Supp. 99-1).

R6-5-5517. Repealed**Historical Note**

Former Section R6-5-5517 repealed effective December 8, 1983 (Supp. 83-6).

R6-5-5518. Repealed**Historical Note**

Former Section R6-5-5518 repealed effective December 8, 1983 (Supp. 83-6).

R6-5-5519. Repealed**Historical Note**

Former Section R6-5-5519 repealed effective December 8, 1983 (Supp. 83-6).

R6-5-5520. Repealed**Historical Note**

Former Section R6-5-5520 repealed effective December 8, 1983 (Supp. 83-6).

R6-5-5521. Repealed**Historical Note**

Former Section R6-5-5521 repealed effective December 8, 1983 (Supp. 83-6).

R6-5-5522. Repealed**Historical Note**

Former Section R6-5-5522 repealed effective December 8, 1983 (Supp. 83-6).

R6-5-5523. Repealed**Historical Note**

Former Section R6-5-5523 repealed effective December 8, 1983 (Supp. 83-6).

R6-5-5524. Repealed**Historical Note**

Former Section R6-5-5524 repealed effective December 8, 1983 (Supp. 83-6).

R6-5-5525. Repealed**Historical Note**

Former Section R6-5-5525 repealed effective December 8, 1983 (Supp. 83-6).

R6-5-5526. Repealed**Historical Note**

Former Section R6-5-5526 repealed effective December 8, 1983 (Supp. 83-6).

Appendix 1. Pre-screening Cue Questions

1. May I have your name, phone number, and relationship to the child? (Assure the reporting source he or she can remain anonymous. Explain that CPS will not be able to contact him/her for additional information without a name and phone number.)
2. What is your concern about the child? How old is the child?
3. What is the family's home address? Does the child live there? If not, where can we locate the child, that is, school, day care, relative? Who is living in the home?
4. Do you know who abused or neglected the child? If so, who? (This includes staff of a licensed or certified DES facility or foster or child care home or a licensed DHS Level I, II, or III Behavioral Health Treatment facility.) Do you know when he or she will see the child next?
5. Did the _____ (parent, guardian, or custodian) know about the abuse or neglect?
6. Is the _____ (parent, guardian, or custodian) letting the child see this person?

Historical Note

New Appendix 1 adopted by final rulemaking at 5 A.A.R. 444, effective January 15, 1999 (Supp. 99-1).

Appendix 2. Cue Questions

IF IT IS DETERMINED TO HAVE ALL OF THE ELEMENTS OF A REPORT FOR FIELD INVESTIGATION (that is, a child victim, maltreatment by a parent, guardian, or custodian, and the child can be located), CHECK CPSCR AND GATHER REPORT DEMOGRAPHICS.

Include the address of the child, the name of the apartment complex, trailer park, and directions as needed.

PHYSICAL ABUSE CUE QUESTIONS:

1. Describe the injury (size, shape, color, and location).
2. Do you know when the injury occurred? Has abuse occurred before? How often does the abuse occur?
3. Did the child say what happened?
4. Do you know if the child was seen by a medical doctor? If so, what is the name and phone number of the doctor? If the source is a medical doctor, is the injury consistent with the explanation?

If the call concerns a licensed or certified DES facility, foster or child care home, or a DHS Level I, II, or III Behavioral Health Treatment facility, ask:

5. Did the injury occur as a result of restraint?
6. What kind of restraint was used?
7. Why was the child restrained?
8. Will the staff person have contact with the child or other children in the facility?
9. Do you know the name of the licensing specialist? If so, what is the name and phone number?
10. Do you know the name of the child's case manager? If so, what is the name and phone number?

EMOTIONAL ABUSE CUE QUESTIONS:

1. Specifically, what is the person doing (to have the impact on the child)?
2. Have you noticed a change in the child's behavior?
3. What signs or behaviors is the child exhibiting?
4. Do you think the child's behavior is related to what the parent, guardian, or custodian is doing? If so, how?
5. Do you know if the child has seen a medical doctor, psychologist, or mental health professional? If so, what is the name and phone number? Do you know the diagnosis?

NEGLECT CUE QUESTIONS:**A. INADEQUATE SUPERVISION**

1. Is the child alone NOW? If yes, how long has the child been alone? Where is the person who is supposed to be watching the child? When will the person return? Have you called the police?
2. If the child is not alone, who is watching the child now? What are your concerns about the person who is watching the child?
3. Do you know how often and when this happens?
4. What happens when the child is alone or inadequately supervised?
5. Does this child know how to contact the parent, guardian, or custodian?
6. Does the child have emergency numbers and know how to use the phone?
7. Do you know if anyone is checking on the child? If so, what is the name and phone number? How often?

If the call concerns a licensed or certified DES facility, foster or child care home, or DHS Level I, II, or III Behavioral Health Treatment facility, ask:

8. What supervision was being provided at the time of the sexual conduct or physical injury between the children?
9. Did the facility or foster or child care home know that the child may physically or sexually assault another child?
10. Did the staff or foster or child care home person know that the child may physically or sexually assault another child?
11. What steps were being taken to prevent the child from assaulting other children?
12. What steps are being taken to restrict contact between the child and other children?
13. Do you know the name of the licensing specialist? If so, what is the name and phone number?
14. Do you know the name of the child's case manager? If so, what is the name and phone number?

B. SHELTER

1. When was the last time you saw the child or the home?
2. Describe any health or safety hazards where they live. Has anything happened to the child?
3. Do you know how long they have been in this situation?
4. Do you know why they live like this?

C. MEDICAL CARE

1. What are the child's symptoms?
2. Is the parent, guardian, or custodian aware of the problem?
3. Do you know when they last saw a medical doctor? Who was the medical doctor? If so, why?
4. Do you know the reasons the person is not getting medical care for the child?

If reporting source is a medical doctor or doctor's representative, ask only the following questions:

5. What is the medical or psychiatric condition or diagnosis of this child and when did it begin?
6. What medical care is needed?
7. What will happen if the child does not receive the medical care?
8. What are your concerns about the parent, guardian, or custodian response to the problem?

D. FOOD

1. What makes you believe the child is not getting enough food? Describe the physical condition of the child.
2. Do you know if someone else is feeding the child? If so, who?
3. When was the last time you saw the child or have you been in the home? If so, describe the food you saw.
4. Do you know if the child has seen a medical doctor? If so, what is the name and phone number?

E. CLOTHING

1. Describe what the child is wearing and the weather conditions.
2. What effect is it having on the child?

SEXUAL ABUSE CUE QUESTIONS:

1. Why do you think the child has been sexually abused or is at risk of sexual abuse (activities, physical signs, or behaviors)?
2. Who saw these activities, signs, or behaviors?
3. Has the child told anyone? If so, who and when?
4. What is the child saying about sexual abuse?
5. Do you know where and when this last occurred?
6. Do you know what contact this person has with the child?
7. Do you know if the child *has* seen a medical doctor? If so, what is the name and number?

ABANDONED CUE QUESTIONS:

1. Do you know where the parent is now?
2. When did the parent last have contact with the child?
3. When do you think the parent is coming back?
4. What arrangements did the parent make for care of this child?
5. How long are you able or willing to care for the child? Are there relatives available?
6. If so, what is the name, address, phone number?

DRUG-EXPOSED INFANTS CUE QUESTIONS:

1. Has the child or mother been tested? If so, what are the results?
2. What is the name of the medical doctor or hospital?
3. What is the parental history of drug use? (What drugs, when was last drug use, used during what trimester?)
4. What is the parental history of drug treatment?
5. Describe the medical and physical condition of the child?
 - a. Birth weight,
 - b. Gestational age,
 - c. Apgar score,
 - d. Prenatal care.

6. Have preparations been made in the home for the new baby?

NONSEXUAL EXPLOITATION CUE QUESTIONS:

1. Describe how the child is being exploited.
2. What reason was given for the exploitation?
3. How long has this been going on?

POTENTIAL ABUSE AND NEGLECT CUE QUESTIONS:

1. Describe behaviors (of the parent, guardian, custodian, or child) that give you reason to believe that abuse or neglect may occur.
2. Has abuse or neglect happened before? If so, when and where?
3. Has the _____ (parent, guardian, or custodian) expressed concerns about hurting or not being able to care for the child?

CLOSURE CUE QUESTIONS

1. Do you know what school or child care facility the child attends? If so, what is the name of the school or child care facility? Dismissal or pick-up time?
2. Has the child expressed concerns about going home? If so, what did the child say to you?
3. Has law enforcement been notified? DR or Badge number?
4. Does the child have any of these special needs or problems?
 - a. Abuse of drugs or alcohol,
 - b. Bizarre behavior,
 - c. Extremely angry or volatile,
 - d. Physically ill,
 - e. Mentally ill,
 - f. Language other than English.
5. Does the _____ (parent, guardian, or custodian) have any of these special needs or problems?
 - a. Abuse of drugs or alcohol,
 - b. Bizarre behavior,
 - c. Extremely angry or volatile,
 - d. Physically ill,
 - e. Mentally ill,
 - f. Language other than English.
6. Do you know if CPS or any other agency has been involved with this family?
7. If this report is assigned for field investigation, are there any issues we need to be aware of to ensure the worker's safety (guns, dogs)?

Historical Note

New Appendix 2 adopted by final rulemaking at 5 A.A.R. 444, effective January 15, 1999 (Supp. 99-1).

ARTICLE 56. CONFIDENTIALITY AND RELEASE OF CPS INFORMATION**R6-5-5601. Definitions**

The definitions contained in A.R.S. §§ 8-531, 8-201, 8-801, R6-5-5501, and the following definitions apply in this Article:

1. "Abuse" means the same as in A.R.S. § 8-201(2).
2. "CASA" or "Court Appointed Special Advocate" means a person appointed under A.R.S. § 8-522.
3. "Caregiver" means a child's parent, guardian, or custodian.
4. "Completed request" means a written communication to the program or a form provided by the Department asking for CPS information with all information filled in.
5. "Copying fee" means the final amount a requester is required to pay to the Department before the Department releases the requested CPS information.
6. "CPS" means Child Protective Services, a program within the Division of Children, Youth and Families (DCYF) to receive and investigate allegations of child

- abuse and neglect and provide protective services as described in A.R.S. § 8-801(4).
7. “CPS Information” means the same as in A.R.S. § 8-807(U)(1) and includes information contained in a hard copy or electronic case record, and both oral and written information.
 8. “DCYF” means the Division of Children, Youth and Families within the Department of Economic Security.
 9. “Department” means the Arizona Department of Economic Security, which is sometimes referred to as “DES” or “ADES.”
 10. “Estimated copying fee” means an amount a requester is required to pay to the Department before the Department copies and redacts requested CPS information.
 11. “FCRB” means the Foster Care Review Board established pursuant to A.R.S. § 8-515.01.
 12. “Neglect” means the same as in A.R.S. § 8-201(22).
 13. “Person that provides oversight” means those individuals, entities, or bodies described in A.R.S. § 8-807(H) and any other individual, entity or body as authorized by law.
 14. “Person who is the subject of CPS information” means a caregiver, child or other person identified in the CPS report.
 15. “Personally identifiable information” means information that specifically identifies a protected individual and includes:
 - a. Name;
 - b. Date of Birth;
 - c. Street address;
 - d. Telephone, fax number, or email address;
 - e. Photograph;
 - f. Fingerprints;
 - g. Physical description;
 - h. Place, address, and telephone number of employment;
 - i. Social security number;
 - j. Tribal affiliation and identification number;
 - k. Driver’s license number;
 - l. Auto license number;
 - m. Any other identifier that is specific to an individual; and
 - n. Any other information that would permit another person to readily identify the subject of the CPS information.
 16. “Protected individual” means a living person who is the subject of a CPS investigation and includes:
 - a. An alleged victim,
 - b. An alleged victim’s sibling,
 - c. A parent,
 - d. A foster parent,
 - e. A child living with the alleged victim,
 - f. The person who made the report of child abuse or neglect, and
 - g. Any person whose life or safety would be endangered by disclosure of CPS information.
 17. “Redacting” means striking or blacking out personally identifiable information contained in CPS hard copy or electronic case records on protected individuals so that no one can read the information.
 18. “Report” means an incoming communication containing an allegation that:
 - a. A child is the subject of abuse or neglect;
 - b. A parent, guardian or custodian inflicted, may inflict, permitted another person to inflict, or had reason to know another person may inflict such abuse or neglect; and
 - c. Contains sufficient information to locate the child.
 19. “Request” means a written communication for CPS information.
 20. “Requester” means an individual, entity, or body that has made a request for CPS information.
 21. “Research requester” means an individual or organization that seeks CPS information for a research or evaluation project.
 22. “Workday” means Monday through Friday excluding Arizona state holidays and mandatory furlough days.

Historical Note

Adopted effective July 6, 1976 (Supp. 76-4). Former Section R6-5-5601 repealed, new Section R6-5-5601 adopted effective January 13, 1977 (Supp. 77-1). R6-5-5601 recodified to A.A.C. R6-8-201 effective February 13, 1996 (Supp. 96-1). New Section adopted by final rulemaking at 5 A.A.R. 1804, effective May 18, 1999 (Supp. 99-2). Amended by final rulemaking at 18 A.A.R. 2708, effective December 2, 2012 (Supp. 12-4).

R6-5-5602. Scope and Application

- A. This Article governs requests for and release of CPS information made under A.R.S. § 8-807.
- B. CPS maintains information in accordance with federal laws under A.R.S. § 8-807.

Historical Note

Adopted effective July 6, 1976 (Supp. 76-4). Former Section R6-5-5602 repealed, new Section R6-5-5602 adopted effective January 13, 1977 (Supp. 77-1). R6-5-5602 recodified to A.A.C. R6-8-202 effective February 13, 1996 (Supp. 96-1). New Section adopted by final rulemaking at 5 A.A.R. 1804, effective May 18, 1999 (Supp. 99-2). Amended by final rulemaking at 18 A.A.R. 2708, effective December 2, 2012 (Supp. 12-4).

R6-5-5603. Procedures for Requesting CPS Information

- A. A person who wishes to obtain CPS information under A.R.S. § 8-807 shall comply with the requirements of this Section, and any applicable limitations and conditions in R6-5-5605 and R6-5-5607.
 1. This Section does not apply to a person or entity entitled to receive CPS information to:
 - a. Meet its duties to provide for the safety, permanency, and well-being of a child;
 - b. Provide services to the child or family to strengthen the family;
 - c. Enforce or prosecute violations of child abuse or neglect laws; or
 - d. Provide CPS information to a defendant as required by an order of the criminal court.
 2. This Section also does not apply to juvenile, domestic relations, family or conciliation courts, the parties or their attorneys in a dependency, guardianship, or termination of parental rights proceeding, the FCRB, a CASA, or a person that provides oversight.
- B. The requester shall send the Department a completed written request or use the form provided by the Department. The request shall include the following information:
 1. Requester’s name, address, and telephone number;
 2. Name of the child victim who is the subject of the CPS report, with as much of the following information as the requester can provide on the child victim:
 - a. Other possible spellings, names, or aliases for the child;
 - b. Date of birth;
 - c. The name of the child’s caregivers; and

- d. The date of the CPS report or time-frame for the report;
- 3. Any other data that the requester believes will be likely to assist the Department in identifying the CPS information requested, such as:
 - a. The name of the child's siblings;
 - b. The child's Social Security number;
 - c. The name of the CPS Specialist handling the case; and
 - d. The location of the alleged abuse or neglect.
- C. Before releasing CPS information under this Section, the Department shall determine that the person or entity requesting the CPS information is a person or entity entitled to receive the CPS information under this Article and A.R.S. § 8-807.

Historical Note

Adopted effective July 6, 1976 (Supp. 76-4). Former Section R6-5-5603 repealed, new Section R6-5-5603 adopted effective January 13, 1977 (Supp. 77-1). R6-5-5603 recodified to A.A.C. R6-8-203 effective February 13, 1996 (Supp. 96-1). New Section adopted by final rulemaking at 5 A.A.R. 1804, effective May 18, 1999 (Supp. 99-2). Amended by final rulemaking at 18 A.A.R. 2708, effective December 2, 2012 (Supp. 12-4).

R6-5-5604. Procedures for Processing a Request for CPS Information

- A. Upon receipt of a request for CPS information, the Department shall determine whether the request is complete. If the request is incomplete, the Department shall either:
 - 1. Return the request to the requester with a statement explaining the additional information the Department needs to process the request; or
 - 2. Contact the requester to obtain the missing information.
- B. Upon receipt of a completed request, the Department shall stamp the receipt date on the request. The receipt date is the day the Department receives the completed request.
- C. Within 30 workdays of the receipt date, the Department shall provide the requester with one of the following written responses:
 - 1. A statement that the requested CPS information does not exist;
 - 2. The requested CPS information;
 - 3. A statement that the Department cannot provide the requested CPS information within 30 workdays, the reason for the delay, and the anticipated time-frame for response; or
 - 4. A statement that the Department cannot release the requested CPS information, with the statutory citation and the reason for the denial.

Historical Note

Adopted effective July 6, 1976 (Supp. 76-4). Former Section R6-5-5604 repealed, new Section R6-5-5604 adopted effective January 13, 1977 (Supp. 77-1). R6-5-5604 recodified to A.A.C. R6-8-204 effective February 13, 1996 (Supp. 96-1). New Section adopted by final rulemaking at 5 A.A.R. 1804, effective May 18, 1999 (Supp. 99-2). Amended by final rulemaking at 18 A.A.R. 2708, effective December 2, 2012 (Supp. 12-4).

R6-5-5605. Procedures for Processing a Request for CPS Information from a Person or Entity Providing Services in Official Capacity

- A. The Department shall release CPS information without obtaining the fee required by R6-5-5610 when a person or entity entitled to receive CPS information requires information to:

- 1. Meet its duties to provide for the safety, permanency, and well-being of a child;
- 2. Provide services to the child or family to strengthen the family;
- 3. Enforce or prosecute a violation of child abuse or neglect laws;
- 4. Provide CPS information to a defendant as required by an order of the criminal court; or
- 5. Provide CPS information to:
 - a. A juvenile, domestic relations, family or conciliation court;
 - b. The parties or their attorneys in a dependency, guardianship, or termination of parental rights proceeding;
 - c. The FCRB;
 - d. A CASA; or
 - e. A person that provides oversight.

- B. Before releasing CPS information under this Section, the Department shall determine that the person requesting CPS information is a person entitled to receive CPS information under this Section and A.R.S. § 8-807.

Historical Note

Adopted effective July 6, 1976 (Supp. 76-4). Former Section R6-5-5604 renumbered as Section R6-5-5605 effective January 13, 1977 (Supp. 77-1). R6-5-5605 recodified to A.A.C. R6-8-205 effective February 13, 1996 (Supp. 96-1). New Section adopted by final rulemaking at 5 A.A.R. 1804, effective May 18, 1999 (Supp. 99-2). Amended by final rulemaking at 18 A.A.R. 2708, effective December 2, 2012 (Supp. 12-4).

R6-5-5606. Release of Summary CPS Information to a Person Who Reported Suspected Child Abuse and Neglect

- A. A person who reports alleged child abuse or neglect to CPS may contact CPS to obtain a summary of the outcome of the investigation, as permitted by A.R.S. § 8-807.
- B. After receiving a request and before releasing CPS information, the Department shall determine that the person requesting CPS information was the person who made the report as follows:
 - 1. Obtain the name and telephone number of the requester, and
 - 2. Compare the requester's name with the name of the person listed as the reporting source on the CPS report.
- C. After determining the identity of the requester, the Department shall call and advise the requester whether the Department has statutory authority to provide the requested CPS information.
- D. If the requester is entitled to receive the requested CPS information, CPS shall verbally provide the person a summary of the outcome with the following CPS information:
 - 1. Disposition of the report;
 - 2. Investigation findings, if available; and
 - 3. A general description of the services offered or provided to the child and family.

Historical Note

Adopted effective July 6, 1976 (Supp. 76-4). Former Section R6-5-5605 renumbered as Section R6-5-5606 effective January 13, 1977 (Supp. 77-1). R6-5-5606 recodified to A.A.C. R6-8-206 effective February 13, 1996 (Supp. 96-1). New Section adopted by final rulemaking at 5 A.A.R. 1804, effective May 18, 1999 (Supp. 99-2). Section R6-5-5606 repealed; new Section R6-5-5606 renumbered from R6-5-5607 and amended by final rulemaking at 18 A.A.R. 2708, effective December 2, 2012 (Supp. 12-4).

R6-5-5607. Release of CPS Information for a Research or Evaluation Project

- A. A person seeking CPS information for a research or evaluation project shall send a written request to the Department. A request shall include the following information:
1. If the person works for a research organization:
 - a. The name of the organization, and
 - b. The organization's mission;
 2. A description of the research or evaluation project, which explains how the results of the project will improve the child protection system;
 3. A description of the plan for maintaining the confidentiality of personally identifiable information and disseminating the results of the project; and
 4. The funding source for the research or evaluation project.
- B. Within 30 workdays of receipt of a completed request from a research requester, the Department shall:
1. Advise the requester whether the Department will provide the requested CPS information,
 2. Inform the requester of the estimated copying fee required under R6-5-5610, and
 3. Inform the requester of the expected time-frame for providing the requested CPS information.
- C. Upon receipt of the copying fee, the Department shall provide the requester with the requested CPS information.

Historical Note

Adopted effective July 6, 1976 (Supp. 76-4). Former Section R6-5-5606 renumbered as Section R6-5-5607 effective January 13, 1977 (Supp. 77-1). R6-5-5607 recodified to A.A.C. R6-8-207 effective February 13, 1996 (Supp. 96-1). New Section adopted by final rulemaking at 5 A.A.R. 1804, effective May 18, 1999 (Supp. 99-2). Section R6-5-5607 renumbered to R6-5-5606; new Section R6-5-5607 renumbered from R6-5-5608 and amended by final rulemaking at 18 A.A.R. 2708, effective December 2, 2012 (Supp. 12-4).

R6-5-5608. Release of CPS Information to a Legislator or Another Person that Provides Oversight

- A. A person that provides oversight of child protective services and seeks CPS information shall send a written request to the Department and include the following information:
1. The name of the person seeking the information;
 2. The purpose of the request and its relationship to the person's official duties; and
 3. The person's signature, or the signature of an authorized agent for an entity or other body, confirming that the person or authorized agent understands the CPS information shall not be further disclosed unless authorized by A.R.S. § 8-807.
- B. A legislator or committee of the legislature seeking CPS information to perform official duties shall send a written request to the presiding officer of the body of which the state legislator is a member and include the name of the person whose case record is to be reviewed and any other information that will assist the Department in locating the record. The legislator shall also sign the request, confirming that the legislator understands that the CPS information shall not be further disclosed unless authorized by A.R.S. § 8-807. The presiding officer shall forward the request to the Department within five workdays of receiving the request.
- C. The copying fee required under R6-5-5610 does not apply to this Section.
- D. Within 10 workdays of receiving the request, the Department shall provide the requester with one of the following written responses:

1. A statement that the requested CPS information does not exist;
2. The requested CPS information;
3. A statement that the Department cannot provide the requested CPS information within 10 workdays, the reason for the delay and the anticipated time-frame for response; or
4. A statement that the Department cannot provide the requested CPS information, with the statutory citation and the reason for denial.

Historical Note

Adopted effective July 6, 1976 (Supp. 76-4). Former Section R6-5-5607 renumbered as Section R6-5-5608 effective January 13, 1977 (Supp. 77-1). R6-5-5608 recodified to A.A.C. R6-8-208 effective February 13, 1996 (Supp. 96-1). New Section adopted by final rulemaking at 5 A.A.R. 1804, effective May 18, 1999 (Supp. 99-2). Section R6-5-5608 renumbered to R6-5-5607; new Section R6-5-5608 renumbered from R6-5-5609 and amended by final rulemaking at 18 A.A.R. 2708, effective December 2, 2012 (Supp. 12-4).

R6-5-5609. Release of CPS Information in a Case of Child Abuse, Abandonment, or Neglect that has Resulted in a Fatality or Near Fatality

- A. A person who requests CPS information under A.R.S. § 8-807 concerning a case of child abuse, abandonment, or neglect that resulted in a fatality or near fatality, shall send a written request to the Department.
- B. Upon receipt of the request, the Department shall stamp the receipt date on the request and begin gathering the requested CPS information.
- C. The Department shall notify the requester in writing of the estimated copying fee. If the requester does not want to proceed, the requester shall notify the Department within 72 hours to cancel the request. If this notification is oral, the requester shall confirm the cancellation in writing.
- D. The requester shall pay the estimated copying fee before the Department copies any CPS information.
- E. After receipt of the final copying fee, the Department shall provide CPS information consistent with A.R.S. § 8-807.

Historical Note

Adopted effective July 6, 1976 (Supp. 76-4). Former Section R6-5-5608 renumbered as Section R6-5-5609 effective January 13, 1977 (Supp. 77-1). R6-5-5609 recodified to A.A.C. R6-8-209 effective February 13, 1996 (Supp. 96-1). New Section adopted by final rulemaking at 5 A.A.R. 1804, effective May 18, 1999 (Supp. 99-2). Section R6-5-5609 renumbered to R6-5-5608; new Section R6-5-5609 renumbered from R6-5-5610 and amended by final rulemaking at 18 A.A.R. 2708, effective December 2, 2012 (Supp. 12-4).

R6-5-5610. Fees

- A. If the Department determines a request for CPS information will result in a copying fee, the Department shall notify the requester of the estimated fee before copying any CPS information.
- B. Unless otherwise exempted by this Chapter, the Department shall charge a copying fee at the current rate set by the Department, as provided on the DES website at <http://www.azdes.gov>.
- C. The copying fee applies to both paper and electronic copies. If the CPS information does not already exist in an electronic format, additional fees that reflect the actual cost of conver-

sion will apply to copy the CPS information to an electronic format.

- D. The Department shall notify the requester in writing of the final copying fee.
- E. The Department shall reimburse the requester if final copying costs are less than the estimated copying fee.

Historical Note

Adopted effective July 6, 1976 (Supp. 76-4). Former Section R6-5-5609 renumbered as Section R6-5-5610 effective January 13, 1977 (Supp. 77-1). R6-5-5610 recodified to A.A.C. R6-8-210 effective February 13, 1996 (Supp. 96-1). New Section adopted by final rulemaking at 5 A.A.R. 1804, effective May 18, 1999 (Supp. 99-2). Section R6-5-5610 renumbered to R6-5-5609; new Section R6-5-5610 renumbered from R6-5-5612 and amended by final rulemaking at 18 A.A.R. 2708, effective December 2, 2012 (Supp. 12-4).

R6-5-5611. Repealed

Historical Note

Adopted effective July 6, 1976 (Supp. 76-4). Former Section R6-5-5610 renumbered as Section R6-5-5611 effective January 13, 1977 (Supp. 77-1). R6-5-5611 recodified to A.A.C. R6-8-211 effective February 13, 1996 (Supp. 96-1). New Section adopted by final rulemaking at 5 A.A.R. 1804, effective May 18, 1999 (Supp. 99-2). Section heading corrected at request of the Department, Office File No. M12-330, filed September 4, 2012 (Supp. 12-2). Repealed by final rulemaking at 18 A.A.R. 2708, effective December 2, 2012 (Supp. 12-4).

R6-5-5612. Renumbered

Historical Note

Adopted effective July 6, 1976 (Supp. 76-4). Former Section R6-5-5611 renumbered as Section R6-5-5612 effective January 13, 1977 (Supp. 77-1). R6-5-5612 recodified to A.A.C. R6-8-212 effective February 13, 1996 (Supp. 96-1). New Section adopted by final rulemaking at 5 A.A.R. 1804, effective May 18, 1999 (Supp. 99-2). R6-5-5612 renumbered to R6-5-5610 by final rulemaking at 18 A.A.R. 2708, effective December 2, 2012 (Supp. 12-4).

R6-5-5613. Recodified

Historical Note

Adopted effective July 6, 1976 (Supp. 76-4). Former Section R6-5-5612 renumbered as Section R6-5-5613 effective January 13, 1977 (Supp. 77-1). R6-5-5613 recodified to A.A.C. R6-8-213 effective February 13, 1996 (Supp. 96-1).

R6-5-5614. Recodified

Historical Note

Adopted effective July 6, 1976 (Supp. 76-4). Former Section R6-5-5613 renumbered as Section R6-5-5614 effective January 13, 1977 (Supp. 77-1). R6-5-5614 recodified to A.A.C. R6-8-214 effective February 13, 1996 (Supp. 96-1).

R6-5-5615. Recodified

Historical Note

Adopted effective July 6, 1976 (Supp. 76-4). Former Section R6-5-5614 renumbered as Section R6-5-5615 effective January 13, 1977 (Supp. 77-1). R6-5-5615 recodified to A.A.C. R6-8-215 effective February 13, 1996 (Supp. 96-1).

96-1).

R6-5-5616. Recodified

Historical Note

Adopted effective July 6, 1976 (Supp. 76-4). Former Section R6-5-5615 renumbered as Section R6-5-5616 effective January 13, 1977 (Supp. 77-1). R6-5-5616 recodified to A.A.C. R6-8-216 effective February 13, 1996 (Supp. 96-1).

R6-5-5617. Recodified

Historical Note

Adopted effective July 6, 1976 (Supp. 76-4). Former Section R6-5-5616 renumbered as Section R6-5-5617 effective January 13, 1977 (Supp. 77-1). R6-5-5617 recodified to A.A.C. R6-8-217 effective February 13, 1996 (Supp. 96-1).

R6-5-5618. Recodified

Historical Note

Adopted effective July 6, 1976 (Supp. 76-4). Former Section R6-5-5617 renumbered as Section R6-5-5618 effective January 13, 1977 (Supp. 77-1). R6-5-5618 recodified to A.A.C. R6-8-218 effective February 13, 1996 (Supp. 96-1).

R6-5-5619. Recodified

Historical Note

Adopted effective July 6, 1976 (Supp. 76-4). Former Section R6-5-5618 renumbered as Section R6-5-5619 effective January 13, 1977 (Supp. 77-1). R6-5-5619 recodified to A.A.C. R6-8-219 effective February 13, 1996 (Supp. 96-1).

R6-5-5620. Recodified

Historical Note

Adopted effective July 6, 1976 (Supp. 76-4). Former Section R6-5-5619 renumbered as Section R6-5-5620 effective January 13, 1977 (Supp. 77-1). R6-5-5620 recodified to A.A.C. R6-8-220 effective February 13, 1996 (Supp. 96-1).

R6-5-5621. Recodified

Historical Note

Adopted effective July 6, 1976 (Supp. 76-4). Former Section R6-5-5620 renumbered as Section R6-5-5621 effective January 13, 1977 (Supp. 77-1). R6-5-5621 recodified to A.A.C. R6-8-221 effective February 13, 1996 (Supp. 96-1).

R6-5-5622. Recodified

Historical Note

Adopted effective July 6, 1976 (Supp. 76-4). Former Section R6-5-5621 renumbered as Section R6-5-5622 effective January 13, 1977 (Supp. 77-1). R6-5-5622 recodified to A.A.C. R6-8-222 effective February 13, 1996 (Supp. 96-1).

R6-5-5623. Recodified

Historical Note

Adopted effective July 6, 1976 (Supp. 76-4). Former Section R6-5-5622 renumbered as Section R6-5-5623 effective January 13, 1977 (Supp. 77-1). R6-5-5623 recodified to A.A.C. R6-8-223 effective February 13, 1996 (Supp. 96-1).

R6-5-5624. Recodified**Historical Note**

Adopted effective July 6, 1976 (Supp. 76-4). Former Section R6-5-5623 renumbered as Section R6-5-5624 effective January 13, 1977 (Supp. 77-1). R6-5-5624 recodified to A.A.C. R6-8-224 effective February 13, 1996 (Supp. 96-1).

ARTICLE 57. REPEALED**R6-5-5701. Repealed****Historical Note**

Adopted effective September 16, 1976 (Supp. 76-4). Former Section R6-5-5701 repealed, new Section R6-5-5701 adopted effective November 5, 1984 (Supp. 84-6).
Repealed effective April 9, 1998 (Supp. 98-2).

R6-5-5702. Repealed**Historical Note**

Adopted effective September 16, 1976 (Supp. 76-4). Former Section R6-5-5702 repealed, new Section R6-5-5702 adopted effective November 5, 1984 (Supp. 84-6).
Repealed effective April 9, 1998 (Supp. 98-2).

R6-5-5703. Repealed**Historical Note**

Adopted effective September 16, 1976 (Supp. 76-4). Former Section R6-5-5703 repealed, new Section R6-5-5703 adopted effective November 5, 1984 (Supp. 84-6).
Repealed effective April 9, 1998 (Supp. 98-2).

R6-5-5704. Repealed**Historical Note**

Adopted effective September 16, 1976 (Supp. 76-4). Former Section R6-5-5704 repealed, new Section R6-5-5704 adopted effective November 5, 1984 (Supp. 84-6).
Repealed effective April 9, 1998 (Supp. 98-2).

R6-5-5705. Repealed**Historical Note**

Adopted effective September 16, 1976 (Supp. 76-4). Former Section R6-5-5705 repealed, new Section R6-5-5705 adopted effective November 5, 1984 (Supp. 84-6).
Repealed effective April 9, 1998 (Supp. 98-2).

R6-5-5706. Repealed**Historical Note**

Adopted effective September 16, 1976 (Supp. 76-4). Former Section R6-5-5706 repealed, new Section R6-5-5706 adopted effective November 5, 1984 (Supp. 84-6).
Repealed effective April 9, 1998 (Supp. 98-2).

R6-5-5707. Repealed**Historical Note**

Adopted effective September 16, 1976 (Supp. 76-4). Former Section R6-5-5707 repealed, new Section R6-5-5707 adopted effective November 5, 1984 (Supp. 84-6).
Repealed effective April 9, 1998 (Supp. 98-2).

R6-5-5708. Repealed**Historical Note**

Adopted effective September 16, 1976 (Supp. 76-4). Former Section R6-5-5708 repealed, new Section R6-5-5708 adopted effective November 5, 1984 (Supp. 84-6).
Repealed effective April 9, 1998 (Supp. 98-2).

R6-5-5709. Repealed**Historical Note**

Adopted effective September 16, 1976 (Supp. 76-4). Former Section R6-5-5709 repealed, new Section R6-5-5709 adopted effective November 5, 1984 (Supp. 84-6).
Repealed effective April 9, 1998 (Supp. 98-2).

ARTICLE 58. FAMILY FOSTER PARENT LICENSING REQUIREMENTS**R6-5-5801. Definitions**

In addition to the definitions contained in A.R.S. §§ 8-201, 8-501, and 8-531, the following definitions apply in this Article:

1. "Abandonment" has the same meaning ascribed to "abandoned" in A.R.S. § 8-546(A)(1).
2. "Abuse" means the infliction or allowing physical injury, impairment of bodily function or disfigurement, or the infliction of or allowing another person to cause serious emotional damage as evidenced by severe anxiety, depression, withdrawal or untoward aggressive behavior and which emotional damage is diagnosed by a medical doctor or psychologist pursuant to section 8-223 and which is caused by the acts or omissions of an individual having care, [physical] custody and control of a child. Abuse shall include inflicting or allowing sexual abuse pursuant to section 13-1404, sexual conduct with a minor pursuant to section 13-1405, sexual assault pursuant to section 13-1406, molestation of a child pursuant to section 13-1410, commercial sexual exploitation of a minor pursuant to section 13-3552, sexual exploitation of a minor pursuant to section 13-3553, incest pursuant to section 13-3608 or child prostitution pursuant to section 13-3212. A.R.S. § 8-546(A)(2).
3. "Adult" means a person age 18 years or older.
4. "Applicant" means a person who submits a written application to the Licensing Authority or a licensing agency to become licensed, or to renew a license as a foster parent. An applicant means both spouses if the adult household caregivers are married, except for a person seeking licensure solely as an in-home respite foster parent.
5. "Case plan" means a written document which is a distinct part of a child's case record, and which identifies the child's permanency goal and target date, desired outcomes, tasks, time-frames, and responsible parties.
6. "Child placing agency" or "placing agency" means:
 - a. The Department, a county probation Department, or the Administrative Office of the Arizona Supreme Court, which are all statutorily authorized to place children into out-of-home care; and
 - b. Any other person or entity authorized to receive children for care, maintenance, or placement in a foster home because the Department has licensed the person or entity as a child welfare agency pursuant to A.R.S. § 8-505.
7. "Corrective action" means a plan that describes steps a foster parent must take to remedy violations of foster care requirements within a specified period of time.
8. "CPS" means Child Protective Services, a Department program responsible for investigating reports of child maltreatment.
9. "CPSCR" means the Child Protective Services Central Registry, a computerized database, which CPS maintains pursuant to A.R.S. § 8-546.03.
10. "Department" or "DES" means the Department of Economic Security.
11. "Developmentally appropriate" means an action which takes into account:

- a. A child's age and family background;
 - b. The predictable changes that occur in a child's physical, emotional, social, cultural, and cognitive development; and
 - c. A child's individual pattern and timing of growth, personality, and learning style.
12. "De-escalation" means a method of verbal communication or non-verbal signals and actions, or a combination of signals and actions, that interrupts a child's behavior crisis and calms the child.
 13. "DHS" means the Department of Health Services.
 14. "Discipline" means a teaching process through which a child learns to develop and maintain the self-control, self-reliance, self-esteem, and orderly conduct necessary to assume responsibilities, make daily living decisions, and live according to generally accepted levels of social behavior.
 15. "Exploitation" means the act of taking advantage of, or making use of a child selfishly, unethically, or unjustly for one's own advantage or profit, in a manner contrary to the best interests of the child, such as having a child panhandle, steal, or perform other illegal activities.
 16. "Foster care requirements" mean the standards for lawful operation of a foster home as prescribed in A.R.S. § 8-501 et seq. and 6 A.A.C. 5, Article 58.
 17. "Household" means a group of people who regularly occupy a single residence.
 18. "Household member" means a person who resides in an applicant's or foster parent's household for 21 consecutive days or longer, or who resides in the household periodically throughout the year for more than a total of 21 days.
 19. "In-home respite foster parent" means an individual licensed to provide respite care in a licensed family foster home that is not that individual's own home.
 20. "License" means a document issued by the Licensing Authority to a foster parent which authorizes the foster parent to operate a foster home in compliance with foster care requirements.
 21. "Licensed medical practitioner" means a person who holds a current license or certification as a physician, surgeon, nurse practitioner or physician's assistant pursuant to A.R.S. §§ 32-1401 et seq., Medicine and Surgery; §§ 32-1800 et seq., Osteopathic Physicians and Surgeons; §§ 32-2501 et seq., Physician's Assistant; and A.R.S. §§ 32-1601 et seq. Nursing and A.A.C. R4-19-503, Registered Nurse Practitioner.
 22. "Licensing agency" means a person who or an entity which performs an investigative family study of an applicant for an initial or renewal foster home license, as prescribed in R6-5-5803 and R6-5-5812, and which monitors the foster home, as prescribed in R6-5-5815. "Licensing agency" includes the Department and may include county probation departments.
 23. "Licensing Authority" means a DES administrative unit which makes foster home licensing determinations, including issuance, denial, suspension, revocation, and imposition of corrective action.
 24. "Maltreatment" means abuse, neglect, exploitation, or abandonment, of a child.
 25. "Mechanical restraint" means:
 - a. An article, device, or garment that:
 - i. Restricts a child's freedom of movement or a portion of a child's body;
 - ii. Cannot be removed by the child; and
 - iii. Is used for the purpose of limiting the child's mobility;
 - b. But does not include an orthopedic, surgical, or medical device which allows a child to heal from a medical condition or to participate in a treatment program.
 26. "Neglect" has the same meaning ascribed to it in A.R.S. § 8-546(A)(7).
 27. "Parent or parents" means the natural or adoptive parents of the child. A.R.S. § 8-501(A)(8).
 28. "Physical restraint" means the use of bodily force to restrict a child's freedom of movement, but does not include the firm but gentle holding of a child with no more force than necessary to protect the child or others from harm.
 29. "Professional foster care" means a foster family based model of care provided by an individual who has received specialized training to provide care and services within a support system of clinical and consultative services to special care children.
 30. "Professional foster home" means the licensed foster home of an individual or couple authorized to provide professional foster care.
 31. "Receiving foster home" means a licensed foster home suitable for immediate placement of children when taken into custody or pending medical examination and court disposition. A.R.S. § 8-501(A)(9).
 32. "Respite care" means the provision of short term care and supervision of a foster child to temporarily relieve a foster parent from the duty to care for the child.
 33. "Respite foster parent" means a licensed foster parent authorized to provide respite care.
 34. "Safeguard" means to take reasonable measures to eliminate the risk of harm to a foster child and to ensure that a foster child will not be harmed by a particular object, substance, or activity. Where a specific method is not otherwise prescribed in this Article, safeguarding may include:
 - a. Locking up a particular substance or item;
 - b. Putting a substance or item out of the reach of a child who is not mobile; or
 - c. Erecting a barrier which prevents a child from reaching a particular place, item, or substance;
 - d. Mandating the use of protective safety devices; or
 - e. Providing supervision.
 35. "Service team" means the group of persons listed in R6-5-5828(A) who participate in the development and review of a child's case plan.
 36. "Significant person" means a person who is important or influential in a child's life and may include a family member or close friend.
 37. "Sleeping area" means a single bedroom or a cluster of two or more bedrooms located in an adjacent area of a dwelling.
 38. "Special care child" means a foster child who has not achieved expected norms for the child's developmental stage in one or more of the following areas: physical, medical, mental, psychological, intellectual, emotional, and social. This includes a child who experiences difficulty in establishing or maintaining developmentally appropriate interpersonal relationships.
 39. "Swimming pool" means any natural or man-made body of water used for swimming, recreational, or decorative purposes, which is greater than 12 inches in depth, and includes spas and hot tubs.
 40. "Work day" means Monday through Friday between 8:00 a.m. and 5:00 p.m., excluding Arizona state holidays.

Historical Note

Adopted effective March 30, 1977 (Supp. 77-2). Former Section R6-5-5801 repealed, new Section R6-5-5801 adopted effective April 1, 1981 (Supp. 81-2). Former Section R6-5-5801 repealed, new Section R6-5-5801 adopted effective January 10, 1997 (Supp. 97-1).

R6-5-5802. Application for Initial License

- A.** A person who wishes to become licensed as a foster parent shall apply to a licensing agency on a form specified by the licensing agency.
- B.** An applicant shall provide the licensing agency with at least the following information on each applicant:
 1. Personally identifying information, including:
 - a. Name,
 - b. Date of birth,
 - c. Social Security number,
 - d. Ethnicity,
 - e. Telephone number,
 - f. Current address,
 - g. Length of Arizona residency, and
 - h. Current marital status and marital history;
 2. Personally identifying information on the applicant's household members, including:
 - a. Name,
 - b. Date of birth,
 - c. Social Security number, and
 - d. Relationship to applicant;
 3. Personally identifying information on the applicant's children who do not live with the applicant, including emancipated children, as follows:
 - a. Name,
 - b. Current address,
 - c. Telephone number, and
 - d. Date of birth;
 4. The applicant's monthly or yearly household budget, showing assets, obligations, debts, and income;
 5. Medical statements for the applicant and any adult household member who will regularly care for foster children, showing that the applicant and household member meet the requirements prescribed in R6-5-5823(4); the statement shall:
 - a. Include a description of the person's general health, and identify any medical problem or physical condition that will prevent or limit the person from caring for a foster child, or that may negatively impact a foster child;
 - b. Include a list of all regularly prescribed medications and the purpose of each medication; and
 - c. Be signed and dated by a licensed medical practitioner who shall have examined the person within six months prior to the date of application for licensure;
 6. Immunization records for each child household member;
 7. A current statement and history of physical and mental health and treatment on the applicant and the applicant's household members, to the extent that such information has not already been provided in response to subsections (B)(5) and (6); the statement and history may be a self-declaration of illness and treatment;
 8. Employment information, including names and addresses of prior employers and positions held during the last 10 years;
 9. Family relationship and support system information on the applicant's family and family of origin;
 10. If the applicant is employed outside the home, the applicant shall provide a statement explaining the child care arrangements the applicant would make for a foster child during the applicant's working hours;
 11. If the applicant is self employed, or conducts a business activity within the home, a statement explaining how the activities related to this business will not interfere with the care of a foster child;
 12. A description of:
 - a. The applicant's daily routine and activities; and
 - b. The applicant's hobbies, and any education or volunteer activities in which the applicant regularly participates;
 13. A description of any spiritual or religious beliefs and practices observed in the applicant's home;
 14. Information on administrative or judicial proceedings in which the applicant has been or is a party, including:
 - a. Proceedings involving allegations of child maltreatment;
 - b. Dependency actions;
 - c. Actions involving severance or termination of parental rights;
 - d. Child support enforcement proceedings;
 - e. Adoption proceedings;
 - f. Criminal proceedings other than minor traffic violations;
 - g. Bankruptcy; and
 - h. Suspension, revocation, or denial of a license or certification;
 15. The name, address, and telephone number of at least five references who can attest to the applicant's character and ability to care for children; no more than two of the references may be related to the applicant by blood or marriage; for married applicants, at least two of the five references shall know the applicants as a couple;
 16. A description of the applicant's home and neighborhood;
 17. A statement from the applicant as to:
 - a. The number of foster children the applicant would consider for placement; and
 - b. The characteristics of foster children the applicant would consider for placement; and
 - c. The characteristics of children, if any, for whom the applicant does not want to provide foster care;
 18. A description of the applicant's prior experience, if any, as a foster parent, including:
 - a. The state in which the applicant provided foster care;
 - b. Whether the applicant was licensed, certified, or approved to provide care; and
 - c. Whether any disciplinary action was taken against the applicant;
 19. A description of the applicant's prior history of adoption certification, if any, including prior applications for certification, and the location and date of any certification denials;
 20. A description of the applicant's child care experience and child rearing practices;
 21. A statement from the applicant regarding the applicant's motivation for becoming a foster parent;
 22. A statement from the applicant describing how all other household members feel about the decision to foster children;
 23. A statement authorizing the licensing agency and the Licensing Authority to:
 - a. Verify the information contained in or filed with the application;

- b. Perform background checks on the applicant and the applicant's household members, as prescribed in R6-5-5803 and R6-5-5807; and
 - c. Arrange for DHS to conduct a health and safety inspection of the applicant's home, as prescribed in A.R.S. § 8-504 and R6-5-5804;
- 24. A statement from the applicant attesting to the truth of the information contained in the application; and
- 25. The applicant's signature and date of application.
- C. The applicant and all adult household members shall also submit to fingerprinting and a criminal history check as prescribed in A.R.S. § 46-141 and this subsection.
 - 1. On a form provided by the Department, the applicant and each adult household member shall certify whether he or she has ever committed, is awaiting trial for, or has ever been convicted of any of the following criminal offenses in this state or similar offenses in another state or jurisdiction:
 - a. Sexual abuse of a minor or vulnerable adult;
 - b. Incest;
 - c. First or second degree murder;
 - d. Kidnapping;
 - e. Arson;
 - f. Sexual assault;
 - g. Sexual exploitation of a minor or vulnerable adult;
 - h. Commercial sexual exploitation of a minor or vulnerable adult;
 - i. Felony offenses within the previous 10 years involving the manufacture or distribution of marijuana or dangerous or narcotic drugs;
 - j. Robbery;
 - k. A dangerous crime against children as defined in A.R.S. § 13-604.01;
 - l. Child abuse or abuse of a vulnerable adult;
 - m. Sexual conduct with a minor;
 - n. Molestation of a child or vulnerable adult;
 - o. Voluntary manslaughter; and
 - p. Aggravated assault.
 - 2. On a form provided by the Department, the applicant and each adult household member shall certify whether he or she has ever been convicted of, found by a court to have committed, or has committed, any of the following criminal offenses in this state or similar offenses in another state or jurisdiction:
 - a. A sex offense;
 - b. A drug-related offense;
 - c. A theft-related offense;
 - d. A violence-related offense;
 - e. Child neglect or neglect of a vulnerable adult; and
 - f. Contributing to the delinquency of a minor.
- D. If an applicant applies to the Department as the licensing agency, the Department shall send the applicant a notice of administrative completeness or deficiencies, as prescribed by A.R.S. § 41-1074, indicating the additional information, if any, that the applicant must provide for a complete application package as described in R6-5-5806. The Department shall send the notice after receiving the application and before expiration of the administrative completeness review time-frame described in R6-5-5813(2)(a).
- E. If the applicant does not supply the missing information, as prescribed in the notice, within 60 days of the notice date, the Department may close the file. An applicant whose file has been closed, who later wishes to become licensed, may reapply.

Historical Note

Adopted effective March 30, 1977 (Supp. 77-2). Former Section R6-5-5802 repealed, new Section R6-5-5802 adopted effective April 1, 1981 (Supp. 81-2). Former Section R6-5-5802 repealed, new Section R6-5-5802 adopted effective January 10, 1997 (Supp. 97-1).

R6-5-5803. Investigation of the Applicant

- A. The licensing agency to which the applicant has applied shall investigate the applicant. Except as otherwise provided in subsection (E) for an in-home respite foster parent, the investigation shall include the measures listed in this Section.
 - 1. A representative of the licensing agency shall personally interview the applicant and the applicant's household members; the interviews shall:
 - a. Occur on at least two separate occasions, at least one of which shall take place at the applicant's residence;
 - b. Comprise no less than four hours of face-to-face contact, at least one hour of which shall be at the applicant's residence;
 - c. Include at least one separate interview with each member of the applicant's household who is age 5 or older; and
 - d. Include at least one joint interview with both applicants if the applicants are married.
 - 2. During the interviews described in subsection (A)(1), the investigator shall explore any instances of family problems and how the applicant has overcome problems in the applicant's current family and family of origin.
 - 3. The licensing agency shall obtain written statements from at least three of the applicant's personal references listed under R6-5-5802(B)(15) and shall personally contact (either in a face-to-face meeting or a telephone call) at least one of the references.
 - 4. The licensing agency shall verify the applicant's financial condition through a review of one or more of the documents listed in subsection (B)(8).
 - 5. The licensing agency shall investigate and evaluate the applicant's past experiences, if any, serving as a foster parent.
 - 6. The licensing agency shall assess the applicant and the family's commitment to providing foster care, and the time available to devote to the care of a foster child.
- B. The licensing agency shall request, and the applicant shall provide, supporting documentation the licensing agency deems necessary to determine an applicant's fitness to serve as a foster parent and ability to comply with foster care requirements. The documentation may include the following:
 - 1. A physician's statement regarding the physical health or immunization record of the applicant's household members;
 - 2. A statement from a psychiatrist or psychologist regarding the mental health of the applicant or the applicant's household members;
 - 3. Birth certificate;
 - 4. Marriage license;
 - 5. Driver's license and automobile registration;
 - 6. Dissolution or divorce papers and orders, including child support documentation;
 - 7. Military discharge papers;
 - 8. Tax returns, pay stubs, W-2 statements, and existing financial statements;
 - 9. Bankruptcy papers;
 - 10. Insurance policy information;
 - 11. Immigration or legal residency registration papers; and

12. Documents related to or filed in judicial or administrative proceedings listed under R6-5-5802(B)(14).
- C. Except as otherwise provided in subsection (E), the licensing agency shall verify that the applicant and adult household members have submitted a fingerprinting and criminal background form as prescribed in R6-5-5802(C).
- D. The licensing agency shall document all personal contacts made, and all information obtained during the investigation.
- E. When a person is seeking licensure solely as an in-home respite foster parent, the licensing agency is not required to:
 1. Interview the applicant's spouse and other household members;
 2. Conduct the applicant's interview at the applicant's home;
 3. Verify the applicant's financial condition as required by subsection (A)(4) and R6-5-5805(B)(7);
 4. Obtain supporting documentation for the applicant's spouse or other household members as required by this Section; or
 5. Document information on the applicant's spouse and household members in the investigative report or application package as required by R6-5-5805 and R6-5-5806.

Historical Note

Adopted effective March 30, 1977 (Supp. 77-2).
 Amended effective August 15, 1979 (Supp. 79-4). Former Section R6-5-5803 repealed, new Section R6-5-5803 adopted effective April 1, 1981 (Supp. 81-2). Former Section R6-5-5803 repealed, new Section R6-5-5803 adopted effective January 10, 1997 (Supp. 97-1).

R6-5-5804. Inspection of the Foster Home; DHS Inspection Report

- A. The licensing agency shall contact the Department of Health Services (DHS) to request that a DHS representative:
 1. Inspect the foster home, as prescribed in A.R.S. § 8-504 and this Section; and
 2. Issue a report describing whether the foster home satisfies foster care requirements.
- B. The applicant shall cooperate with the DHS representative by making the home available for inspection and allowing the DHS representative unrestricted access to the entire foster home and the surrounding premises to perform the following checks on the systems, equipment, and conditions:
 1. Check the home's heating, cooling, ventilation and lighting systems, and major appliances;
 2. Look at furniture, fixtures, and equipment for evidence of loose hardware, rusting parts, and other damage;
 3. Check walls, ceilings, and floors for evidence of flaking paint or plaster, loose tiles, boards, and panels, and exposed or unsafe wiring that may pose a danger or health risk to a child;
 4. Check the home and surrounding premises for evidence of dirt, animal waste, and vermin;
 5. Check whether the sewage disposal system functions and is in good repair;
 6. Check the system, method, and timing for refuse and waste storage and removal;
 7. Check whether dangerous objects, materials, or conditions, have been locked, safeguarded, or removed as prescribed in this Article;
 8. Determine whether the home has the equipment and space prescribed in R6-5-5838 through R6-5-5846.
- C. The DHS representative shall prepare a written report of the inspection and send a copy to the licensing agency.
- D. To determine if a foster home and its surrounding premises are safe, sanitary, and in good repair, the licensing agency or

Licensing Authority shall evaluate the DHS written report to determine whether the home has any natural or man-made conditions that pose a risk of harm to a foster child, and whether a foster parent has taken or can take reasonable measures to eliminate that risk of harm and ensure that a foster child will not be harmed by a particular object, substance, or activity.

- E. This Section does not apply to a person seeking licensure solely as an in-home respite foster parent.

Historical Note

Adopted effective March 30, 1977 (Supp. 77-2). Former Section R6-5-5804 repealed, new Section R6-5-5804 adopted effective April 1, 1981 (Supp. 81-2). Former Section R6-5-5804 repealed, new Section R6-5-5804 adopted effective January 10, 1997 (Supp. 97-1).

R6-5-5805. Investigative Report and Licensing Recommendation

- A. The licensing agency shall summarize the results of the investigation in a written report, which shall include:
 1. A recommendation to grant or deny a license;
 2. Any recommendations for terms, conditions, or limitations to be placed on the license.
- B. In determining whether to recommend that a license be granted or denied, the licensing agency and Licensing Authority shall consider all information acquired during the investigation, and all factors bearing on the applicant's fitness to foster a child and comply with foster care requirements including:
 1. Instances of family problems in the applicant's current family or family of origin, including whether the applicant was maltreated as a child, and the applicant's success in overcoming those problems;
 2. The applicant's past history of parenting or caring for children;
 3. The length and stability of the applicant's marital relationship, if applicable;
 4. The applicant's age and health;
 5. Past, significant disturbances or events in the applicant's immediate family, such as involuntary job separation, bankruptcy, divorce, or death of spouse, child, or parent;
 6. Past criminal history or record of child maltreatment for the applicant or the applicant's household members;
 7. The applicant's financial stability, exclusive of anticipated foster care maintenance payments, and ability to financially provide for a foster child;
 8. The applicant's history of providing financial support to the applicant's other children, including compliance with court ordered child support obligations; and
 9. The DHS report on the foster home and whether the applicant has corrected any deficiencies or problems noted in the report.
- C. The investigative summary shall specifically note any instances where an applicant has been:
 1. Charged with, been convicted of, pled no contest to, or is awaiting trial on charges of an offense listed in R6-5-5802(C); and
 2. A party to an action for dependency or termination of parental rights.
- D. R6-5-5805(B)(3), (7), and (9) do not apply to a person seeking licensure solely as an in-home respite foster parent.

Historical Note

Adopted effective March 30, 1977 (Supp. 77-2). Former Section R6-5-5805 repealed, new Section R6-5-5805 adopted effective April 1, 1981 (Supp. 81-2). Former

Section R6-5-5805 repealed, new Section R6-5-5805 adopted effective January 10, 1997 (Supp. 97-1).

R6-5-5806. Complete Application Package: Contents

- A. The licensing agency shall send a complete application package to the Licensing Authority for consideration.
- B. A complete application package includes the following:
 - 1. A copy of the applicant's completed application form and criminal history certification form containing the information prescribed in R6-5-5802(B) and (C);
 - 2. The investigative report, as prescribed in R6-5-5805;
 - 3. Evidence that the applicant and adult household members have been fingerprinted and their fingerprints subjected to a criminal history check;
 - 4. Evidence that the applicant has completed the training prescribed by A.R.S. § 8-509(B) and R6-5-5825(A), or a statement of hardship as prescribed in R6-5-5810; and
 - 5. Evidence that the applicant's dwelling has passed the health and safety inspection prescribed by A.R.S. § 8-504 and R6-5-5804.
- C. Upon receipt of an application package from a licensing agency other than the Department, the Licensing Authority shall:
 - 1. Determine whether the application is complete; and
 - 2. Send the applicant and the licensing agency a notice of administrative completeness or deficiencies, as prescribed by A.R.S. § 41-1074, within the administrative completeness review time-frame described in R6-5-5813(1)(a).
- D. If the applicant does not supply the missing information, as prescribed in the notice, within 60 days of the notice date, the licensing agency may close the file. An applicant whose file has been closed, who later wishes to become licensed, may reapply.

Historical Note

Adopted effective March 30, 1977 (Supp. 77-2).
Amended as an emergency effective May 28, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-3). Former Section R6-5-5806 repealed, new Section R6-5-5806 adopted effective April 1, 1981 (Supp. 81-2). Former Section R6-5-5806 repealed, new Section R6-5-5806 adopted effective January 10, 1997 (Supp. 97-1).

R6-5-5807. CPSCR Check; Additional Investigation by Licensing Authority

- A. The Licensing Authority shall conduct a CPSCR check on the applicant and, with the exception of an in-home respite foster parent applicant, on all household members for reports of child maltreatment.
- B. Upon receipt of a complete application package, as prescribed in R6-5-5806, the Licensing Authority may do additional investigation, as prescribed in this Section, if the Licensing Authority needs additional information in order to determine the applicant's fitness to serve as a foster parent, and ability to comply with foster care requirements.
 - 1. The Licensing Authority may directly obtain information by:
 - a. Interviewing the applicant, either in-person or telephonically;
 - b. Contacting additional references;
 - c. Verifying information provided in the application package, including past history of licensure as a foster parent;
 - d. Visiting the applicant's home; and
 - e. Requesting additional supporting documentation as prescribed in R6-5-5803(B).

- 2. The Licensing Authority may contact the licensing agency and request that the licensing agency obtain additional information, as prescribed in subsection (B)(1).

Historical Note

Adopted effective March 30, 1977 (Supp. 77-2). Former Section R6-5-5807 repealed, new Section R6-5-5807 adopted effective April 1, 1981 (Supp. 81-2). Former Section R6-5-5807 repealed, new Section R6-5-5807 adopted effective January 10, 1997 (Supp. 97-1).

R6-5-5808. License: Form; Issuance; Denial; Term; Termination

- A. Within 30 days of receiving a complete application, the Licensing Authority shall issue a written licensing decision.
 - 1. If the Licensing Authority grants the license, the Licensing Authority shall send the license with the notification letter. The license shall be in the name of the applicant and the foster home location as identified in the application. The license shall specify the number, age, and gender of children the foster home may accept.
 - 2. The Licensing Authority may place terms on the license as to the type of child the foster home may accept for placement. Such terms may include the following:
 - a. A restriction that the foster home can accept only a specifically named child or specifically named children; and
 - b. A provision that the home can provide a particular service, or accept children with particular behavior problems or physical conditions.
 - 3. A license for a person being licensed solely as an in-home respite foster parent shall include only the licensee's name and the type of care, but no specific location or other terms.
 - 4. If the Licensing Authority denies the license, the notice shall include the reasons for the denial, with a statement of the applicant's right to appeal the licensing decision, as prescribed in R6-5-5821.
- B. A license expires one year from the date of issuance. If a foster parent receives a provisional license as prescribed in R6-5-5810, and the provisional license is converted to a regular license during the licensing year, the regular license shall expire one year from the date the provisional license was issued.
- C. A foster parent shall not transfer or assign a license. A license expires if the foster parent moves to a different dwelling unless the licensing agency has first notified the Licensing Authority of the planned move or a foster parent has requested an amendment to the license as prescribed in R6-5-5814. This requirement does not apply to a person licensed solely as an in-home respite foster parent.
- D. Issuance of a license does not guarantee placement of a foster child.
- E. A license terminates when:
 - 1. The license expires by its own terms and is not renewed;
 - 2. The Licensing Authority revokes the license pursuant to disciplinary proceedings as prescribed in R6-5-5819;
 - 3. The foster parent moves out of state; or
 - 4. The foster parent voluntarily surrenders the license.

Historical Note

Adopted effective March 30, 1977 (Supp. 77-2).
Repealed effective April 1, 1981 (Supp. 81-2). New Section R6-5-5808 adopted effective January 10, 1997 (Supp. 97-1).

R6-5-5809. Provisional License

Notwithstanding any other provision of this Article, the Licensing Authority may issue a provisional license to a foster parent who has not completed training, when the Licensing Authority makes a finding of hardship as prescribed in A.R.S. § 8-509(D). The Licensing Authority may find a condition of hardship when failure to issue a provisional license would result in displacement of a child or the inability to place a particular child.

1. The term of a provisional license shall not exceed six months,
2. A provisional license is not renewable.

Historical Note

Adopted effective March 30, 1977 (Supp. 77-2).

Amended subsection (G) as an emergency effective March 12, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-2). Amended effective August 15, 1979 (Supp. 79-4). Amended as an emergency effective May 28, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-3). Repealed effective April 1, 1981 (Supp. 81-2). New Section R6-5-5809 adopted effective January 10, 1997 (Supp. 97-1).

R6-5-5810. Application for License Renewal

- A. At least 60 days before the expiration date of a license, the licensing agency shall send a foster parent a notice of license expiration.
- B. A foster parent may apply to a licensing agency for license renewal by submitting a complete renewal application to the licensing agency at least 30 days before the expiration of the current license.
- C. A complete renewal application shall contain the following information:
 1. A description of any changes to the information provided in the original application or last renewal application, including changes in personal, family, social, medical, or financial circumstances;
 2. At least once every third year following original licensure, a licensed medical practitioner's statement on the physical health of the foster parent and any household members who regularly care for children;
 3. Evidence that the foster parent has obtained the annual training required by A.R.S. § 8-509(C); and
 4. The statements, signature, and date prescribed in R6-5-5802(B)(23) through (25).
- D. A foster parent shall submit copies of the supporting documents listed in R6-5-5803(B) if so requested by the licensing agency.
- E. The foster parent and adult household members shall comply with any investigative requirement for fingerprint clearance.

Historical Note

Adopted effective March 30, 1977 (Supp. 77-2).
Repealed effective April 1, 1981 (Supp. 81-2). New Section R6-5-5809 adopted effective January 10, 1997 (Supp. 97-1).

R6-5-5811. Renewal Investigation; Licensing Report and Recommendation

- A. A licensing agency that receives a renewal application shall conduct a face-to-face interview with the foster parent at the foster parent's residence. The licensing agency is not required to conduct the interview of a person licensed solely as an in-home respite foster parent at the person's residence. During the interview, the licensing agency shall discuss the following:
 1. The foster parent's experiences in serving as a foster parent during the expiring licensing year;
 2. Any changes identified in the renewal application; and

3. Any complaints made against the foster parent during the expiring licensing year.
- B. The licensing agency shall obtain any supplemental information the agency needs to determine the foster parent's continuing fitness to serve as a foster parent.
- C. The licensing agency shall request a statewide criminal history records information check every year for the foster parent and, with the exception of an in-home respite foster parent, all adult household members.
- D. The licensing agency shall request that DHS perform a health and safety inspection of the foster parent's home, as prescribed in R6-5-5804, at least once every third year following original licensure. This inspection is not required of a person licensed solely as an in-home respite foster parent.
- E. The licensing agency shall summarize the results of the renewal investigation in a report and make a licensing recommendation as prescribed in R6-5-5805. The report shall explain any complaints, as described in R6-5-5816, R6-5-5817, and R6-5-5818, made against the foster parent during the expiring license period.
- F. No less than 15 working days before the date that the applicant's current license expires, the licensing agency shall provide the Licensing Authority with a complete renewal application as prescribed in R6-5-5810, and the agency's renewal investigation report as prescribed in R6-5-5811.

Historical Note

Adopted effective March 30, 1977 (Supp. 77-2).
Repealed effective April 1, 1981 (Supp. 81-2). New Section R6-5-5811 adopted effective January 10, 1997 (Supp. 97-1).

R6-5-5812. Renewal License

- A. The Licensing Authority shall process a renewal application package following the procedures described in R6-5-5806(C), R6-5-5807, and R6-5-5808.
- B. In determining whether to renew a license, the Licensing Authority shall consider the renewal application package, and the foster parent's past record of service, including conduct during all prior licensing periods.
- C. The Licensing Authority may renew a foster parent's license when the foster parent:
 1. Demonstrates the ability to fulfill foster care requirements,
 2. Has complied with foster care requirements during prior licensing periods, and
 3. Has cooperated with the licensing agency in providing the information required for license renewal.

Historical Note

Adopted effective January 10, 1997 (Supp. 97-1).

R6-5-5813. Licensing Time-frames

For the purpose of A.R.S. § 41-1073, the Department has adopted the licensing time-frames listed in this Section.

1. Initial applications submitted to a licensing agency other than the Department: When a person applies for foster parent licensure through a licensing agency other than the Department, and the licensing agency submits the completed application package to the Licensing Authority on behalf of the applicant, the licensing time-frames are:
 - a. Administrative completeness review time-frame: 30 days;
 - b. Substantive review time-frame: 30 days; and
 - c. Overall time-frame: 60 days.
2. Initial application submitted to the Department as the licensing agency: When a person applies directly to the Department for foster parent licensure, and the Depart-

ment performs the activities described in R6-5-5803 through R6-5-5806, the licensing time-frames are:

- a. Administrative completeness review time-frame: 90 days;
 - b. Substantive review time-frame: 30 days; and
 - c. Overall time-frame: 120 days.
3. Renewal applications submitted to a licensing agency other than the Department: When a person applies for renewal of a foster parent license through a licensing agency other than the Department, and the licensing agency submits the completed renewal application package to the Licensing Authority on behalf of the applicant, the licensing time-frames are:
 - a. Administrative completeness review time-frame: 21 days;
 - b. Substantive review time-frame: 21 days; and
 - c. Overall time-frame: 42 days.
 4. Renewal applications submitted to the Department as the licensing agency: When a person applies directly to the Department for renewal of a foster parent license, and the Department performs the activities described in R6-5-5812, the licensing time-frames are:
 - a. Administrative completeness review time-frame: 40 days;
 - b. Substantive review time-frame: 20 days; and
 - c. Overall time-frame: 60 days.

Historical Note

Adopted effective January 10, 1997 (Supp. 97-1).

R6-5-5814. Amended License; Change in Household Members

- A. The following changes require a license amendment:
 1. A change in any circumstances or conditions placed on the license, as prescribed in R6-5-5808(A)(2);
 2. Expanded or reduced capacity of the foster home;
 3. A move to a different residence;
 4. The divorce of the foster parent, if the divorce changes any circumstance or condition placed on the license;
 5. Marriage of the foster parent;
 6. The death of the foster parent's spouse if the death changes any circumstance or condition placed on the license; and
 7. A change of name.
- B. The foster parent may request a license amendment or the licensing agency may initiate the amendment in response to an observed change. The Licensing Authority may issue an amended license to reflect a change in circumstances when the change does not cause the foster parent or foster home to fall out of compliance with foster care requirements.
- C. If the foster parent has moved to a different residence or remodeled an existing residence, the Licensing Authority shall not issue an amended license until the different or remodeled residence has passed a health and safety inspection as prescribed in R6-5-5804.
- D. An amended license expires at the end of the foster parent's current licensing year.
- E. If the foster parent adds a household member during the course of a licensing year, the foster parent shall:
 1. Obtain prior approval from the licensing agency;
 2. Ensure that a new adult household member submits a criminal history certification and submits to fingerprinting as prescribed in R6-5-5802(C), within 10 work days of the member's arrival;
 3. Ensure that a new child household member obtains any missing, routine immunizations within 30 calendar days of the member's arrival; and

4. Cooperate in additional interviews and submit additional documentation that the licensing agency or Licensing Authority may require to determine whether the addition of the new member will cause the foster parent to fall out of compliance with foster care requirements.

- F. In determining whether to approve the addition of the new household member, the licensing agency shall consider:
 1. The relationship of the new household member to the foster parent;
 2. The length of time the foster parent has known the new household member;
 3. The background of the new household member including any criminal history;
 4. The financial arrangements, if any, between the foster parent and the new household member;
 5. What, if any, child care responsibilities the new household member may have;
 6. Whether the new household member has any physical or emotional conditions that present a risk to foster children and current household members; and
 7. Whether the home will still meet the equipment and space requirements prescribed in R6-5-5838 through R6-5-5846 with the addition of the new household member.
- G. If the foster parent marries during the course of a licensing year:
 1. The foster parent's spouse shall submit an application for a license as prescribed in R6-5-5802 and R6-5-5803;
 2. The foster parent's spouse shall be investigated in accordance with R6-5-5803, R6-5-5805, R6-5-5806, R6-5-5807, R6-5-5823, and R6-5-5824; and
 3. The foster parent shall comply with subsection (E) and with subsection (C) if the foster parent moves.
- H. A person licensed solely as an in-home respite foster parent is exempt from the requirements of subsections (B)(2) and (3), (C), (E), (F), and (G).

Historical Note

Adopted effective January 10, 1997 (Supp. 97-1).

R6-5-5815. Monitoring the Foster Home and Family

- A. A licensing agency shall monitor its foster homes.
- B. Monitoring activities may include the following:
 1. Announced and unannounced visits to the foster home;
 2. Interviews with the foster parent and household members over age 5;
 3. Interviews with foster children placed with a foster parent, if developmentally appropriate; any interviews with a foster child may occur with the foster child separated from the foster parent; and
 4. A review of any records a foster parent is required to maintain.
- C. A foster parent shall cooperate with monitoring requirements by:
 1. Making the foster home available for inspection, and
 2. Participating in interviews and permitting interviews with household members.
- D. When a licensing agency finds a violation of a foster home requirement, the licensing agency shall orally notify the Licensing Authority of the violation, and shall follow the oral report with a written report that shall include a recommendation for any licensing action or a corrective action plan, as prescribed in R6-5-5818 and R6-5-5819.

Historical Note

Adopted effective January 10, 1997 (Supp. 97-1).

R6-5-5816. Investigation of Complaints About a Foster Home

- A.** When a licensing agency receives a complaint about a foster home or licensee, the licensing agency shall:
1. Immediately report allegations of child abuse, neglect, or maltreatment to Child Protective Services Central Intake as prescribed in A.R.S. § 13-3620; and
 2. Report all complaints to the Licensing Authority within five days and investigate all complaints, not reported to CPS, as prescribed in this Section.
- B.** An investigation may include:
1. Interviews with the complaining party and members of the foster home;
 2. Inspections of the foster parent's records and documents related to the issues raised in the complaint;
 3. Interviews of witnesses to the matters at issue; and
 4. Any other activities necessary to substantiate or refute the complaint.
- C.** The licensing agency shall complete the investigation within 60 days. If the investigation cannot be completed within 60 days, the licensing agency shall notify the Licensing Authority and provide a date for completion of the investigation.
- D.** When the investigation is completed, the licensing agency shall send the Licensing Authority a written summary of the results.

Historical Note

Adopted effective January 10, 1997 (Supp. 97-1).

R6-5-5817. Licensing Authority Action On Complaints

After the licensing agency reports the results of its investigation, the Licensing Authority shall determine what action to take against a licensee, as prescribed in this Section.

1. If the licensee did not violate foster care requirements, the Licensing Authority shall take no further action.
2. If the licensee violated a foster care requirement, but has corrected the problem giving rise to the violation, the Licensing Authority shall record the incident in the licensing file, and may take no further action.
3. If the licensee violated a foster care requirement and there is reasonable cause to believe that the licensing violation is continuing or may reoccur, the Licensing Authority shall take licensing action as prescribed in R6-5-5819, or require corrective action as prescribed in R6-5-5818.

Historical Note

Adopted effective January 10, 1997 (Supp. 97-1).

R6-5-5818. Corrective Action

- A.** If a deficiency giving rise to a substantiated complaint is correctable within a specified period of time and does not jeopardize the health or safety of a foster child, the Licensing Authority, in consultation with the licensing agency, may place the foster parent on a corrective action plan to remedy the deficiency.
- B.** In determining whether to require corrective action, the Licensing Authority shall consider the following criteria:
1. The nature of the violation;
 2. Whether the violation can be corrected;
 3. Whether the foster parent understands the violation and shows a willingness and ability to participate in corrective action;
 4. The length of time required to implement corrective action;
 5. Whether the same or similar violations have occurred on prior occasions;

6. Whether the foster parent has had prior corrective action plans, and, if so, the foster parent's success in achieving the goals of the plan;
7. The foster parent's history as a foster parent; and
8. Other similar or comparable factors demonstrating the foster parent's ability and willingness to follow through with a corrective action plan and avoid future violations.

Historical Note

Adopted effective January 10, 1997 (Supp. 97-1).

R6-5-5819. License Denial, Suspension, and Revocation

- A.** The Licensing Authority may deny, suspend, or revoke a license when:
1. An applicant or licensee has violated or is not in compliance with foster care requirements, Arizona state or federal statutes, or city or county ordinances or codes;
 2. An applicant or licensee refuses or fails to cooperate with the Licensing Authority in providing information required by these rules or any information required to determine compliance with these rules;
 3. An applicant or licensee misrepresents or fails to disclose material information to the Licensing Authority, the licensing agency, or a placing agency regarding qualifications, experience, or performance of duties;
 4. An applicant or licensee is unable to meet the physical, emotional, social, educational, or psychological needs of children; or
 5. A licensee fails to comply with a corrective action plan.
- B.** In determining whether to take disciplinary action against a licensee, or to grant or renew a license, the Licensing Authority may consider the applicant or licensee's past history from other licensing periods, and shall consider a repetitive pattern of violations of applicable child welfare or foster care rules or statutes, as evidence that a licensee applicant or licensee is unable or unwilling to meet the needs of children.
- C.** The Licensing Authority shall deny a license when an applicant, licensee, or household member has been convicted of or is awaiting trial on the criminal offenses listed in R6-5-5802(C)(1) in Arizona or the same or similar offenses in other jurisdictions.
- D.** The Licensing Authority may deny a license when an applicant, licensee, or household member has been convicted of, found by a court to have committed, or is reasonably believed to have committed any criminal offense, other than those listed in R6-5-5802(C)(1). To determine whether the criminal history of an applicant, licensee, or household member affects a person's fitness to be a licensee, the Licensing Authority shall consider all relevant factors, including the following:
1. The extent of the person's criminal record;
 2. The length of time which has elapsed since the offense was committed;
 3. The nature of the offense;
 4. The mitigating circumstances surrounding the offense;
 5. The degree of participation by the person in the offense;
 6. The extent of the person's rehabilitation, including:
 - a. Completion of probation or parole;
 - b. Whether the person has made restitution or paid compensation for the offense;
 - c. Evidence of positive action to change criminal behavior, such as completion of a drug treatment program or counseling; and
 - d. Personal references attesting to the person's rehabilitation.
- E.** The Licensing Authority may deny, suspend, or revoke a license if the applicant, licensee, or household member is, or resides with, a person who has a record of substantiated or

undetermined child maltreatment in this state or any other jurisdiction. To determine whether an applicant, licensee, or household member's history of child maltreatment affects a person's fitness to serve as a foster parent, the Licensing Authority shall consider all relevant factors, including, but not limited to, the following:

1. Whether the person was subjected to child maltreatment in his or her family of origin;
 2. The extent of the person's child maltreatment record;
 3. The length of time which has elapsed since the maltreatment occurred;
 4. The nature of the maltreatment;
 5. The circumstances surrounding the maltreatment;
 6. The degree to which the person participated in the maltreatment;
 7. The extent of the person's rehabilitation;
 8. Whether the person is on probation or parole; and
 9. Whether legal proceedings were initiated as a result of the maltreatment.
- F.** The person seeking to establish fitness to be a licensee under subsection (D) has the burden of proving mitigating circumstances, indirect involvement, and the completion of probation or parole.
- G.** The Licensing Authority shall not deny, suspend, or revoke the license of an in-home respite foster parent based on the actions of the foster parent's household members as identified in (C), (D), and (E) unless such actions interfere with the foster parent's ability to comply with this Article or relate to any child for whom the foster parent provides respite care.

Historical Note

Adopted effective January 10, 1997 (Supp. 97-1).

R6-5-5820. Adverse Action; Notice; Effective Date

- A.** When the Licensing Authority denies, suspends, or revokes a license, the Licensing Authority shall send a written, dated notice of the action by certified mail to:
1. The applicant or licensee;
 2. The licensing agency; and
 3. The placing agency for any child placed with the licensee at the time of the action.
- B.** The notice shall specify:
1. The action taken and the date the action will be effective;
 2. A citation to the legal authority, and a description of the reasons supporting the action; and
 3. The procedures by which the applicant or licensee may contest the action taken, and the time periods in which to do so.
- C.** A revocation is effective:
1. Twenty-one days after the postmark date of the revocation notice; or
 2. If the licensee appeals the revocation, on the date that an administrative hearing officer issues a written decision affirming the revocation.

Historical Note

Adopted effective January 10, 1997 (Supp. 97-1).

R6-5-5821. Appeals

- A.** An applicant or licensee may appeal the denial, suspension, or revocation of a license as prescribed in 6 A.A.C. 5, Article 75. Imposition of a provisional license or a corrective action plan is not appealable.
- B.** To appeal, an applicant or licensee shall file a written notice of appeal with the Licensing Authority no later than 20 days from the date of the notice prescribed in R6-5-5820(A) and (B).

- C.** The notice of appeal shall specify the action being appealed and a statement of why the Licensing Authority's action was wrong.
- D.** Appeals from the decision of a hearing officer are governed by A.R.S. §§ 41-1992(D) and 41-1993 and A.A.C. R6-5-7518 through R6-5-7520.

Historical Note

Adopted effective January 10, 1997 (Supp. 97-1).

Amended June 4, 1998 (Supp. 98-2).

R6-5-5822. Alternative Methods of Compliance

- A.** The Licensing Authority, in consultation with the Attorney General's office, may substitute an alternative method of compliance for a foster care requirement contained in this Article and not otherwise required by law if the following conditions are met:
1. The Licensing Authority, in consultation with the licensing or placing agency, determines that placement in the foster home requesting an alternative method of compliance is in the best interests of a particular foster child; and
 2. The purpose of the requirement being replaced is fulfilled through the alternative method of compliance.
- B.** If the Licensing Authority approves an alternative method of compliance for a foster care requirement contained in this Article, the Licensing Authority shall make written findings of fact and conclusions explaining how the requirements of subsection (A) are met.
- C.** The Licensing Authority has no obligation to approve an alternative method of compliance and shall consider the particular facts and circumstances of each case when making such a determination.

Historical Note

Adopted effective January 10, 1997 (Supp. 97-1).

R6-5-5823. Foster Parent: General Qualifications

To qualify for and maintain licensure as a foster parent, a person shall meet the criteria listed in this Section.

1. The person shall be at least 21 years old at the time of application.
2. The person shall have sufficient income, exclusive of the foster care maintenance payment, to meet the needs of the foster parent and the foster parent's own children and household members.
3. The applicant, foster parent, and adult household members shall be free of conviction or indictment for, or involvement in the criminal offenses listed in R6-5-5802(C).
4. The applicant, foster parent, and household members shall not have any physical or mental health conditions which preclude compliance with foster care requirements.
5. Each child residing in the foster home shall have all childhood immunizations appropriate to the child's age and health.
6. An applicant or foster parent shall not:
 - a. Conduct home business activities which prevent the applicant or foster parent from caring for a foster child in accordance with foster care requirements; or
 - b. Provide foster care for adults.
7. An applicant's or foster parent's household members shall agree to and support the decision to provide foster care.
8. An applicant or foster parent shall:
 - a. Cooperate with the licensing agency, the placing agency, and the Licensing Authority regarding any inspections or investigative activities; and

- b. Provide information as prescribed in this Article.

Historical Note

Adopted effective January 10, 1997 (Supp. 97-1).

R6-5-5824. Foster Parent: Personal Characteristics

To qualify for and maintain licensure as a foster parent, a person shall be a responsible, stable, emotionally mature individual who can exercise sound judgment. A person meets this requirement by demonstrating the following characteristics on the person's application and during the interview and investigation process:

1. The ability to realistically determine which foster children the person can accept, work with, and successfully integrate into the person's family;
2. Knowledge of child development, nutrition, health, and the various experiences a child may have, with which the foster parent may need assistance and guidance;
3. The willingness and ability to protect children from harm;
4. Knowledge and understanding of child discipline and ways of helping a child build positive personal relationships;
5. The following personal attributes:
 - a. The capacity to give and receive affection;
 - b. Enjoyment in being a parent or foster parent;
 - c. Flexibility in expectations, attitudes, behavior, and use of help when it is needed;
 - d. The ability to deal with separation, loss, frustration, and conflict;
6. The capacity to respect persons with differing life styles and philosophies, and persons of different races, cultures, and religious beliefs;
7. The ability to accept a foster child's relationship with the child's parent and birth family; and
8. The willingness and ability to commit the time necessary to provide a foster child with supervision and guidance in accordance with foster care requirements and a foster child's individual needs.

Historical Note

Adopted effective January 10, 1997 (Supp. 97-1).

R6-5-5825. Training and Development

- A. Before receiving an initial license, an applicant shall complete at least 12 clock hours of initial foster parent training as prescribed in A.R.S. § 8-509(B). The training shall cover at least the following subjects:
1. Characteristics and needs of children who may be placed in the foster home;
 2. The role of the foster parent as a member of the care and treatment team;
 3. The importance of birth parent and family involvement in a child's life;
 4. Methods for appropriately addressing the cultural, ethnic, and religious needs of a child in care;
 5. Attachment, separation, and loss issues for children and families;
 6. Behavior management policies and practices as prescribed in R6-5-5833;
 7. Confidentiality;
 8. Emergency procedures;
 9. Resources and supportive services available to foster children and foster parents;
 10. Foster care payment procedures;
 11. Placing agency and Licensing Authority contact persons and procedures;
 12. The impact of fostering on the foster parent and the foster parent's own family;

13. Addressing and coping with the impacts described in subsection (A)(12);
14. Specialized topics related to child welfare, health, growth, or development; and
15. The Indian Child Welfare Act of 1978 (PL 95-608).

- B. Each licensing year, prior to license renewal, a foster parent shall attend and complete at least six clock hours of ongoing training as prescribed in A.R.S. § 8-509(C). Annual training may include:
1. Advanced training in the subjects listed in subsection (A);
 2. Special subjects relating to child health, growth, or development, including:
 - a. Child management techniques based on the developmental needs of children in care;
 - b. Discipline, crisis intervention, and behavior management techniques; and
 3. Review of placing agency policies.
- C. An applicant or licensee shall also complete any additional training required by the Licensing Authority, or the foster parent's licensing agency or placing agency to develop specialized skills and to meet or maintain compliance with foster care requirements.

Historical Note

Adopted effective January 10, 1997 (Supp. 97-1).

R6-5-5826. Compliance With Licensing Limitations; Adult - Child Ratios

- A. A foster parent shall limit the number of children in the home as prescribed in subsections (A)(1) and (2). As used in this Section, "children in the home" means any child in the foster home, including children placed for respite care, child care services, or baby-sitting, the foster parent's own children, and children residing in the foster home.
1. At all times, the total number of children in the home who are 5 years old or under shall not exceed more than four in the care of one adult.
 2. At all times, the total number of children in the home who are less than 1 year old, shall not exceed more than two in the care of one adult.
- B. A foster parent shall not care for more foster children than allowed and identified on the foster parent's license, and shall not exceed five foster children in addition to other children in the home.
- C. A foster parent shall abide by any terms or conditions placed on the foster parent's license when accepting a child for placement.

Historical Note

Adopted effective January 10, 1997 (Supp. 97-1).

R6-5-5827. Placement Agreement

- A. For each child placed with a foster parent the foster parent shall have a written placement agreement meeting the requirements of subsection (B) with the foster child's placing agency.
- B. The placement agreement shall set forth the responsibilities of both the placing agency and the foster parent regarding:
1. Provision of services for the foster child, including medical care, dental care, mental health care, other social services or treatment, and transportation;
 2. Requirements for interaction with the foster child's birth family.
- C. If a foster parent does not receive a copy of a placement agreement at the time of placement, the foster parent shall obtain an agreement within five work days following the date of placement. If the placing agency refuses to provide an agreement, the foster parent shall notify the Licensing Authority.

Historical Note

Adopted effective January 10, 1997 (Supp. 97-1).

R6-5-5828. Participation in Case Planning

- A.** A foster parent is a member of the service team for a foster child in the care of the foster parent. The service team includes the case manager, the foster parent, the licensing agency representative, and persons providing services, such as attorneys, physicians, psychologists, therapists, Court Appointed Special Advocates, and school, law enforcement, and probation personnel.
- B.** A foster parent shall participate as a team member by:
 - 1. Attending team meetings when:
 - a. The foster parent receives reasonable advance notice of the date, time, and place of the meeting; and
 - b. The meetings are held at a time and place which is accessible to the foster parent, and compatible with the foster parent's work schedule and child care schedule;
 - 2. Participating in team meetings through alternative methods, which may include:
 - a. Telephonic conference calls,
 - b. Submission of oral comments, and
 - c. Expressing concerns and comments to other team members who will attend the meeting;
 - 3. Reporting to the team on the foster child's progress and problems;
 - 4. Assisting in development of the case plan; and
 - 5. Assisting in case plan reviews.
- C.** A foster parent shall implement the case plan by:
 - 1. Performing the tasks assigned to the foster parent in the case plan,
 - 2. Helping a foster child to attain any goals identified in the case plan,
 - 3. Assisting a foster child to obtain any services specified in the case plan, and
 - 4. Observing any limitations or conditions contained in the case plan.

Historical Note

Adopted effective January 10, 1997 (Supp. 97-1).

R6-5-5829. Daily Care and Treatment of a Foster Child; Foster Child Rights

- A.** Non-exploitation and equitable treatment
 - 1. A foster parent shall not exploit a foster child or permit a child to be exploited.
 - 2. A foster parent shall permit a foster child to exercise the rights, freedoms, and responsibilities of family life in a manner that is comparable to those exercised by foster family members, subject to:
 - a. Reasonable and developmentally appropriate household rules, and
 - b. Restrictions prescribed in a foster child's case plan and foster care requirements.
 - 3. As used in this Section, "reasonable" means conduct which takes into account:
 - a. The foster family's physical environment,
 - b. The chores and responsibilities assigned to other household members,
 - c. The foster child's school schedule and educational needs, and
 - d. The foster child's social and recreational needs.
- B.** Religious and ethnic heritage
 - 1. A foster parent shall recognize, encourage, and support the religious beliefs, cultural and ethnic heritage, and language of a foster child and the child's birth family.

- 2. A foster parent shall coordinate with the placing agency to provide opportunities for each foster child to participate in religious, cultural, and ethnic activities.
- 3. A foster parent shall not directly or indirectly compel a foster child to participate in religious activities or cultural and ethnic events against the child's will or the wishes of the child's birth parent.
- C.** Interaction with parents and birth family. A foster parent shall maintain a working relationship with a foster child's parent, birth family, and other significant persons, in accordance with the child's case plan and in cooperation with the placing agency staff.
- D.** Food and nutrition
 - 1. A foster parent shall provide a foster child with well-balanced daily meals and sufficient food to meet the child's nutritional needs.
 - 2. The foster parent shall provide for a foster child's special dietary needs as prescribed in the child's case plan, or the orders of a licensed medical practitioner.
- E.** Education
 - 1. A foster parent shall send a foster child to public school unless alternative educational arrangements, such as private, charter, or home schooling, have been approved in the child's case plan.
 - 2. A foster parent shall help the child in obtaining other educational services as prescribed in the child's case plan.
- F.** Clothing
 - 1. A foster parent shall provide a foster child with clean, seasonal clothing appropriate to the child's age, sex, size, and individual needs.
 - 2. A foster parent shall permit a foster child to participate in making decisions about clothing choices to the extent developmentally appropriate for the child.
- G.** Funds
 - 1. A foster parent shall use monies provided by the placing agency for designated purposes only.
 - 2. A foster parent shall retain receipts to document the use of designated monies except monies designated for room and board.

Historical Note

Adopted effective January 10, 1997 (Supp. 97-1).

R6-5-5830. Medical and Dental Care

- A.** A foster parent shall arrange for a foster child to have routine medical and dental care which shall include an annual medical exam, semi-annual dental exams, immunizations, and standard medical tests.
- B.** When a foster child is placed with a foster parent, the foster parent shall determine whether the child has had a comprehensive medical exam within the past two months, and, for a child age 3 or older, a dental exam within the past six months.
- C.** If a foster child has not had the medical or dental exam, the foster parent shall schedule the child for an exam within two weeks after the foster child is placed with the foster parent.
- D.** As used in subsection (B), a comprehensive medical exam shall include:
 - 1. Screening for communicable disease,
 - 2. Screening for vision and hearing,
 - 3. A general physical examination by a licensed physician,
 - 4. Provision of any routine immunizations or immunization boosters, and
 - 5. Tests appropriate for the child's age and history.

Historical Note

Adopted effective January 10, 1997 (Supp. 97-1).

R6-5-5831. Child Care

- A. A foster parent shall have a plan for supervision and care of a foster child placed with the foster parent.
- B. The plan shall be consistent with the foster child's case plan, and with the child's developmental, emotional, and physical needs, and the needs of the foster parent.
- C. A foster parent shall inform the placing agency and obtain approval for use of any person given the responsibility for care of a foster child, unless otherwise provided for in the child's case plan. The case plan may include the name of a specific child care agency or provider, and may give the foster parent discretion to allow the child to go on overnight visits with specifically named persons.

Historical Note

Adopted effective January 10, 1997 (Supp. 97-1).

R6-5-5832. Transportation

- A. A foster parent shall provide or arrange appropriate local transportation to meet the routine educational, medical, recreational, social, spiritual, and therapeutic needs of a foster child, in accordance with the child's case plan, or, if not specified in the case plan, as provided in the placement agreement.
- B. A foster parent transporting foster children shall have a valid driver's license.
- C. A foster parent shall provide for the safety of a foster child when the child is transported in a motor vehicle by:
 - 1. Providing and using safety restraints appropriate to the age and weight of each child transported; and
 - 2. Prohibiting the number of persons in any vehicle from exceeding the number of available seats and seat belts in the vehicle.

Historical Note

Adopted effective January 10, 1997 (Supp. 97-1).

R6-5-5833. Behavior Management; Discipline; Prohibitions

- A. A foster parent shall set limits and rules for children in care. The foster parent shall tell the children about the foster parent's expectations regarding child behavior, including forbidden conduct, and the foster parent's methods for disciplining children who violate expectations, limitations, and rules.
 - 1. A foster parent shall use discipline which is reasonable, developmentally appropriate, related to the infraction, and consistent with any guidelines in the child's case plan.
 - 2. A foster parent shall use disciplinary methods which help a foster child to build self-control, self-reliance, and self-esteem.
 - 3. A foster parent shall communicate rules, consequences, and disciplinary methods to a foster child in a manner appropriate to the child's age, developmental capacity, and ability to understand.
 - 4. A foster parent shall explain the foster parent's limits, rules, and expectations to any placing agency or person that places a child with the foster parent.
- B. A foster parent shall not delegate the responsibility for imposing discipline on a foster child to any person other than an adult assigned responsibility for the foster child, as prescribed in R6-5-5831(C), and made known to the child. If a foster parent delegates supervisory responsibility to another person, the foster parent shall instruct the person in the foster home limits, rules, and expectations, disciplinary methods specific to the foster child, and the limitations prescribed in this Article.
- C. A foster parent shall not punish or maltreat a foster child, and shall not allow any other person to do so. As used in this Section, "punishment or maltreatment" include, but are not limited to, the following actions:

- 1. Any type or threat of physical hitting or striking inflicted in any manner upon the body;
 - 2. Verbal abuse, including arbitrary threats of removal from the foster home;
 - 3. Disparaging remarks about a foster child or a foster child's birth family members or significant persons;
 - 4. Deprivation of meals, clothing, bedding, shelter, or sleep;
 - 5. Denial of visitation or communication with a foster child's birth family members and significant persons when such denial is inconsistent with the foster child's case plan;
 - 6. Cruel, severe, depraved, or humiliating actions;
 - 7. Locking a foster child in a room or confined area inside or outside of the foster home; and
 - 8. Requiring a foster child to remain silent or be isolated for time periods that are not developmentally appropriate.
- D. A foster parent shall not use mechanical restraints.
 - E. A foster parent shall not use physical restraint unless:
 - 1. Permission to use physical restraint is specified in the child's case plan; and
 - 2. The foster parent has been trained in the proper use of the physical restraint to be used with a particular foster child.

Historical Note

Adopted effective January 10, 1997 (Supp. 97-1).

R6-5-5834. Notification of Foster Child Death, Illness, Accident, Unauthorized Absence, or Other Unusual Events

- A. Within two hours after a foster child suffers any of the following events, a foster parent shall notify the child's placing agency:
 - 1. Death;
 - 2. Serious illness or injury requiring hospitalization or emergency room treatment;
 - 3. Any non-accidental injury or sign of maltreatment;
 - 4. Unexplained absence;
 - 5. Severe psychiatric episode;
 - 6. Fire or other emergency requiring evacuation of the foster home;
 - 7. Removal of a foster child from the foster home by any person or agency other than the placing agency, or attempts at such removal; and
 - 8. Any other unusual circumstance or incident which might seriously affect the health, safety, or the physical or emotional well-being of a foster child.
- B. Within 48 hours of occurrence, a foster parent shall notify the placing agency of any other events likely to affect the well-being of a foster child in the foster parent's care, including the following circumstances:
 - 1. Involvement of a foster child with law enforcement authorities;
 - 2. Serious illness or death involving a member of the foster family's household or a significant person;
 - 3. Change in foster family or household composition; and
 - 4. Absence of one foster parent from a two-parent household for more than seven continuous days.
- C. Within 24 hours of giving notice as prescribed in subsection (A) or (B), a foster parent shall send the placing agency and licensing agency a written report on the event. The report shall include the following information:
 - 1. A description of the event, with the date and time of occurrence;
 - 2. The names and telephone numbers of any persons involved in the event;
 - 3. Any measures taken to address, correct, or resolve the event, including treatment obtained, and persons notified.

- D. Within two days of receipt of the written report prescribed in subsection (C), the licensing agency shall send the written report to the Licensing Authority.

Historical Note

Adopted effective January 10, 1997 (Supp. 97-1).

R6-5-5835. Notification of Events or Changes Involving the Foster Family or the Foster Home

- A. A foster parent shall notify the licensing agency of any changes in the foster family's composition including, but not limited to the following events:
1. Marriage;
 2. Divorce;
 3. Addition of a new household member, including a temporary visitor expected to stay one month or longer; and
 4. Death or departure of a current household member.
- B. A foster parent shall notify the Licensing Authority of any substantial changes to the foster home, including:
1. Fire or emergency requiring evacuation of the foster home;
 2. Moving to a new residence; and
 3. Remodeling the foster home.
- C. When a foster parent has advance knowledge of an event or change listed in subsection (A) or (B), the foster parent shall give reasonable advance notice of the anticipated event or change. Reasonable advance notice means notice which permits the licensing agency time to conduct an inspection, and the Licensing Authority time to issue an amended license, as prescribed in R6-5-5814, without disruption of a placement.
- D. If the event or change is unexpected, a foster parent shall give notice as soon as the event occurs or change is known.
- E. For events or persons not specifically listed in subsection (A) or (B), the foster parent shall give notice within five work days of the event or change.

Historical Note

Adopted effective January 10, 1997 (Supp. 97-1).

R6-5-5836. Maintenance of a Foster Child's Records

- A. A foster parent shall maintain records for each foster child placed with the foster parent in accordance with the placing agency's requirements and this Section.
- B. The foster parent shall ensure that the records include at least the following:
1. Information on a foster child, the foster child's birth family, and any other significant persons in the foster child's life, if the placing agency has provided such information to the foster parent, as follows:
 - a. Name,
 - b. Address,
 - c. Telephone number, and
 - d. A description of the person's relationship to the child.
 2. A record of the foster child's contacts with birth family members and other significant persons, including the person contacted, and the date and method of contact (visit, telephone call, or written communication);
 3. Medical and health information provided by the placing agency;
 4. A consent form or notice from the foster child's guardian authorizing the foster parent to obtain routine, nonsurgical medical care, and emergency medical and surgical treatment for the foster child;
 5. A record of the medical and dental care provided to the foster child during the placement, including:
 - a. Date of appointment;
 - b. Description of any illness, injury, or health problem;

- c. Name, address, and telephone number of the medical practitioner who treated the child; and
- d. Resulting diagnosis and treatment, any prescribed medications, and any hospitalization;

6. Reports of any medical tests, information, or counseling received regarding routine, emergency, chronic, or handicapping conditions;
 7. A copy of the child's current case plan;
 8. Any progress notes the foster parent may record;
 9. Notations or records of significant incidents, events, and activities;
 10. Identification of any schools attended with dates of attendance, any school reports;
 11. Memorabilia to help the foster child retain a memory of placement and a life record; the memorabilia may include photographs, diaries, journals, souvenirs, scrapbooks, and art projects;
 12. Placement agreement with the placing agency;
 13. A clothing inventory (clothing brought with the foster child at the time of placement) and a record of clothing purchased for the child during placement; and
 14. At the time of the child's departure from the foster home, a description of the foster child's daily routine and personal preferences and habits such as favorite foods, fears, and bedtime routines.
- C. A foster parent shall provide the record to the placing agency upon termination of the foster child's placement.

Historical Note

Adopted effective January 10, 1997 (Supp. 97-1).

R6-5-5837. Confidentiality

- A. A foster parent shall maintain the confidentiality of all personally identifiable information about a foster child and a foster child's birth family. A foster parent may release information when so authorized by a foster child's placing agency, and, in an emergency, when release is necessary to protect the health or safety of the child.
- B. A foster parent shall safeguard a foster child's records in a manner that prevents loss, tampering, or unauthorized use.

Historical Note

Adopted effective January 10, 1997 (Supp. 97-1).

R6-5-5838. Foster Home: General Requirements

- A. The foster home parent shall:
1. Keep the foster home safe, in good repair, and sanitary, as described in R6-5-5804(C) through (E) and R6-5-5838 through R6-5-5846; and
 2. Keep the outside area around the foster home free from objects, materials, and conditions which constitute a danger to the occupants.
- B. If the foster parent accepts and provides care to a child with special physical needs, the foster parent shall equip the foster home with any equipment needed to accommodate the particular child's special needs.

Historical Note

Adopted effective January 10, 1997 (Supp. 97-1).

R6-5-5839. Foster Home: General Safety Measures

- A. The foster home shall have a telephone or other mechanical device allowing two-way communication with the outside community.
- B. A foster parent shall safeguard all hazardous chemicals, cleaning materials, toxic substances, and hazardous materials, objects, and equipment.
- C. A foster parent shall safeguard medical equipment and lock medications, except that the foster parent shall safeguard those

medications that must be immediately and readily available for a family member or foster child.

- D. When a foster home has a private source of water, the foster parent shall have evidence that a state or local health authority has approved the water as potable water.
- E. The foster parent shall maintain the warm water in the foster home at a temperature that does not exceed 120° F.
- F. A foster parent shall store firearms and ammunition in locked storage which is inaccessible to children.
 - 1. A firearm shall be trigger-locked or fully inoperable while in storage.
 - 2. Ammunition shall be stored in a location separate from firearms.
- G. A foster parent shall not maintain any animal that poses a danger to a foster child.
- H. A foster parent shall provide evidence that dogs belonging to the foster family or routinely present on the foster home premises, have current vaccinations against rabies.

Historical Note

Adopted effective January 10, 1997 (Supp. 97-1).

R6-5-5840. Exterior Environment; Play Area; Play Equipment

- A. The foster parent shall keep the outside play areas clean and safe. The play area shall be fenced if there are conditions which may pose a danger to a child playing outside. The age and developmental abilities of the child are considerations for determining risk to the child.
- B. The foster parent shall provide a variety of safe play equipment, toys, and supplies for each child. The age and developmental abilities of the child and standards in the community are considerations for determining the variety of play equipment, toys, and supplies required.

Historical Note

Adopted effective January 10, 1997 (Supp. 97-1).

R6-5-5841. Swimming Pools and Pool Safety

- A. A foster home's swimming pool shall meet the requirements of this Section and the "swimming pool/spa" and "swimming pool guidelines" Section in the Sanitation Inspection Guidelines published by the Department of Health Services (DHS) (January 1996), and not including any later amendments or editions, which are incorporated by reference. Copies of these sections from the guidelines are available for inspection at the Secretary of State's Office, Public Services Department, 1700 West Washington, Phoenix, Arizona 85007, and for inspection and copying at the Department of Economic Security, Authority Library, 1789 West Washington, Phoenix, Arizona 85007, and the DHS, Office of Child Care Licensure, 1647 East Morten, Suite 230, Phoenix, Arizona 85020.
- B. If the foster parent cares for a foster child who is age 5 or under, the swimming pool shall be fenced so that the pool is separated from the house, or, otherwise made physically inaccessible to a foster child.
- C. A foster parent shall supervise a child who is in the swimming pool or surrounding area, in accordance with the child's age, capabilities, and developmental level.
- D. A foster parent shall have at least one person currently certified in cardiopulmonary resuscitation (CPR) present in the foster home's swimming pool area when a foster child age 13 and under is swimming in the foster home swimming pool.

Historical Note

Adopted effective January 10, 1997 (Supp. 97-1).

R6-5-5842. Bedrooms; Bedding; Sleeping Arrangements

A foster parent shall provide safe sleeping arrangements which accommodate the privacy needs of a foster child, as prescribed in this Section.

1. The foster family and a foster child shall sleep in bedrooms. An unfinished attic, a basement area, or a space normally and primarily used for passageways and purposes other than sleeping are not bedrooms.
2. A bedroom in the foster home shall have a finished ceiling, floor-to-ceiling permanently affixed walls, a door, finished flooring, light, ventilation, and a usable exit to the outdoors.
3. A foster parent shall provide each foster child with a bed.
 - a. The bed shall be appropriate to a child's age and needs.
 - b. For the purpose of this Section, "bed" does not include a cot, couch, convertible couch, portable bed, sleeping bag or mat, except as approved by the Licensing Authority.
 - c. No foster child shall sleep in a bunk bed of more than two tiers.
 - d. A foster child under age 8 shall not sleep in the top bunk of a two tier bunk bed.
4. A foster parent shall provide the following for each foster child:
 - a. A sanitary mattress;
 - b. A clean pillow;
 - c. Clean bed linens;
 - d. Blankets or covers, as appropriate to the weather;
 - e. A waterproof protective mattress cover, as needed; and
 - f. Furniture or shelving near the bed to store clothing and personal belongings.
5. A foster parent shall not allow a foster child to share a bedroom with an adult except as specified in this subsection.
 - a. A foster child under age 3 may share a bedroom with the foster parent.
 - b. A foster child who is age 3 or older may share a bedroom with the foster parent when:
 - i. The sleeping arrangement and the reason for it are described in a foster child's case plan; or
 - ii. The foster child temporarily requires the foster parent's attention during sleeping hours.
 - c. A foster child who has regularly shared a bedroom with another child in the foster home who has turned 18 may continue to share the bedroom with the child who has turned 18 unless the placing agency determines that the arrangement is contrary to the best interests of the foster child.
6. A foster parent shall not allow a foster child who is age 6 or over to share a bedroom with a child of the opposite gender.
7. Notwithstanding any other provision of this Section, a foster child who is a minor parent may share a room with her own child.

Historical Note

Adopted effective January 10, 1997 (Supp. 97-1).

R6-5-5843. Bathrooms

- A. A foster home shall have at least one toilet, one wash basin, and one bathtub or shower.
- B. A foster parent shall:
 1. Maintain the foster home's toilets, washbasins, bathtubs, and showers in good working order; and
 2. Have slip resistant flooring for bathtubs and showers.

- C. A foster home bathroom shall have interior plumbing with both warm and cold water.

Historical Note

Adopted effective January 10, 1997 (Supp. 97-1).

R6-5-5844. Kitchen

- A. A foster home shall have a kitchen that is equipped for safe and sanitary preparation, serving, and storage of food.
- B. The kitchen shall have interior plumbing with both warm and cold water.
- C. The kitchen shall have an operable refrigerator, stove, and oven.

Historical Note

Adopted effective January 10, 1997 (Supp. 97-1).

R6-5-5845. Fire Safety and Prevention

- A. The foster parent shall install and maintain at least 1, single-station smoke detector approved by a nationally recognized testing laboratory in the following areas of the foster home:
1. On each floor in a multi-story dwelling;
 2. In each separate sleeping area.
- B. A foster parent shall install and maintain at least one ABC-type fire extinguisher on each floor of the foster home; except if the foster home is a manufactured home, the foster parent shall have at least two fire extinguishers placed at opposite ends of the home.
- C. A foster parent shall not use portable space heaters during sleeping hours.
- D. A foster home shall not rely on portable space heaters as the sole source of heat.

Historical Note

Adopted effective January 10, 1997 (Supp. 97-1).

R6-5-5846. Emergencies, Exits, and Evacuation

- A. A foster parent shall have a plan for emergency evacuation of the foster home.
- B. All household members and persons who care for a foster child in the foster home shall be knowledgeable about the emergency and evacuation plans and procedures.
- C. Within 48 hours after a foster child is placed in a foster home, a foster parent shall give the foster child a developmentally appropriate explanation of the emergency and evacuation plan, and ensure that the foster child can follow the plan in the event of a fire or emergency.
- D. A foster home shall have the following exits:
1. On each floor used by a foster child, two exits which are remote from one another;
 2. On each floor, at least one exit with a direct, unobstructed and safe means of travel to the outdoors, and a safe method to reach street or ground level;
 3. A window serving as a second exit only if:
 - a. It is accessible to children and care-givers;
 - b. It can be readily opened; and
 - c. It is of a size and design to permit a child or care-giver to pass through it; and
 4. On windows with security bars or devices, an emergency release mechanism maintained in good repair.

Historical Note

Adopted effective January 10, 1997 (Supp. 97-1).

R6-5-5847. Special Provisions for a Receiving Foster Home

A foster parent who operates a receiving foster home shall comply with all foster home requirements, in addition to the following:

1. A receiving foster parent shall be prepared to accept a foster child, according to the capacity and terms of the

foster home license, 24 hours per day, seven days per week, unless the foster parent has made other arrangements with the placing and licensing agency.

2. A receiving foster parent may simultaneously provide receiving care, family foster care, and respite care so long as the total number of children in the foster home at any one time does not exceed the ratios prescribed in R6-5-5826 and the terms of the foster home license.

Historical Note

Adopted effective January 10, 1997 (Supp. 97-1).

R6-5-5848. Special Provisions for a Respite Foster Home

- A. A foster parent who operates a respite foster home shall comply with all foster home requirements, except as provided in this Section.
1. A respite foster parent may simultaneously provide respite care, family foster care, and receiving care so long as the total number of children in the foster home at any one time does not exceed the ratios prescribed in R6-5-5826 and the terms of the foster home license.
 2. A respite foster parent may use sleeper sofas, rollaway beds, couches, cots, and sleeping bags or mats as acceptable sleeping accommodations for a child receiving respite care, provided the respite care does not exceed six consecutive days.
- B. A respite foster parent shall request and receive information and instruction from the regular foster home licensee on at least the following:
1. Information and instruction about the specific personal care of a child in respite care;
 2. Information and instruction about the provision of medications required by a child in respite care;
 3. Behavior management policies and practices and specific instructions for a child in respite care; and
 4. Emergency contacts and telephone numbers for a child in respite care.

Historical Note

Adopted effective January 10, 1997 (Supp. 97-1).

R6-5-5849. Special Provisions for an In-home Respite Foster Parent

- A. A person applying for licensure solely as an in-home respite foster parent shall comply with all foster home requirements except as otherwise provided in this Section.
- B. An in-home respite foster parent applicant shall comply with R6-5-5802 and R6-5-5823 except the applicant is not required to provide the following:
1. Immunization records for each child in the applicant's household as required by R6-5-5802(B)(6) and R6-5-5823(5);
 2. Documentation of sufficient income as required by R6-5-5823(2);
 3. A statement explaining the child care arrangements the applicant would make for a foster child, or the applicant's own children, during the applicant's working hours as required by R-6-5802(B)(10);
 4. A statement explaining how activities related to a business activity will not interfere with the care of a foster child as required by R6-5-5802(B)(11);
 5. A description of the applicant's home and neighborhood as required by R6-5-5802(B)(16);
 6. A statement authorizing the licensing agency or the Licensing Authority to arrange for DHS to conduct a health and safety inspection of the applicant's home as required by R6-5-5802(B)(23)(c).

7. Household members are not required to submit to fingerprinting or a criminal history check as required by R6-5-5802(C) and R6-5-5823(3).
- C. The following rules do not apply to a person seeking licensure solely as an in-home respite foster parent:
 1. R6-5-5827. Placement Agreements;
 2. R6-5-5828. Participation in Case Planning, unless requested to do so;
 3. R6-5-5830. Medical and Dental Care;
 4. R6-5-5834. Notification of Foster Child Death, Illness, Accident, Unauthorized Absence, or Other Unusual Events, subsections (B)(3) and (4), unless the change or event directly affects the licensee's ability to provide respite care and comply with these rules;
 5. R6-5-5835. Notification of Events or Changes Involving the Foster Family or the Foster Home, subsection (A), unless the change or event directly affects the licensee's ability to provide respite care and comply with these rules, and subsection (B), except a fire or emergency requiring evacuation of the foster home;
 6. R6-5-5836. Maintenance of a Foster Child's Records, except to document any behavioral incidents, medical care, provision of medication, and any other event or service required by the case plan or which may be requested by the regular foster parent while the in-home respite foster parent has responsibility for the foster child in care;
 7. R6-5-5838. Foster Home: General Requirements;
 8. R6-5-5839. Foster Home: General Safety Measures;
 9. R6-5-5840. Exterior Environment; Play Area; Play Equipment
 10. R6-5-5841. Swimming Pools, subsections (A) and (B);
 11. R6-5-5842. Bedrooms; Bedding; Sleeping Arrangements;
 12. R6-5-5843. Bathrooms;
 13. R6-5-5844. Kitchen;
 14. R6-5-5845. Fire Safety and Prevention, subsections (A) and (B); and
 15. R6-5-5846. Emergencies, Exits, and Evacuation, subsections (A), (C), and (D).
- D. An in-home respite foster parent shall request and receive information and instruction from the regular foster home licensee on at least the following:
 1. The behavior management policies and practices of the home as required by R5-5-5833 and specific instructions which apply to a child in respite care;
 2. Household policies and practices for emergency situations;
 3. Routine household management practices which will provide for continuity in operation of the foster home for the comfort and support of a foster child in care.
- E. An in-home foster parent shall not permit any unlicensed person to accompany or assist the in-home foster parent while providing respite care.
- C. A professional foster parent shall complete the following training:
 1. At least 12 clock hours of pre-service training and six clock hours of ongoing training in addition to the requirements of R6-5-5825(A) and (B);
 2. Training in cardiopulmonary resuscitation (CPR) and first aid; and
 3. Pre-service training related to the type of care and services required by a child to be placed into the professional foster parent's care, which may include the following:
 - a. Training in de-escalation;
 - b. Training in physical restraint practices, as needed; and
 - c. Training in medical and health care issues, procedures, and techniques including:
 - i. The purpose, use, and administration of medications;
 - ii. Medication interactions; and
 - iii. Potential medication reactions.
- D. Notwithstanding any other provisions of this Article, a professional foster home is subject to the licensing limitations in this subsection.
 1. A professional foster home shall have no more than two special care foster children.
 2. The licensing agency may recommend an exception to allow the professional foster parent to care for up to five special care foster children when the foster parent has demonstrated the ability to provide care for more than two special care children.
 3. In deciding whether to recommend increased capacity as allowed by subsection (D)(2), the licensing agency shall assess:
 - a. The professional foster parent's motivation for fostering more than two special care children;
 - b. Any CPS reports involving the professional foster parent; and
 - c. Whether the professional foster parent has demonstrated:
 - i. Verified, successful professional foster parenting experience with two special care children;
 - ii. A minimum of one year of verified, successful work experience with special care children; or
 - iii. Verified specialized skills and training in the care of special care children.
 4. The Licensing Authority shall evaluate the recommendation and determine whether to approve the exception.
- E. Except when temporarily replaced by an approved alternative care provider, a professional foster parent shall serve as the foster child's primary caregiver and be available to provide direct physical and specialized professional services as required in the foster child's case plan.
- F. A professional foster parent shall use best efforts to participate as a member of the service team as prescribed in R6-5-5828(B), through at least one of the following methods:
 1. Personal attendance at team meetings,
 2. Telephonic conference calls,
 3. Provision of a written report on a foster child's progress and problems including any recommendations for service.
- G. A professional foster parent shall maintain at least a weekly record of a special care child's progress and problems, unless more frequent documentation is required, in addition to maintaining the records required by R6-5-5836.

Historical Note

Adopted effective January 10, 1997 (Supp. 97-1).

R6-5-5850. Special Provisions for a Professional Foster Home

- A. A professional foster home shall comply with all foster home requirements except as otherwise provided in this Section.
- B. A professional foster parent applicant shall provide to the licensing agency or the Licensing Authority documentation or demonstration of:
 1. Verified, successful foster parenting experience; or
 2. Verified experience working with or the ability to care for special care children.

- H.** Within the license renewal application, a professional foster parent shall include evidence of current CPR and first aid certification.

Historical Note

Adopted effective January 10, 1997 (Supp. 97-1).

ARTICLE 59. GROUP FOSTER HOME LICENSING STANDARDS

R6-5-5901. Expired

Historical Note

Adopted effective January 18, 1977 (Supp. 77-1). Section expired under A.R.S. § 41-1056(E) at 7 A.A.R. 5257, effective October 31, 2001 (Supp. 01-4).

R6-5-5902. Expired

Historical Note

Adopted effective January 18, 1977 (Supp. 77-1). Section expired under A.R.S. § 41-1056(E) at 7 A.A.R. 5257, effective October 31, 2001 (Supp. 01-4).

R6-5-5903. Definitions

- A.** "Authorized representative." A designated employee of the Department or of the contract provided.
- B.** "Child." Any person under 18 years of age.
- C.** "Department." The Arizona State Department of Economic Security.
- D.** "Foster care." A social service which, for a planned period, provides substitute care for a child when its own family cannot care for it for a temporary or extended period of time. Foster care may be in a private family home, a group home or an institution.
- E.** "Foster care." A child placed in a foster home or a child welfare agency. (A.R.S. § 8-501(3)).
- F.** "Foster child." "A home maintained by an individual or individuals having the care and control of minor children other than those related to each other by blood or marriage, or related to such individuals, or who are legal wards of such individuals." (A.R.S. § 8-501(4))
- G.** "Group foster home." A licensed regular or special foster home suitable for placement of more than five minor children but not more than ten minor children." (A.R.S. § 8-501(5))
 - 1. "Group family home." A licensed regular group foster home for six to ten minor children whose needs are not adequately met in their own family homes and who cannot tolerate close, intimate parent-child relationships.
 - 2. "Group community home." A licensed special group foster home for six to ten minor children who require special care, including adjudicated delinquents, and those with physical, mental or emotional handicap problems. Caretakers of these homes are skilled in caring for such problems.
 - 3. "Group receiving home." A licensed group foster home appropriate for the immediate placement of children when taken into custody or pending medical examination and court disposition, suitable for placement of more than five minor children but not more than ten minor children.
- H.** "License." Includes the whole or part of any agency permit, certificate, approval, registration, charter or similar form of permission required by law.
- I.** "Licensed medical practitioner." "Any physician or surgeon licensed under the laws of this state to practice medicine pursuant to Title 32, Chapters 13 and 17." (A.R.S. § 36-501(4))
- J.** "Licensing." Includes the agency process respecting the grant, denial, renewal, revocation, suspension, annulment, withdrawal or amendment of a license.

- K.** "Parent or parents." "The natural or adoptive parent or parents of the child." (A.R.S. § 8-501(6))

Historical Note

Adopted effective January 18, 1977 (Supp. 77-1).

R6-5-5904. Responsibilities of the Department

- A.** The Department shall establish rules, regulations and standards for:
 - 1. Recruiting, licensing, re-licensing, classification and supervision of group foster homes.
 - 2. Uniform amounts of payment for all group foster homes according to type of license.
 - 3. Form and content of investigations, reports and studies concerning licensing.
 - 4. Denying, revoking or suspending foster home licenses.
- B.** The Department shall provide training, consultation and technical assistance to group foster parents.
- C.** The Department shall investigate and take action to prevent continued operation of group foster homes being conducted or maintained without a license.
- D.** The Department will ensure that standards represent current child welfare practices which are considered necessary to promote a safe environment for children, and which will contribute toward the normal growth and development of foster children, and which will encourage the development of meaningful relationships with peers, adults and the community.
- E.** The Department shall not be obligated to make referrals or payments to a licensed group foster home.

Historical Note

Adopted effective January 18, 1977 (Supp. 77-1).

R6-5-5905. Expired

Historical Note

Adopted effective January 18, 1977 (Supp. 77-1). Section expired under A.R.S. § 41-1056(E) at 7 A.A.R. 5257, effective October 31, 2001 (Supp. 01-4).

R6-5-5906. Licensing Requirements

- A.** Consultation. Individuals, associations, institutions or corporations considering the establishment of a group foster home shall consult the Social Services Bureau of the Department about such plans before a specific program is developed, before action is taken to establish such a home, and before an application is filed.
- B.** Application. Individuals, associations, institutions or corporations, whether operating for profit or without profit, which desire to conduct or manage a group foster home shall make written application to the department on the prescribed forms.
- C.** Fingerprints
 - 1. Foster parents and members of the household, 18 years of age or older, must be fingerprinted and the fingerprints submitted to the Department for a criminal records check.
 - 2. Where group foster care is provided by a firm, corporation, association or organization, all members of the staff having contact with the foster children must be fingerprinted and the fingerprints submitted to the Department for a criminal records check.
 - 3. A license for a group foster home will not be issued, or will be revoked, if any member of the household, 18 years of age or older, or any staff member, has ever been convicted of a sex offense, or involved in child abuse, child neglect, trafficking in narcotics, a criminal offense pattern, or contributing to the delinquency of a minor.
- D.** Demonstration of health

1. The potential foster care applicant, or any staff member, prior to licensing shall furnish the Department, on the prescribed form, with a physical examination report.
2. Physical examinations must demonstrate that the person has good health and is free from any communicable disease.
3. A licensed medical practitioner must certify on the form prescribed by the Department that the health of the foster parents is adequate to undertake the tasks expected.
4. The foster parents, or group foster home Director, shall notify the Department when an individual residing or working in the group foster home contracts a disease or illness which may present a threat to the health of the foster child.
5. Prior to licensing, children of the foster care applicant shall have current immunizations as prescribed by the Arizona Department of Health Services.

E. References

1. Applicants for the original license only shall provide the Department with at least three references as to their character and their ability to provide foster care.
2. The references may not be relatives of any degree of blood or marriage.

F. Home study

1. A study will be made by an authorized representative of the Department to evaluate the potential and actual ability of the foster parents in this specific building and neighborhood to give care and protection to children placed in the home according to the standards prescribed in this Article.
2. To obtain this information, the authorized representative must make at least one home visit to inspect the house and yard and evaluate the neighborhood, interview all persons living in the home including children old enough to interview, and observe relationships.
3. In addition, the authorized representative shall interview the foster parents, the group home Director and staff to obtain information regarding the services to be provided.
4. The Department may request staff of other governmental agencies to make inspections or investigations to determine if the applicant meets standards of the Department. These will include, but not be limited to, inspections for fire, safety, and health.

G. Agreements

1. Prior to being licensed, group foster parents or the group foster home Director must sign the Foster Home Agreement form as prescribed by the Department.
2. Subsequent to being licensed, if the group foster home is going to be used by the Department, there must be a Contract Provider Agreement signed.

Historical Note

Adopted effective January 18, 1977 (Supp. 77-1).

R6-5-5907. Denial, Suspension, or Revocation of a License

- A.** The Department shall deny, suspend, or revoke any license when:
 1. The foster home is not in compliance with the licensing standards of the Department, Arizona state or federal statutes, city or county ordinances or codes;
 2. The physical or emotional needs of foster children are not met;
 3. Needed medical care is not arranged, or when a foster child's medical or psychiatric plan of treatment is not followed; or
 4. There is misrepresentation or the violation of public confidence.

- B.** When the applicant for the licensing or re-licensing of a foster home does not meet, or is in violation of, Department standards, the applicant shall be notified by certified mail, return receipt requested, that the application is being denied.

1. The written notice shall state the reason why the application is denied, with references to applicable statutes, regulations and standards.
2. When a license has been denied, suspended or revoked, the Department shall notify the foster parents of the right to a fair hearing.
3. When a hearing is requested, the denial, suspension, or revocation of the license is not final until after the hearing officer issues a decision.
4. The Department shall conduct appeals as prescribed in 6 A.A.C. 5, Article 75.

Historical Note

Adopted effective January 18, 1977 (Supp. 77-1).

Amended effective June 4, 1998 (Supp. 98-2).

R6-5-5908. Re-licensing Requirements

- A.** Every license shall expire one year from the date of issuance and may be renewed annually on application of the group foster home.

1. License renewal is not automatic.
2. License renewal requires:
 - a. A consultation;
 - b. An application;
 - c. Physical examinations;
 - d. A home study;
 - e. The foster home agreement; and
 - f. The contract provider agreement.

- B.** An application for the renewal of a license for a foster home shall be made in the same manner as the original application. A licensee should reapply when:

1. The present license will expire within 30 to 60 days.
2. The marital status of the licensee has changed;
3. There is a change in the original program and/or purpose of the home.

Historical Note

Adopted effective January 18, 1977 (Supp. 77-1).

R6-5-5909. Standards for Licensing and Operating Group Foster Homes

- A.** Requirements for family group home foster parents

1. Attitude and ability
 - a. Applicants for licensing and licensed group foster parents shall:
 - i. Have previous training or experience with the type of children for which the foster home is certified;
 - ii. Be able to identify with the Department's programs and goals, work within its policies and follow the recommendations of the authorized representatives of the Department;
 - iii. Participate in training designated by the Department;
 - iv. Have a wholesome attitude toward, and understanding of child development, discipline, health, nutrition, sex education, and the various experiences which a child may have and with which a child may need assistance and guidance; and
 - v. Be capable of accepting the child's relationship with his/her parents.
 - b. Children under the age of 18 years, of applicants for licensing and licensed foster parents must demon-

- strate a willingness to share their parents and home with foster children.
2. Age
 - a. Foster parent applicants must be over the age of 18 years and under the age of 65 years.
 - b. Persons over the age of 65 years may be licensed if recommended by an authorized representative of the Department and if a licensed medical practitioner attests that the health of the foster parents is adequate to undertake the tasks expected.
 3. Marital status
 - a. The presence of both a foster father and a foster mother is considered desirable. However, this requirement may be waived at the discretion of the Department.
 - b. If the foster parents consist of a husband and wife, they shall have been married to each other for at least 12 months prior to the original application for license.
 - c. Single parents may apply for licensing if they can demonstrate the ability to care for children adequately.
 - d. A single parent whose marriage has been dissolved by divorce or death, or who has had a legal separation, must wait 12 months before applying for a license to provide foster care. This does not apply to group foster parents who are currently licensed.
 4. Employment
 - a. Foster parents will not be licensed for the care of children under six years of age if both parents work.
 - b. Working parents who apply for licensing or relicensing must demonstrate to the authorized representative of the Department the ability to give adequate care and supervision to foster children.
- B. Requirements for community group home staff**
1. The administrator of a community group home shall have:
 - a. A bachelor's degree plus two years of verifiable experience in the field of residential child care, education or other allied profession and shall be responsible for the management of the business and program of the community group home; or
 - b. A high school diploma and shall have had four years of verifiable work experience in the fields indicated above, including administrative responsibility.
 2. Each child care staff member shall have prior successful experience in child care or related areas or have an academic background relating to this field.
- C. Requirements for the organization of a community group home**
1. Every community group foster home, whether it is operated on a profit or a nonprofit basis, shall be incorporated under the laws of the state of Arizona.
 2. There shall be a board of directors composed of members of the community, none of whom are members of the staff of the community group foster home.
 3. The board of directors shall be responsible for appointing an administrator to assume the full responsibility of directing the business and program of the community group foster home.
- D. Financial resources**
1. Family group home. Foster parents shall have sufficient income to meet the needs of the family unit without dependence upon the payments made in behalf of the foster children.
 2. Community group home
 - a. A community group home shall have a sound plan of financing to assure sufficient funds to enable it to carry out the planned program for children.
 - b. The community group home shall operate on a budget which has been approved by its governing board before the beginning of the fiscal year. The current budget of a community group home shall reflect sufficiency of funds to pay the costs associated with the home's functions.
- E. Supervision and care of foster children. The following requirements apply to both the family group home and the community group home.**
1. General guidelines
 - a. The group foster home shall provide care, training, guidance and controls.
 - b. The group foster home shall see that each child attends school as required by law. Each child shall be given the opportunity to complete high school or vocational training in accordance with the youngster's aptitude.
 - c. The group foster home shall at no time leave children overnight unless attended by a responsible adult.
 - d. The group foster home shall never leave unattended children under 12 years of age or an older child who needs special care for physical, mental or emotional reasons.
 - e. The group foster home shall not accept for care a foster child who has any evidence of a communicable disease or accept for care any foster child when there is evidence of communicable disease in the group foster home.
 - f. The group foster home shall not release a foster child to anyone for care other than the agency from whom the child was received or a person specifically designated by the child placing agency.
 - g. The group foster home shall provide training in good health practices, including proper habits in eating, bathing, personal grooming and hygiene suitable to the child's age and needs.
 - h. The group foster home shall plan activities that stimulate and provide for social relationships, creative activities and hobbies.
 - i. The group foster home shall give children opportunities to participate in neighborhood, school and other community groups appropriate to the age and needs of the youngster.
 - j. The group foster home shall give children opportunity to invite friends to the foster home and to visit in the homes of friends.
 2. Maintenance of appropriate family ties
 - a. The group foster home, unless otherwise indicated by the authorized representative of the child placing agency, shall make every reasonable effort to maintain meaningful ties between the child and his/her family. This would include provision for letter writing between parent and child, planning with the placing agent for parental visits to the child, and home visits by the child when appropriate.
 - b. The group foster home shall provide and encourage reasonable opportunities for the child to maintain contact with all family members and with other individuals important to the child's welfare, consistent with case planning.
 - c. The group foster home shall not deny children opportunities to visit with the parent(s) or guardian

- unless such visits have been restricted by court action or when the representative of the child placing agency has advised that the visit would be detrimental to the welfare of the child.
3. Religious training. The group foster home shall permit children to attend the church of their choice and have religious training opportunities.
 4. Discipline and controls
 - a. Discipline shall be handled with kindness and understanding.
 - b. Correction must be fair, reasonable and consistent, and must be related to the offense.
 - c. Well-defined rules that set the limits of behavior shall be established.
 - d. When appropriate, children shall participate in establishing the rules.
 - e. No child within the group foster home shall be subjected to cruel, severe, unusual or corporal punishment inflicted in any manner upon the body.
 - f. No youngster shall be subjected to verbal abuse or derogatory remarks about himself/herself or family.
 - g. The child shall not be deprived of visits from significant others in the child's life as a form of punishment when the authorized representative of the child placing agency has identified the visitation as appropriate.
 - h. Punishment connected with functions of living, such as sleeping or eating, shall not be used.
 - i. Discipline should be administered in such a way as to help this child develop self-control, and to assume responsibility for behavior.
 - j. Appropriate remedial action shall be taken when children in care commit delinquent acts.
 5. Exploitation of children
 - a. The group foster home shall assign tasks and work assignments which are appropriate to the age and abilities of the child and which do not interfere with school, health or necessary recreation.
 - b. The group foster home shall not identify children by name or by clear description and must not allow them to be photographed in any publication or other printed or broadcast media. Only the Department may approve exceptions to this rule.
 - c. The group foster home shall not permit children in care to commit illegal acts.
 - d. The group foster home shall not provide or permit the use of alcohol or drugs unless prescribed by a licensed medical practitioner.
 - e. The group foster home shall not use children for money making endeavors or for soliciting on behalf of the facility.
 6. Clothing and personal items
 - a. Each child shall have his/her own clothing and personal possessions as well as storage space for them.
 - b. Clothing shall be of the proper size, of correct weight for climatic conditions and shall be kept clean and in good repair.
 7. Health care of foster children
 - a. The group foster home shall make arrangements for and/or with health care and treatment facilities to minimize and prevent health problems and illness, to give proper attention to those who are ill, and to correct treatable physical and emotional problems.
 - b. The group foster home shall closely observe children for signs of illnesses such as skin rashes, inflamed eyes, running noses, coughs and elevated temperatures, and obtain prompt medical attention.
 - c. The group foster home shall not ignore a child's complaint of pain or illness.
 - d. The group foster home shall obtain the services of specialists to provide care, treatment and consultation when recommended by the licensed medical practitioner used by the group foster home.
 - e. The group foster home shall not place any child in isolation unless recommended by a licensed medical practitioner.
 8. Nutrition. Diets shall be well balanced and adequate to meet the nutritional needs of the children. When ordered by a licensed medical practitioner, special diets shall be provided. No dented or bloated canned foods shall be used. There should be a minimum of three meals per day with one being a cooked full-course meal. Only pasteurized milk shall be used. Appropriate snacks will be provided.
- F. Number of children**
1. The number of children in a group foster home shall not exceed the number for which it has been licensed by the Department.
 2. A sufficient number of staff must be on duty at all times in order to assure proper care for all children. The minimum ration of group foster home child caring staff, not including clerical, housekeeping and maintenance staff, shall be as follows:
 - a. For children from infancy through six years of age, no more than eight children to one staff member on duty at all times.
 - b. For children from 7 to 18 years of age, no more than ten children to one staff member on duty at all times.
 - c. A staff member shall be present in each building where children sleep during sleeping hours, and at least one staff member must be on duty in a family setting if children are present.
 - d. Where there are pre-school, handicapped, bedridden, or other non-ambulatory children present, the ratio shall be no more than five children to one child care staff member for all hours, including sleeping hours.
- G. One category of care**
1. The group foster home shall not be used for categories of care other than group foster care for children. For example, no home shall offer, at the same time, full-time care and care for part of the day.
 2. The group foster home shall not combine care of adults and children except in the care of an unmarried mother and her child, or in the case of persons under 21 years of age who voluntarily remain in foster care and who are currently enrolled in and regularly attending any high school.
 3. The group foster home shall not house adult roomers and/or boarders; the only exception would be if the roomer or boarder has been with the family for a long period of time and is considered a member of the family. In this case, all the requirements for the family must also be met by the roomers and/or boarders.
 4. Foster children reaching the age of 18 years may remain in the group foster home as roomers or boarders, if this plan is approved by the Department.
- H. Records and reports**
1. Children's records. The group foster home shall maintain a confidential record for each child in care. The information in the child's record shall be made available only to

staff of the group foster home and to authorized representatives of the Department and/or the child placing agency. The record of each child shall contain basic identification, and historical, educational, social, medical and psychological information, along with service plans and progress reports.

2. Financial records

- a. The community group home must maintain complete financial records of all receipts, disbursements, assets and liabilities.
- b. The community group home, as requested by the Department, must provide budgetary information. The facility must provide for an annual audit of all accounts by an auditor who is not an employee of the facility or a member of its Board of Directors. The person or firm preparing the audit must be certified or registered with the Arizona State Board of Accountancy.
- c. The group foster home shall maintain a written record of expenditures for clothing and personal allowances for each child.

3. Reports

- a. The group foster home shall report immediately to the child placing agency whenever a child is injured, runs away, or when there is any other significant change in the child's situation.
- b. The group foster home shall report all new placements and discharges within five working days.
- c. The group foster home shall report to the Department any planned change of address, change in program, or other change which significantly affects the care provided. The Department shall be notified 30 days prior to any planned changes.
- d. Family group home foster parents shall report any change of marital status, and any new roomers or boards in the house.
- e. The community group home shall report to the Department any change in staff within five days of employment or discharge.

I. Requirements of home and equipment

1. Location. The group foster home must be in a district where schools and medical care are accessible, and where children can associate with other children and participate in community activities. The group foster home shall be on, or accessible to, a road passable 12 months of the year. The foster parent(s) or staff shall be able to provide private transportation or public transportation shall be near and available. The group foster home must comply with local zoning requirements.
2. Financial records
 - a. The group foster home shall comply with any building, health, fire or other codes in effect in the jurisdiction where it is located. Health inspections will be requested and inspections or clearances may be requested from fire, building, and zoning officials when necessary to verify conformity.
 - b. A mobile home may not be licensed as a group home.
 - c. The house shall be in good repair and large enough to prevent crowding.
 - d. Every habitable room shall be heated so that a 70 degree temperature can be maintained when measured at a height of 3 feet from the floor. Every habitable room shall have adequate cooling in those areas of the state with a warm desert climate. House and garden insecticides, medicines, and all corrosive

materials shall be kept in locked storage out of the reach of the children. Such storage shall not be in or near kitchen or food storage areas.

3. Windows and doors

- a. Every sleeping room shall have at least one window and one door. The window must open to the outside. The window in every livable room shall be a minimum of 22 inches in width with 5 square feet in area to provide clear access to the outside without grills or other obstructions, and to provide adequate lighting and ventilation. The sill shall be a maximum of 48 inches from the floor.
- b. In sleeping rooms where there is no mechanical ventilation which draws a portion of its air from the outside, there must be one window to the outside of at least ten square feet, half of which can be opened.

4. Room dimensions and areas

- a. Rooms shall have a minimum ceiling height of 7 feet, 6 inches. Hallways, corridors, and bathrooms shall have ceiling height of at least 7 feet to the lowest projection from the ceiling.
- b. If any room has a sloping ceiling, the prescribed ceiling height for the room is required in only one-half the room except that no portion of the room where the ceiling height is less than 5 feet will be counted as available space.
- c. All rooms must contain 70 square feet minimum area except bathrooms and kitchens. No rooms may have any dimension less than 70 feet except kitchens and bathrooms.

5. Sleeping rooms

- a. General requirements. Each child shall have a bed equipped with springs, a clean, comfortable covered mattress, spread, a suitable pillow with case, two sheets, and suitable blankets for warmth. Sheets and pillow cases shall be cleaned at least weekly. Use of bedrooms should not be restricted to sleeping only.
- b. Each child shall have a place to store his clothing and personal belongings and have easy access to the possessions. Individual dressers or drawer space and closet space is essential for each child.

6. Space requirements. There shall be 50 square feet of floor space (excluding closet space) per child in sleeping rooms. The capacity of each sleeping room will be determined individually.
7. Sleeping arrangements

- a. A child shall not sleep in a bed with an adult.
- b. No child over three years of age shall share a bedroom with an adult.
- c. Children over five years of age shall not sleep in the same room with children of the opposite sex.
- d. Every child shall have his own bed.
- e. Children shall sleep within calling distance of an adult member of the family. No foster child shall sleep in a detached building, unfinished attic, basement, stairway, hall, or room commonly used for other than bedroom purposes. No caretaker's child or other child in the household shall be displaced and made to occupy such sleeping quarters because of a foster child.
- f. Bunkbeds of more than two tiers shall not be used. Two-tier bunkbeds shall not be used, however, for children under eight. The beds must be constructed so as to offer comfort and safety and provide sufficient head room.

8. Bathing and toilet facilities

- a. General requirements
 - i. Lavatories, bathrooms, and toilets shall be adjacent and easily accessible to sleeping rooms. Rooms shall be adequately ventilated to the outside air and shall not open directly onto any pantry, kitchen, serving-room, or dining room.
 - ii. Tubs and/or showers shall have safety strips applied, rubber bath-mats, or other provisions made to prevent slipping.
 - iii. Adequate provision shall be made for keeping individual toilet articles.
 - b. Number of facilities. Each group foster home shall have at least two complete bathrooms that are accessible to the children. (A bathroom with only one exit door into the bedroom of the caretaker(s) will not be considered accessible to children.) There shall be at least one bathtub and/or shower, one toilet, and one waste basin for each six to ten children residing in the home.
9. Kitchen. Approval of the Arizona State Department of Health Services is required for all food services and equipment in accordance with the provisions of A.R.S. § 8-504.
 10. Dining area
 - a. The dining area shall be furnished with the necessary furniture to accommodate those living in the group foster home.
 - b. Location of the dining area shall be convenient to the kitchen.
 11. Living room. There shall be an adequately furnished living room or living area.
 12. Medicine cabinets. Medicines shall be stored in a clean, locked cabinet that is designated for this use only. All medications which have been prescribed for past illnesses or for children discharged from the foster home shall be destroyed.
 13. Laundry. Adequate provisions shall be made to care for the laundry.
 14. Space and water heaters. Space and water heaters must be vented to the outside, adequately grounded, and installed to comply with building, plumbing, electric and fire codes.
 15. Water supply. Where a municipal water system does not supply water to the home, the water must be tested once a year by the General Sanitation Section of Arizona State Department of Health Services.
 16. Swimming and wading pools
 - a. Swimming pools shall meet the requirements of the Arizona State Department of Health Services.
 - b. The pool shall be made inaccessible to children under the age of six; they shall be supervised at all times.
 - c. During the swimming season, the swimming pool shall be tested and logged daily for free chlorine and to determine the pH of the water. Water safety courses are required.
 - d. Tests shall comply with the requirements of the Arizona State Department of Health Services.
 17. Play area
 - a. There shall be adequate space for both indoor and outdoor play.
 - b. The premises, inside and out, shall be equipped and maintained in a manner which is not hazardous to children.
 18. Fire protection
 - a. All group foster homes shall have a written fire evacuation plan posted and should conduct fire drills at least once every two months.
 - b. Portable fire extinguishers of a type approved for the intended use are strongly urged.
 19. Telephone. There shall be telephone service in the group foster home.
 20. Vehicle(s). The vehicle(s) for transporting children shall be in a safe operating condition and all drivers shall have a current driver's license.
 21. Insurance
 - a. The group foster home shall provide for insurance coverage for adequate protection against accidents.
 - b. Insurance coverage must include liability insurance to cover acts of children or staff, and protection against damages to, or loss of, buildings and other valuable properties.
 - c. There shall be liability insurance on all vehicles transporting children.

Historical Note

Adopted effective January 18, 1977 (Supp. 77-1).
Amended effective February 21, 1980 (Supp. 80-1).

R6-5-5910. Confidentiality

The rules and regulations of the Department for securing and using confidential information concerning the client will be followed. Refer to Title 6, Chapter 5, Article 23, "Safeguarding of Records and Information."

Historical Note

Adopted effective January 18, 1977 (Supp. 77-1).

R6-5-5911. Expired**Historical Note**

Adopted effective January 18, 1977 (Supp. 77-1). Section expired under A.R.S. § 41-1056(E) at 7 A.A.R. 5257, effective October 31, 2001 (Supp. 01-4).

R6-5-5912. Expired**Historical Note**

Adopted effective January 18, 1977 (Supp. 77-1). Section expired under A.R.S. § 41-1056(E) at 7 A.A.R. 5257, effective October 31, 2001 (Supp. 01-4).

ARTICLE 60. COMPREHENSIVE MEDICAL/DENTAL PROGRAM FOR FOSTER CHILDREN

R6-5-6001. Objective

The goal of the Comprehensive Medical/Dental Program for Foster Children is to provide, in the most cost effective manner, full coverage for those medical and dental services which are necessary to the achievement and maintenance of an optimal level of physical and mental health for children in foster care.

Historical Note

Adopted effective March 11, 1977 (Supp. 77-2).
Amended effective March 28, 1978 (Supp. 78-2).

R6-5-6002. Authority

Article 60 is adopted pursuant to the power vested in the Director of the Department of Economic Security by A.R.S. §§ 8-511(A)(2), (A)(3), (B) and (C) and 8-512.

Historical Note

Adopted effective March 11, 1977 (Supp. 77-2).

R6-5-6003. Definitions

A. "Adjudicated child." A child adjudicated by the court as dependent, neglected or delinquent residing in a licensed foster family home or child welfare agency.

- B.** “Ambulatory care institution.” A health care institution licensed by the Arizona Department of Health Services with inpatient beds providing limited hospital services on an outpatient basis including an outpatient surgical center and an outpatient treatment center.
- C.** “Ancillary services.” Special services and items furnished to an institutional recipient, which are separately payable in addition to the daily room and board charge.
- D.** “Authorization.” An approval given by the designated Departmental representative or representative of the fiscal intermediary to a specific medical/dental provider to render services or items to a specific recipient.
- E.** “Claim.” The invoice submitted by the medical/dental provider for reimbursement for covered services.
- F.** “Comprehensive Medical/Dental Program for Foster Children.” The name for the program authorized by legislation and regulated as shown herein by the Department.
- G.** “Covered services.” As defined in R6-5-6005.
- H.** “Dentist.” An individual licensed to practice dentistry and/or oral surgery by the appropriate regulatory board of the state of Arizona. The term shall include such individual only when practicing within the scope of the license.
- I.** “Department.” The Department of Economic Security.
- J.** “Director.” The Director of the Department of Economic Security.
- K.** “Emergency dental services.”
 - 1. Those services necessary to control bleeding, relieve pain, eliminate acute infections.
 - 2. Operative procedures which are required to prevent pulpal death and the imminent loss of teeth.
 - 3. Treatment of injuries to the teeth or supporting structures.
 - 4. Palliative therapy for pericoronitis associated with impacted teeth.
 - 5. Reduction of maxillary and mandibular fractures.
- L.** “Emergency services.” Those services required for alleviation of severe pain or for immediate diagnosis or treatment of an unforeseen medical condition which, if not immediately diagnosed and treated, would lead to rapid deterioration of the health status.
- M.** “Eye care services.” Diagnostic eye examinations to detect the presence or absence of ocular abnormality or visual disability, treatment related thereto, and the dispensing of eye glasses or other optical devices, when necessary, to improve visual performance.
- N.** “Eye glasses.” Frames with lenses prescribed by an ophthalmologist, other licensed medical practitioner or optometrist to aid or significantly improve visual performance.
- O.** “Foster care provided.” A home or child-caring agency licensed by the state as a foster home, group home or child welfare agency, which provides care and maintenance for foster children.
- P.** “Foster child.” A child adjudicated by the court as dependent, neglected or delinquent or on whom the parent(s) have signed the necessary paperwork for voluntary foster care and who are residing in a licensed foster home or child welfare agency.
- Q.** “Hearing aid.” Any wearable instrument or device designed for or represented as aiding, improving or compensating for defective human hearing, and any parts, attachments or accessories of such instrument or device, including earmolds.
- R.** “Hearing aid evaluation.” The application and interpretation of a battery of tests by an otolaryngologist, otologist, other licensed medical practitioner or audiologist to determine if amplification may be advantageous to an individual’s hearing and what parameters of amplification are required to obtain a satisfactory result.
- S.** “Identification card.” A plastic card for each foster child issued by the Department to establish the identity of the child eligible for the covered services.
- T.** “Inpatient.” A person who has been admitted to a hospital or skilled nursing facility for bed occupancy for purposes of receiving inpatient services. A person will be considered an inpatient when formally admitted as an inpatient, i.e., when admitted for a period of more than 12 hours or through the census hour.
- U.** “Inpatient hospital services.” Those services and items furnished by the hospital for the care and treatment of inpatients under the direction of a physician or dentist.
- V.** “Inpatient hospital services.” Those services and items furnished by the hospital for the care and treatment of inpatients under the direction of a physician or dentist.
- W.** “Legend drugs.” Those drugs which, under federal or state law or regulations, may be dispensed only by prescription.
- X.** “Medical/dental provider.” Any person, institution or entity which provides covered services to an eligible foster child recipient under the program.
- Y.** “Medical equipment.” Durable items and appliances that can withstand repeated use, are designed primarily to serve a medical purpose and are not generally useful to a person in the absence of a condition, illness or injury.
- Z.** “Nursing services.” Those services that are performed by or under the supervision of a registered nurse at the direction of a licensed practitioner.
- AA.** “Ophthalmologist.” A licensed medical practitioner who specializes in the diagnosis and treatment of the eye and its related structures.
- BB.** “Optometrist.” A person registered with the state medical board to practice optometry.
- CC.** “Orthodontic condition.” A clinically obvious physical abnormality of tooth and/or jaw relationships.
- DD.** “Orthopedic devices.” Supportive or corrective devices used for treatment of a musculoskeletal abnormality or injury.
- EE.** “Otolaryngologist.” A licensed medical practitioner whose practice is limited to the specialty of conditions or disease of the ear, nose and throat and who qualifies as a specialist in those areas.
- FF.** “Otolologist.” A physician who limits his practice to the specialty of conditions and diseases of the ear and who qualifies as a specialist in this area.
- GG.** “Outpatient.” Not an inpatient.
- HH.** “Palliative services.” Those services required to reduce the severity or relieve the symptoms of a condition, illness or injury.
- II.** “Physical therapist.” A person registered to practice physical therapy.
- JJ.** “Physical therapy services.” Those services provided by or under the supervision of a physical therapist.
- KK.** “Physician.” An individual licensed to practice medicine or medicine and surgery (including an osteopathic practitioner), a podiatrist or an optometrist. The term shall include such individuals who have been granted a license to practice by the appropriate regulatory board of the state of Arizona and shall include them only when they are practicing within the scope of such license. The term shall also include a Christian Science practitioner recognized by the Mother Church and listed as such in the “Christian Science Journal.”
- LL.** “Prescription.” An order to a provider for covered services issued, signed and transmitted by an individual authorized to prescribe such services.
- MM.** “Preventive services.” Those health services designed to forestall a condition, illness or injury.

- NN.** “Prior authorization.” This term shall have the definition given it by the terms and procedures of R6-5-6007.
- OO.** “Prosthesis.” An artificial substitute for a missing body part including but not limited to an arm, leg, eye, tooth, etc.
- PP.** “Psychologist.” An individual certified by the State Board of Psychologist Examiners.
- QQ.** “Radiological services.” Professional and technical X-ray and radioisotope services ordered by a licensed medical practitioner or dentist for diagnosis, prevention, treatment or assessment of a medical condition. Radiological services includes portable X-ray, radioisotope, medical imaging and radiation oncology.
- RR.** “Rehabilitation services.” Physical, occupational, speech and respiratory therapy, audiology services and other restorative services and items ordered by a physician to attain maximum reduction of physical or mental disability and restoration of the individual to an optimum functional level.
- SS.** “Routine physical examinations.” Medical examinations performed without relationship to treatment or diagnosis of a specific condition, illness or injury. This includes physical examinations for employment.
- TT.** “Skilled nursing facility.” A health care institution which is licensed by the Department of Health Services as a skilled nursing facility.
- UU.** “Speech therapist.” A person who has been granted the Certificate of Clinical Competence in the American Speech and Hearing Association or who has completed the equivalent educational requirements and work experience required for such a certificate.
- VV.** “Therapeutic services.” Those curative services required for treatment of a condition, illness or injury and includes acute, chronic and emergency care.
- WW.** “Treatment plan.” That portion of the authorization process which requires that the attending physician and other professional allied health personnel involved in the care of a recipient establish and review periodically a plan of treatment and care for each recipient.
- XX.** “Fee schedule.” Allowable amounts established by the Department for medical, dental, and psychological care for foster children.

Historical Note

Adopted effective March 11, 1977 (Supp. 77-2).
Amended effective March 28, 1978 (Supp. 78-2).

R6-5-6004. Eligibility

- A.** The Department shall pay or cause to be paid the cost of necessary covered services, up to the maximum allowed by the fee schedule, rendered to children who are:
1. Placed in a licensed foster home or licensed child welfare agency by:
 - a. The Department of Economic Security; or
 - b. The Department of Corrections; or
 - c. The Juvenile Probation Office.
 2. Placed in a licensed receiving foster care facility (shelter care).
 3. Or for whom temporary custody has been awarded to the Department, and who are placed in a hospital for care and treatment.
- B.** Children born to an eligible foster child (as defined in subsection (A) of this Section) shall be eligible for payment of routine newborn care and treatment up to and including the third day of life. This period may be extended where the need is established by such persons as the Director shall designate.
- C.** Persons under the age of 21 who were placed in a foster family home or institution prior to the age of 18, and who voluntarily remain in such care and who are currently enrolled in and regularly attending any high school.

Historical Note

Adopted effective March 11, 1977 (Supp. 77-2).

Amended effective March 28, 1978 (Supp. 78-2).

Amended effective May 25, 1979 (Supp. 79-3).

R6-5-6005. Definition of Covered Services

Comprehensive medical/dental services shall include but not be limited to the following covered services:

1. A complete preplacement medical examination prior to the initial foster placement in a regular or special foster home. Such examination shall include as a minimum:
 - a. Vaccinations to prevent mumps, rubella, smallpox and polio if not previously provided to the foster child.
 - b. Tests for anemia, coccidioidomycosis and tuberculosis.
 - c. Urinalysis, blood count and hemoglobin tests.
 - d. Standard medical procedures used for determining the recipient's general health, hearing and vision, including prescribing corrective devices when needed.
 - e. Further evaluation and diagnosis as is medically necessary.
2. Periodic medical examinations, not less than once each year, subsequent to initial placement for a child placed in a setting other than his parents' home.
3. Inpatient care. Benefits shall be paid for necessary inpatient hospital or skilled nursing facility care, including diagnosis and treatment, for physical or mental illness, for injury or for pregnancy, and shall include items and services which are ordered pursuant thereto by a physician, dentist or psychologist and which are ordinarily furnished by the hospital or skilled nursing facility for care and treatment of inpatients. Included shall be:
 - a. Bed and board, including dietary services and general nursing care, in a semi-private room (i.e., room with two or more beds) or a private room if medically necessary.
 - b. Professional services furnished through or by the hospital, including the services of a physician, dentist or psychologist; physical therapy; rehabilitation services; and medical social services.
 - c. Ancillary services as follows:
 - i. Laboratory, therapeutic and diagnostic services including radiological services.
 - ii. Use of operating room, recovery room emergency room and intensive care.
 - iii. Drugs, blood, oxygen, medical supplies, equipment and appliances related to care and treatment in the hospital.
 - iv. Prosthetic and orthopedic devices.
4. Inpatient professional care. To include surgery, assistance at surgery, administration of anesthesia, hospital visits and consultations, professional administration and interpretation of laboratory and radiological procedures and test results, and other necessary care and procedures and rendered by a physician, dentist or psychologist in accordance with all rules and regulations of the hospital.
5. Outpatient professional evaluation, care and treatment. To include preventive, palliative, diagnostic, therapeutic, rehabilitative, surgical, or other such items and services which are administered or provided on an outpatient basis for the necessary diagnosis or treatment of injury, pregnancy, physical or mental illness.

6. Laboratory and x-ray services ordered by a physician, dentist or psychologist for diagnosis and treatment.
7. Dental care provided by or under the direct supervision of a dentist. To include oral examinations, diagnostic radiography, oral prophylaxis, topical fluoride applications, restoration of permanent and primary teeth, pulp therapy, extraction when necessary, fixed space maintainers where needed, oral hygiene instruction, orthodontia and other service procedures necessary for relief of pain and infection.
8. Prescription and non-legend drugs prescribed by a physician or dentist.
9. Ambulance services.
10. Private duty nursing.
11. Injections, immunizations, allergy testing and treatment.
12. Physical therapy, speech therapy, respiratory therapy, radiation therapy, etc.
13. Electrocardiograms, electroencephalograms and other similar diagnostic procedures.
14. Medical equipment, corrective medical appliances and orthopedic devices or prostheses.
15. Services of an ambulatory care institution.
16. Eye care services and eyeglasses.
17. Hearing evaluations, hearing aid evaluations and hearing aids.
9. Care and services rendered to an individual who is not an eligible foster child.
10. Any covered service for which no charge would have been rendered in the absence of this program.
11. Any admission, service, item, or otherwise covered service requiring prior authorization where such authorization has not been obtained or has been denied.
12. Services of naturopaths and chiropractors.
13. Psychological services or other diagnostic or treatment services for a foster child in a child welfare agency which provides such care as part of its contractual services which are already paid for by the Department, including services provided by the agency's staff.
14. Care and services rendered to a foster child under the Bureau of Indian Affairs foster care program.
15. Care and services rendered a foster child placed in Arizona by another state whether voluntarily or under jurisdiction of the court of another state.
16. Non-medical items such as, but not limited to, slippers, hair cuts, snack bar merchandise, shampoos and writing paper.
17. The following dental care services:
 - a. Any care which requires prior authorization and for which prior authorization was not sought or was sought but was not granted, unless ordered by the Court.
 - b. Oral hygiene instruction which exceeds \$6.00 per fiscal year.
 - c. Porcelain-fused-to-metal crowns.
 - d. Acrylic veneered gold crowns whose position in the mouth is posterior to the second bicuspid.
 - e. Full crowns except when teeth cannot be restored by a pin-reinforced restoration.
 - f. Gold inlays.
 - g. Temporary restorations, except to the extent they are considered part of and paid for as a part of the finished restoration.
 - h. Building up any tooth, except to the extent it is considered part of and paid for as a part of the finished restoration.
 - i. Building up a tooth beneath a crown.

Historical Note

Adopted effective March 11, 1977 (Supp. 77-2).

R6-5-6006. Exceptions, Limitations and Exclusions

The Department shall not pay for:

1. The cost of any covered service which is not medically necessary for prevention, diagnosis or treatment of a condition, illness or injury.
2. That portion of the cost of any covered service which exceeds the charges set by the fee schedule. The medical/dental provided is hereby prohibited from rendering a bill for additional amounts to the Department, its representatives, any fiscal intermediary the Department may contract with to administer this program, the foster child, his guardian, his estate, the foster child's foster parents, his natural parents or any other party.
3. The cost of care and services payable through any federal, state, county or municipal program to which an eligible foster child may be entitled except for the cost of care and services in excess of any such program.
4. The cost of care and services payable through an insurance carrier which provides coverage for the eligible foster child except for the cost of care and services in excess of any such insurance benefits.
5. Psychiatric or psychological evaluations and treatment unless performed or ordered by a licensed medical practitioner or psychologist certified by the State Board of Psychologist Examiners.
6. Any expenses submitted for reimbursement after 180 days following provision or delivery or otherwise covered services.
7. Any service or item furnished primarily for cosmetic purposes rather than for the correction of defects resulting from a condition, illness or injury. In determining whether a service is furnished primarily for cosmetic purposes, consideration will be given to the eligible foster child's psychological welfare and future occupational opportunities. Orthodontic services are included in this category.
8. Non-legend drugs which are not prescribed by a physician or dentist.

Historical Note

Adopted effective March 11, 1977 (Supp. 77-2).

Amended effective March 28, 1978 (Supp. 78-2).

R6-5-6007. Prior Authorization

- A. As hereafter more fully described, authorization is required before certain covered services are rendered in order for those services to be paid for under this Article and A.R.S. §§ 8-511 and 8-512.
- B. Payment will not be made for any covered service which requires prior authorization and either
 1. Was not submitted for such prior authorization or
 2. Was submitted but such prior authorization was not granted.
- C. Any medical/dental provider is hereby prohibited from rendering a bill for charges subject to prior authorization which are not granted prior authorization, such prohibition extending to charges rendered to the Department, its representatives, any fiscal intermediaries the Department may contract with to administer this program, the foster child, his guardian, his estate, the foster child's foster parents, his natural parents or any other party.
- D. Prior authorization shall not be required for the following covered services as actually provided or proposed to be provided:

1. Services necessary to care for acute physical illness, chronic physical illness, acute injury or pregnancy insofar as treatment is consistent with the diagnosis.
 2. Emergency services in all instances, including emergency dental services.
 3. Complete preplacement examination as required by A.R.S. § 8-511(A)(2).
 4. First- and second-year well-baby care not to exceed a total of \$200 for both years.
 5. Initial dental examination and treatment indicated thereby but not to exceed \$50 per fiscal year.
 6. Emergency inpatient psychiatric care not to exceed ten inpatient days.
 7. Rental or purchase of medical equipment when accompanied by physician prescription where cost does not exceed or could reasonably be expected not to exceed \$25 per fiscal year in the aggregate for all such costs in one fiscal year.
 8. Prescription and non-legend drugs which are necessary to the foster child's medical care and appropriate to his treatment regimen.
 9. Eyeglasses for which the cost does not exceed \$60 per pair, including lenses and frames, or which are replacement lenses and/or frames obtained more than 12 months following the preceding pair.
 10. Psychiatric or psychological diagnostic evaluation not to exceed \$200.
 11. Initial psychiatric or psychological interview not to exceed \$50.
- E.** Prior authorization shall be required for the following covered services:
1. Psychiatric or psychological therapy, whether proposed on an individual or group.
 2. Continuation of therapy shown in (1) above past ten outpatient sessions, and thereafter in accordance with appropriate judgment as to what constitutes necessary care as determined from the treatment plan and/or medical record.
 3. Inpatient psychiatric care beyond ten consecutive inpatient days, and thereafter in accordance with appropriate judgment as to what constitutes necessary care as determined from the treatment plan and/or hospital record.
 4. Elective (non-emergency) surgery and expenses associated with such surgery.
 5. First- and second-year well-baby care which exceeds or is expected to exceed a total of \$00 for both years.
 6. Eyeglasses costing more than \$60, including lenses and frames, or which are replacement lenses and/or frames obtained less than 12 months following the preceding pair.
 7. The following specific types of dental care:
 - a. Any service or combination of services which exceeds \$50 in any fiscal year.
 - b. Any treatment plan which proposes a full crown or crowns.
 - c. Any treatment plan which involves replacement of any tooth or teeth, by either removable or fixed appliances.
 - d. Any treatment plan which proposes a fixed bridge.
 - e. Any treatment plan which proposes a partial denture.
 - f. Any treatment plan which proposes treatment of a dentofacial abnormality (orthodontic services).
 8. Rental or purchase of medical equipment (unless necessary due to a medical emergency) when accompanied by physician prescription.
 9. Outpatient therapy services and treatment modalities such as, but not limited to, speech therapy, physical therapy, respiratory therapy, and radiation therapy.

Historical Note

Adopted effective March 11, 1977 (Supp. 77-2).

Amended effective March 28, 1978 (Supp. 78-2).

R6-5-6008. Coordination of Benefits

- A.** The Department shall determine the possible existence of any primary insurance coverage for all eligible foster children at the time the need for foster care is established. The possible existence of such coverage shall be redetermined at least every six months.
- B.** The Department shall request the court to include a statement in its court order requiring parent(s) or guardian of adjudicated children to cooperate with Department of Economic Security in coordinating benefits with any existing health insurance carrier and to maintain any health insurance coverage presently existing which covers the child(ren).
- C.** The Department shall advise the court when parent(s) or guardian of adjudicated children refuse to cooperate with Comprehensive Medical/Dental Program (CMDP) in providing and/or signing appropriate documents required in order to coordinate insurance benefits, or fail to maintain any existing insurance coverage for the child.
- D.** In voluntary placements, the parent(s) or guardian must cooperate with Comprehensive Medical/Dental Program (CMDP) in providing and/or signing appropriate documents required to coordinate health insurance benefits.
- E.** In the absence of health insurance coverage, the Department shall determine what additional resources are available to cover medical and dental costs.

Historical Note

Adopted effective March 11, 1977 (Supp. 77-2).

Amended effective March 28, 1978 (Supp. 78-2).

R6-5-6009. Identification Card

- A.** The Department shall issue, or cause to be issued, an identification card for each eligible foster child.
- B.** The caseworker shall apply for an identification card for the eligible foster child.
- C.** The Department shall immediately upon placement inform the foster care provider in writing that the identification card is not transferable and that the card is to be used only for medical/dental covered services for the foster child whose name appears on the card only so long as said foster child shall remain eligible under this Program.
- D.** The foster care provider shall be given oral and written instructions regarding the use of the identification card when procuring medical and dental care for the eligible foster child.
- E.** When an eligible foster child is terminated from foster care, the foster care provider shall immediately return the identification card to the Department.
- F.** The foster care provider shall return the identification card to the Department seven days from the date an eligible foster child runs away from the foster care provider.

Historical Note

Adopted effective March 11, 1977 (Supp. 77-2).

R6-5-6010. Payment and Review of Claims

- A.** Claims for payment shall be submitted by medical/dental providers in the manner prescribed by the Department.
- B.** Claims for payment for covered expenses shall not be paid if an appointment is not kept and/or if covered services were not rendered or provided.

- C. Claims for payment shall not be accepted or paid prior to the delivery of covered services.
- D. Claims for covered services shall be accepted from medical/dental providers both in and outside the state of Arizona.

Historical Note

Adopted effective March 11, 1977 (Supp. 77-2).

R6-5-6011. Abuse and Misuse of the Program

- A. The Department shall establish a procedure to investigate any alleged abuse of the Comprehensive Medical/Dental Program. If abuse is substantiated, administrative or legal action shall be taken.
- B. The Department shall monitor the activity of the Comprehensive Medical/Dental Program to ensure compliance with the program requirements.

Historical Note

Adopted effective March 11, 1977 (Supp. 77-2).

R6-5-6012. Consent for Treatment

- A. For an eligible foster child adjudicated by the court, the Department shall secure a court order and, if possible, the consent of the parent or guardian for surgery, general anesthesia, blood transfusion, or pelvic examination of a child.
- B. For a foster child in voluntary placement, consent of the parent or guardian shall be necessary only for medical treatment involving surgery, general anesthesia, blood transfusion, or pelvic examination of a child, except for emergency situations described in subsection (C).
- C. In cases of emergency, in which a foster child is in need of immediate hospitalization, medical attention or surgery, and when the parents cannot readily be located, the foster care provider or caseworker may give consent pursuant to A.R.S. § 44-133 for hospital care, medical attention or surgery.
- D. Persons under the age of 21 who were placed in a foster family home or institution prior to the age of 18, and who voluntarily remain in such care, and who are currently enrolled in and regularly attending any high school may give consent for their own treatment.

Historical Note

Adopted effective March 11, 1977 (Supp. 77-2).
Amended effective May 25, 1979 (Supp. 79-3).

R6-5-6013. Administration of the Program

- A. The Department shall have the ability to contract with any insurer, insurance plan, hospital service plan, or any health service plan authorized to do business in this state, or with any fiscal intermediary or with any combination of such plans or methods. Such contract will be entered into for purposes of administering this Comprehensive Medical/Dental Program for foster children in a manner consistent with its authorizing legislation and these regulations.
- B. Such contract, if entered into by the Department, shall be specific as to the responsibilities of each party to the contract and shall provide for reasonable payment to the contractor for his administrative services as required by the contract.
- C. The terms of such contract, if entered into by the Department, shall reflect these regulations. If the Department and the contractor, in the future, determine that certain additions, deletions, corrections or alterations in the contract are required so as to cause the administration of the program to be consistent with the authorizing legislation, these regulations and the intents thereof, such additions, deletions, corrections or alterations shall be made in the contract by mutual written consent, signed by authorized representatives of the Department and the contractor, without first having to alter these regulations.

Historical Note

Adopted effective March 11, 1977 (Supp. 77-1).

R6-5-6014. Case Management

- A. Determining financial need. Financial eligibility for the CMDP is limited to foster children who reside in licensed facilities.
- B. Case management
 - 1. Confidentiality. The rules and regulations of the Department regarding the disclosure and use of confidential information concerning the client, as set forth in A.A.C. Title 6, Chapter 5, Article 23, "Safeguarding of Records and Information" shall apply to all services provided under this Article.
 - 2. Appeals. The rules and regulations of the Department set forth in A.A.C. Title 6, Chapter 5, Article 25, "Complaints and Appeals" shall apply to all services provided under this Article.
 - 3. The rules and regulations of the Department set forth in A.A.C. Title 6, Chapter 5, Article 26, "Civil Rights" shall apply to all services provided under this Article.
- C. Closing the service. Service shall be closed when the child is no longer in foster care.

Historical Note

Adopted effective March 11, 1977 (Supp. 77-2).
Amended effective March 28, 1978 (Supp. 78-2).

R6-5-6015. Fee Schedule

- A. The Comprehensive Medical and Dental Program shall pay providers in accordance with the established fee schedule unless otherwise specified by contract or required by this Article.
- B. A current fee schedule shall be maintained in the central office of the CMDP for reference use during customary business hours. Relevant information or portions of the fee schedule shall be made available to service providers and other interested persons on request.

Historical Note

Adopted effective May 15, 1990 (Supp. 90-2).

EXHIBIT 1. REPEALED**Historical Note**

Exhibit as filed is incomplete. Exhibit adopted effective March 28, 1978 (Supp. 78-2). Amended by adding Maximum Allowable Anesthesia Fee Schedule effective April 17, 1980 (Supp. 80-2). Amended Medicine - Psychiatric Services; Radiology - Urinary Tract; Dental - Restorative, Endodontics, and Fixed Prosthodontics effective September 17, 1980; Maximum Allowable Anesthesia Fee Schedule not included (Supp. 80-5). Repealed effective May 15, 1990 (Supp. 90-2).

ARTICLE 61. REPEALED**R6-5-6101. Repealed****Historical Note**

Adopted effective August 11, 1976 (Supp. 76-4). Former Section R6-5-6101 repealed, new Section R6-5-6101 adopted effective August 29, 1984 (Supp. 84-4).
Repealed effective June 5, 1997 (Supp. 97-2).

R6-5-6102. Repealed**Historical Note**

Adopted effective August 11, 1976 (Supp. 76-4). Former Section R6-5-6102 repealed, new Section R6-5-6102 adopted effective August 29, 1984 (Supp. 84-4).
Repealed effective June 5, 1997 (Supp. 97-2).

R6-5-6103. Repealed**Historical Note**

Adopted effective August 11, 1976 (Supp. 76-4). Former Section R6-5-6103 repealed, new Section R6-5-6103 adopted effective August 29, 1984 (Supp. 84-4). Repealed effective June 5, 1997 (Supp. 97-2).

R6-5-6104. Repealed**Historical Note**

Adopted effective August 11, 1976 (Supp. 76-4). Former Section R6-5-6104 repealed, new Section R6-5-6104 adopted effective August 29, 1984 (Supp. 84-4). Repealed effective June 5, 1997 (Supp. 97-2).

R6-5-6105. Repealed**Historical Note**

Adopted effective August 11, 1976 (Supp. 76-4). Former Sections R6-5-6105 through R6-5-6108 repealed effective August 29, 1984 (Supp. 84-4).

R6-5-6106. Repealed**Historical Note**

Adopted effective August 11, 1976 (Supp. 76-4). Former Sections R6-5-6105 through R6-5-6108 repealed effective August 29, 1984 (Supp. 84-4).

R6-5-6107. Repealed**Historical Note**

Adopted effective August 11, 1976 (Supp. 76-4). Former Sections R6-5-6105 through R6-5-6108 repealed effective August 29, 1984 (Supp. 84-4).

R6-5-6108. Repealed**Historical Note**

Adopted effective August 11, 1976 (Supp. 76-4). Former Sections R6-5-6105 through R6-5-6108 repealed effective August 29, 1984 (Supp. 84-4).

ARTICLE 62. REPEALED

Former Article 62 consisting of Sections R6-5-6201 through R6-5-6209 repealed effective August 29, 1984.

ARTICLE 63. REPEALED

Former Article 63 consisting of Sections R6-5-6301 through R6-5-6304 repealed effective November 8, 1982.

ARTICLE 64. REPEALED

Former Article 64 consisting of Sections R6-5-6401 through R6-5-6408 repealed effective February 1, 1979.

**ARTICLE 65. DEPARTMENT ADOPTION FUNCTIONS
AND PROCEDURES FOR PROVIDING ADOPTION
SERVICES**

R6-5-6501. Definitions

In addition to the definitions in A.R.S. § 8-101, the following definitions apply in this Article and in Articles 66, 70, and 71, unless the context requires otherwise:

1. “Adoptable child” means a child who is legally available for adoption but who has not been placed for adoption.
2. “Adoptee” means a child who is the subject of a legal petition for adoption.
3. “Adoption agency” has the same meaning ascribed to “agency” in A.R.S. § 8-101(2).
4. “Adoption entity” or “entity” means a person or organization performing a particular adoption service, and includes an adoption agency and the Department but does

not include a private attorney who is licensed to practice law in the state of Arizona and who is only assisting in a direct placement adoption to the extent allowed by A.R.S. § 8-130(C).

5. “Adoption placement” or “placement” means the act of placing an adoptable child in the home of an adoptive parent who has filed, or who contemplates filing, a petition to adopt the child.
6. “Adoption services” means activities conducted in furtherance of an adoption and includes the activities listed in R6-5-6504 and R6-5-7002(B).
7. “AHCCCS” means the Arizona Health Care Cost Containment System established pursuant to A.R.S. Title 36, Chapter 29.
8. “AHCCCSA” means the Arizona state government agency which administers the AHCCCS program.
9. “Birth parent” means the biological mother or father of a child.
10. “Central Adoption Registry” or “Registry” means the computerized bank of information described in A.R.S. § 8-105(O).
11. “Certification application” means the form which a prospective adoptive parent submits to an adoption entity or to the court to request a certification investigation.
12. “Certification investigation” means the process referred to in A.R.S. § 8-105(C) by which an adoption entity determines if a prospective adoptive parent is a fit and proper person to adopt.
13. “Certification order” means a judicial determination that a prospective adoptive parent is a fit and proper person to adopt.
14. “Certification report” or “adoptive home study” means the written report described in A.R.S. § 8-105(H) in which an adoption entity summarizes the results of a certification investigation and makes a recommendation for or against certification of a prospective adoptive parent.
15. “Certified adoptive parent” means a person who has been certified as fit and proper to adopt and who is awaiting placement of an adoptable child.
16. “Child with special needs” means a child who has one of the special needs listed in A.R.S. § 8-141(A)(14).
17. “Client” means a person who is receiving adoption services from an adoption entity and includes adoptive children, adoptive families, adoptive parents, and birth parents.
18. “CPS” means Child Protective Services, a Department program responsible for investigating reports of child abuse or neglect.
19. “CPSCR” means the Child Protective Services Central Registry, a computerized data bank of information concerning reports of child abuse or neglect, which CPS maintains pursuant to A.R.S. § 8-546.03.
20. “Department” has the same meaning ascribed to “Division” in A.R.S. § 8-101(7).
21. “Developmentally appropriate” means an action which takes into account:
 - a. A child’s age and family background;
 - b. The predictable changes that occur in a child’s physical, emotional, social, cultural, and cognitive development; and
 - c. The individual child’s pattern and history of growth, personality, and learning style.
22. “Document” means to make and retain, in a record or file, a written summary of a fact, a contact, a communication, an observation, or an event.

23. “Final report to the court” means a written report about an investigation which an adoption entity performs pursuant to A.R.S. § 8-112, in which the entity advises the court of the entity’s assessment and recommendations about finalization of a particular adoption.
24. “Foster parent” has the same meaning prescribed in A.R.S. § 8-501(A)(5).
25. “ICPC” means the Interstate Compact on the Placement of Children described in A.R.S. § 8-548.
26. “ICWA” means the Indian Child Welfare Act described in 25 U.S.C. 1901 et seq.
27. “License” means a document that the Department issues to an agency authorizing the agency to perform adoption services.
28. “License applicant” means a person, group, or business entity which seeks to become licensed or to renew a license as an adoption agency.
29. “Open adoption” means an adoption in which the adoptive parent and the birth parent agree to a full exchange of personally identifying information and to meet each other at the time of adoption, and to have ongoing written or personal contact with each other in the future.
30. “Out-of-state agency” means any person who, or business which, is authorized or licensed by a state other than Arizona, or a foreign country, to perform adoption services.
31. “Placed child” means an adoptable child who has been placed with an adoptive parent and the adoptive parent has not yet filed a petition to adopt the child.
32. “Placement investigation” means the process referred to in A.R.S. § 8-105(F) by which an adoption entity determines if a particular placed child is suitable for adoption by a particular adoptive parent.
33. “Placement report,” “report to the court on placement of a child,” or “RCPC” means the written report described in A.R.S. § 8-105(I) in which an adoption entity summarizes the results of the placement investigation and makes a recommendation as to whether a particular child is suitable for adoption by a particular adoptive parent.
34. “Placement supervision period” or “probationary period” means the time period from the date of adoption placement until the court enters a final order of adoption, during which the petitioner has the rights prescribed in A.R.S. § 8-113(D).
35. “Prospective adoptive parent” means a person who has applied to an adoption entity to become certified to adopt a child.
36. “Reasonable fee” means
 - a. A fee commensurate with:
 - i. The actual cost of providing a specific service or item to a specific individual, or
 - ii. The average cost of a service or item if the adoption entity routinely uses an averaging method to determine the cost of a particular service or item.
 - b. A reasonable fee may include reasonable compensation for officers and employees and a reasonable profit margin above actual or averaged costs. As used in this Section, reasonableness is determined as prescribed in R6-5-6503(G).
37. “Semi-open adoption” means an adoption in which the adoptive parent and the birth parent agree to share some personally identifying information or to have one meeting at the time of adoption and which may include some form of limited communication in the future, such as exchange of annual letters or photographs.

38. “Social study” or “home study” means the investigation an adoption entity performs, pursuant to A.R.S. § 8-112, after a petition for adoption has been filed.

Historical Note

Adopted effective July 6, 1977 (Supp. 77-4). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-6502. Central Adoption Registry: Information Maintained; Confidentiality

- A. The Department shall maintain and keep current the Central Adoption Registry in accordance with A.R.S. § 8-105(O). The Registry shall include the following current information for each child or adoptive parent listed on the Registry:
 1. The child’s availability for adoptive placement,
 2. The adoptive family’s certification status,
 3. The adoptive family’s availability for adoptive placement, and
 4. The type of child the adoptive family is open to considering for adoption.
- B. Upon request, the Department shall provide personally identifiable Registry information to:
 1. Licensed adoption agencies, including out-of-state agencies;
 2. Adoption registries and exchanges; and
 3. The Court.
- C. Before providing information, the Department shall obtain, from the person requesting the information, the following:
 1. The name and affiliation of the person requesting the information;
 2. The reason for the request; and
 3. If the requesting party is other than a court representative, a signed statement acknowledging that the information is confidential and promising not to release the information to anyone except as allowed by A.R.S. §§ 8-120 and 8-121.
- D. In lieu of the signed statement described in subsection (C)(3), the Department shall accept a signed commitment to treat all Registry information in accordance with the provisions of subsection (C)(3). The signed commitment is effective for one year and shall be annually renewed.

Historical Note

Adopted effective July 6, 1977 (Supp. 77-4). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-6503. Expired

Historical Note

Adopted effective July 6, 1977 (Supp. 77-4). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 1722, effective July 29, 2011 (Supp. 11-3).

R6-5-6503.01. Expired

Historical Note

Adopted effective January 2, 1996 (Supp. 96-1). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 1722, effective July 29, 2011 (Supp. 11-3).

R6-5-6504. Department Adoption Services

- A. The Department provides the following adoption services in accordance with the limitations and provisions of A.R.S. Title 8, Chapter 1, Article 1:
 1. Recruiting prospective adoptive parents;
 2. Informing persons interested in adopting a child about the adoption process;

3. Conducting certification investigations of prospective adoptive parents as provided in A.R.S. § 8-105(C), (D), and (E);
4. Preparing certification reports as provided in A.R.S. § 8-105(E) and (H);
5. Taking adoption consents from birth parents;
6. Preparing non-identifying, preplacement information on adoptive children for adoptive parents, as required by A.R.S. § 8-129(A);
7. Submitting the names and profiles of adoptable children and certified adoptive parents for listing in the Central Adoption Registry;
8. Preparing children for adoptive placement;
9. Matching adoptable children with certified adoptive parents;
10. Placing adoptable children in the homes of certified adoptive parents;
11. Investigating and reporting to the court on the suitability of particular placements as provided in A.R.S. § 8-105(F) and (I);
12. Monitoring adoption placements during the placement supervision period;
13. Providing services to placed children and adoptive families to assist with family adjustment to the adoption placement;
14. Conducting social studies pursuant to A.R.S. § 8-112 and preparing final reports to the court; and
15. Assisting county attorneys by providing legal documents to enable families to complete the adoption process.

- B.** When performing adoption services, the Department shall adhere to the standards established for adoption agencies in Articles 66 and 70.

Historical Note

Adopted effective July 6, 1977 (Supp. 77-4). Amended effective November 22, 1978 (Supp. 78-6). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-6505. Department Procedures for Processing Certification Applications

- A.** Upon receipt of a certification application, the Department shall mail the applicant written notice that the application is either complete or incomplete. An application is complete when it contains the information and supporting documentation described in R6-5-6604. If the application is incomplete, the notice shall specify what information is lacking.
- B.** An applicant with an incomplete application has 30 calendar days from the date of the notice to provide the missing information. If the applicant fails to do so, the Department may close the file. An applicant whose file has been closed and who later wishes to apply for certification, shall apply anew.
- C.** Upon receipt of a complete application, the Department shall decide whether to accept the application for processing, according to the priority schedule listed in R6-5-6506, and the availability of the Department's resources. If the Department cannot accept the application, the Department shall return the original application and all supporting documentation to the applicant.
- D.** After the Department accepts the completed application, the Department shall mail the applicant written notice of the acceptance and shall complete the certification investigation in accordance with the procedures specified in R6-5-6605 within 90 days of the date of notice. The Department shall prepare a certification report in accordance with R6-5-6606.
- E.** The Department shall process a renewal application in accordance with the requirements of this rule and R6-5-6607.

Historical Note

Adopted effective July 6, 1977 (Supp. 77-4). Amended effective November 22, 1978 (Supp. 78-6). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-6506. Department Priorities for Receipt of Services

The Department shall accept and process certification applications and render adoption services according to the following priority schedule:

1. First priority: applicants seeking to adopt a particular adoptable child with special needs;
2. Second priority: applicants who wish to adopt a child with special needs;
3. Third priority: applicants who have indicated they would consider adopting a child with special needs;
4. Fourth priority: applicants for whom the court has ordered the Department to do a certification investigation and report; and
5. Fifth priority: all other applicants.

Historical Note

Adopted effective July 6, 1977 (Supp. 77-4). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-6507. Department Recruitment Efforts

The Department shall actively recruit persons to adopt children with special needs by:

1. Publicizing the need for such adoptive parents;
2. Registering adoptable children, as appropriate, with the following:
 - a. The Central Adoption Registry,
 - b. Arizona adoption agencies,
 - c. The National Adoption Exchange,
 - d. The Arizona Adoption Exchange Book, and
 - e. Other exchange books and publications;
3. Advising prospective adoptive parents of the availability of children with special needs, the procedures involved in adopting such children, and the support services and subsidies which may be available to persons adopting such children; and
4. Other measures similar to those described in this Section.

Historical Note

Adopted effective July 6, 1977 (Supp. 77-4). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-6508. Referrals to Other Sources

- A.** The Department shall offer certified adoptive parents, who are awaiting placement through the Department, the option of referral to the following adoption resources:
1. The National Adoption Exchange,
 2. The Arizona Adoption Exchange, and
 3. Other regional and national exchanges outside Arizona.
- B.** Upon request, and to the extent that resources are available, the Department may assist families interested in adopting a child with special needs with registration on the National Adoption Exchange and other regional and national exchanges outside Arizona. Such assistance may include sending the family's application to other adoption exchanges or computer banks.

Historical Note

Adopted effective July 6, 1977 (Supp. 77-4). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-6509. Fees

- A.** The Department shall charge the following fees for performing adoption services:
1. \$800.00 for performing a certification investigation and preparing a certification report, which is due with an applicant's completed application form; and
 2. \$50.00 for performing a records search for a confidential intermediary, as set forth in A.R.S. § 8-134.
- B.** The Department may waive or defer payment of part or all of a certification fee if the applicant demonstrates and the Department finds that payment of a fee would:
1. Cause the applicant financial hardship,
 2. Be detrimental to an adoptive child, or
 3. Preclude the applicant from making application.
- C.** An applicant who seeks a fee waiver or deferral shall file a written request for waiver explaining the reason for the request.
- D.** The Department shall act on the request within 14 calendar days of receiving the request. If the Department denies the request, the Department shall notify the applicant of the denial in writing and advise the applicant to submit the fee to complete the application. Denial of a fee waiver is not appealable.

Historical Note

Adopted effective July 6, 1977 (Supp. 77-4). Amended effective November 22, 1978 (Supp. 78-6). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-6510. International Adoptions

- A.** The Department shall make available to prospective adoptive parents interested in adopting a foreign-born child, the names of international adoption agencies.
- B.** The Department shall not provide adoptive supervision services to international adoption agencies unless there is no other resource to do so within the county where the child is placed, and the Department has the resources available to provide supervision without exceeding the standards for acceptable caseloads prescribed in R6-5-7020.

Historical Note

Adopted effective January 2, 1996 (Supp. 96-1).

R6-5-6511. Termination of Services

- A.** The Department may terminate services to an adoptive parent in the following circumstances:
1. A child is placed, the adoption is finalized, and no further adoption-related services are required;
 2. The prospective or certified adoptive parent requests closure before receiving a child for placement;
 3. The prospective or certified adoptive parent ceases to be a resident of Arizona before receiving a child for placement;
 4. The court declines to certify the prospective adoptive parent;
 5. The prospective adoptive parent refuses to comply with requirements set forth in A.R.S. Title 8, Chapter 1, Article 1, or Articles 65 or 66 of these rules; or
 6. The prospective adoptive parent fails to submit a completed certification application within 90 days of the date on which the Department sent the person an application form.
- B.** The Department may terminate services to an adoptive child when:
1. The Court issues a final adoption order; or
 2. The child's case management team determines that adoption is no longer the most appropriate case plan for the

child, and the Department provides alternate services consistent with the child's new case plan.

Historical Note

Adopted effective January 2, 1996 (Supp. 96-1).

ARTICLE 66. ADOPTION SERVICES**R6-5-6601. Definitions**

The definitions in R6-5-6501 apply in this Article.

Historical Note

Adopted effective January 18, 1978 (Supp. 78-1). Amended effective August 15, 1980 (Supp. 80-4). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-6602. Recruitment

- A.** When recruiting clients, an adoption entity shall comply with the requirements of this Section.
- B.** The adoption entity shall conduct recruitment efforts pursuant to a written plan, which shall describe:
1. Specific recruitment goals, including:
 - a. Number and composition of adoptive parents the entity will serve; and
 - b. The type of children the entity will accept for placement, if limited as to age, race, or other specific characteristics;
 2. Methods of recruitment;
 3. The number and professional qualifications of staff designated to handle recruitment; and
 4. The means by which the adoption entity shall fund its recruitment efforts.
- C.** The adoption entity's recruitment efforts shall be consistent with the personal characteristics of the children the entity has available for adoption and reasonably expects will become available through the entity.
- D.** An adoption entity shall not:
1. Promise to place more children than the entity's prior history shows it can reasonably expect to place,
 2. Promise to place a child in less time than the average waiting period demonstrated by the entity's past practice,
 3. Promise that an adoption will be subsidized prior to formal approval of an adoption assistance agreement which meets the requirements of A.R.S. § 8-141 et seq., or
 4. Make any other statements or promises the entity knows or reasonably should know are false, misleading, or inaccurate.

Historical Note

Adopted effective January 18, 1978 (Supp. 78-1). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-6603. Orientation: Persons Interested in Adoption

- A.** Prior to accepting a certification application from a person contemplating adoption of a child, or an application for placement from a person who intends to seek a placement through the entity, an adoption entity shall provide the person with adoption orientation, which shall explain the following:
1. The adoption process, including all legally mandated procedures and estimated time-frames for completion of such procedures;
 2. The adoption entity's policies and procedures that directly affect services to adoptive parents;
 3. The adoption entity's fee structure and written fee agreement;
 4. The types and number of children the agency typically has had and reasonably expects to have available for

- adoption placement and the average length of time between certification and placement;
5. The Department's responsibility for licensing and monitoring agencies, and the public's right to register a complaint about an agency as prescribed in R6-5-7034;
 6. The function of the Central Adoption Registry and the adoptive parent's right to decide whether to be included in the Registry;
 7. Confidentiality requirements, open adoptions, and the confidential intermediary program described in A.R.S. § 8-134; and
 8. The requirements prescribed in A.R.S. § 8-548.07, to reimburse AHCCCSA for the cost of prenatal care and delivery of a child placed pursuant to the ICPC.
- B.** A person who is already knowledgeable about all or part of the matters listed in subsection (A) may waive orientation on those matters which are familiar, with the approval of the adoption entity. A person may be knowledgeable due to a prior adoption through an Arizona adoption entity, or employment in adoption services, or for other similar reasons.
- C.** An adoption entity shall maintain written documentation showing that any person who has applied to the entity for certification or for placement of a child has received the orientation described in subsection (A), as prescribed in R6-5-7027(1), or has obtained a waiver as prescribed in subsection (B). If some or all orientation is waived, the adoption entity shall document the matters waived and the reasons for the waiver.
- D.** An adoption entity shall not charge a person for anything other than a certification application fee, or enter into an adoption fee agreement with a person, until the person has received the orientation described in subsection (A).

Historical Note

Adopted effective January 18, 1978 (Supp. 78-1).
 Repealed effective August 15, 1980 (Supp. 80-4). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-6604. Application for Certification; Fees; Waiver

A person who wishes to become certified as an adoptive parent shall apply for certification as provided in A.R.S. § 8-105(A). An adoption entity shall require an applicant to provide at least the following information:

1. Personally identifying information for each prospective adoptive parent, including:
 - a. Name and date of birth;
 - b. Social Security number;
 - c. Race and nationality;
 - d. Physical description;
 - e. Current address and duration of Arizona residency; and
 - f. Marital history; and
 - g. The name, address, and phone number of immediate family members, including emancipated adult children;
2. The name, birthdays, and social security number of persons residing with the applicant;
3. A listing of the applicant's insurance policies, including any insurance that may be available to cover the medical expenses of a birth mother or adoptive child; the applicant shall specify the name of the insured, the insurance policy number, and the effective dates of coverage;
4. A current financial statement which shall describe the applicant's assets, income, debts, and financial obligations;
5. A physician's statement as to the applicant's current physical and mental health;
6. A medical and psychological history on the applicant and the applicant's household family members; such history may be a self-declaration of past physical and mental illness;
7. The applicant's employment history;
8. The applicant's social history;
9. A statement from the applicant as to the type of child the applicant seeks to adopt and whether the applicant desires to adopt or would consider adopting a child with special needs;
10. Information on the following legal proceedings in which the applicant has been a party:
 - a. Dependency actions,
 - b. Severance or termination of parental rights actions,
 - c. Child support enforcement actions,
 - d. Actions involving allegations of child maltreatment,
 - e. Adoption proceedings, or
 - f. Criminal proceedings other than minor traffic violations;
11. The applicant's prior history of adoption certification, including prior applications for certification and the dates of any certification denials;
12. An inquiry as to whether the applicant wishes to be listed on the Registry;
13. A fingerprint card on each applicant; and
14. The names, addresses, and phone numbers of five personal references who have known the applicant at least two years and who can attest to the applicant's character and fitness to adopt. At least three references shall not be related to the applicant by blood or marriage.

Historical Note

Adopted effective January 18, 1978 (Supp. 78-1). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-6605. Certification Investigation

- A.** Following acceptance of a completed certification application, the adoption entity shall conduct a certification investigation which shall include, at a minimum, the following:
1. Personal interviews with the adoptive family. Such interviews shall:
 - a. Occur on at least two separate occasions, at least one of which shall be at the adoptive family's residence;
 - b. Comprise no less than four hours of face-to-face contact, at least one hour of which shall take place at the adoptive family's residence;
 - c. Include at least one separate interview with each member of the adoptive family's household who is age 5 or older; and
 - d. Include at least one joint interview with both adoptive parents if the adoptive family is a couple;
 2. Written statements from and personal contact (either a face-to-face meeting or a telephone call) with at least three of the applicant's personal references;
 3. An inquiry as to whether the applicant wishes to be listed in the Central Adoption Registry;
 4. Verification of the applicant's financial condition through a review of one or more of the documents listed in subsection (A)(7)(g) below;
 5. A request to the Department for a check of the CPSCR to determine if the applicant has a past record of complaints of child abuse or neglect;
 6. An evaluation of the success of the placement of other children adopted by the applicant;

7. A review of any supporting documentation the adoption entity reasonably deems necessary to determine an applicant's fitness to adopt, which may include the following:
 - a. A physician's statement regarding the physical health of the applicant's other children;
 - b. A statement from a psychiatrist or psychologist regarding the mental health of the applicant or the applicant's other household members;
 - c. Birth certificates;
 - d. Marriage certificate;
 - e. Dissolution or divorce papers and orders, including child support documentation;
 - f. Military discharge papers;
 - g. Financial statements, tax returns, pay stubs, and W-2 statements;
 - h. Bankruptcy papers;
 - i. Insurance policy information; or
 - j. Documentation showing Arizona residency.
- B. A social worker who meets the qualifications listed in R6-5-7014 shall perform the certification investigation and shall document all personal contacts made and all information reviewed and considered during the investigation.

Historical Note

Adopted effective January 18, 1978 (Supp. 78-1).
 Amended subsection (C) effective August 15, 1980 (Supp. 80-4). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-6606. Certification Report and Recommendation

- A. Upon completion of the certification investigation, the adoption entity shall prepare a certification report in compliance with A.R.S. § 8-105(E) and (H).
- B. In determining whether to recommend certification of an applicant, the adoption entity shall consider all factors bearing on fitness to adopt, including, but not limited to:
 1. The factors listed in A.R.S. § 8-105(E);
 2. The length and stability of the applicant's marital relationship, if applicable;
 3. The applicant's age and health;
 4. Past, significant disturbances or events in the applicant's immediate family, such as involuntary job separation, divorce, or death of spouse, child, or parent, and history of child maltreatment;
 5. The applicant's ability to financially provide for an adoptee; and
 6. The applicant's history of providing financial support to the applicant's other children, including compliance with court-ordered child support obligations.
- C. The certification report shall specifically note any instances where an applicant has:
 1. Been charged with, been convicted of, pled no contest to, or is awaiting trial on charges of, an offense listed in A.R.S. § 46-141; or
 2. Lost care, custody, control, or parental rights to a child as a result of a dependency action or action to terminate parental rights.
- D. If the report recommends denial of certification, the adoption entity shall send the applicant written notice of the unfavorable recommendation and an explanation of the applicant's right under A.R.S. § 8-105(M) to petition the court for review. The adoption entity shall mail the notice to the applicant at least five work days prior to filing the certification report with the court.
- E. The adoption entity shall notify the prospective adoptive parent of the court's certification decision if the Court fails to do so.

Historical Note

Adopted effective January 18, 1978 (Supp. 78-1).
 Amended effective August 15, 1980 (Supp. 80-4). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-6607. Renewal of Certification

- A. A certified adoptive parent who has not filed a petition for adoption within one year of the original certification order, may apply for an extension of certification, as provided in A.R.S. § 8-105(K).
- B. If the Court directs an adoption entity to investigate a certified adoptive parent who has requested a renewal of certification, the entity shall obtain, from the adoptive parent seeking renewal, the following information:
 1. A copy of the request for renewal of certification;
 2. A statement of any changes in the certified adoptive parent's social, family, medical, and financial circumstances;
 3. New fingerprint clearance at least every third year following original certification;
 4. A current medical report for all members of the applicant's household at least every third year following original certification; and
 5. Such other information as the Court may request.
- C. When investigating a request for renewal of certification, the adoption entity shall, at a minimum, complete the following:
 1. Conduct a face-to-face interview at the applicant's home with the applicant and the applicant's other household members over the age of 5,
 2. Investigate any change in circumstances described in the request for renewal as necessary to determine continuing fitness to adopt, and
 3. Document all action.
- D. Upon completion of the renewal investigation, the adoption entity shall prepare and file with the Court a report of the investigation, which shall contain a recommendation for or against renewal of certification.
- E. If the adoption entity recommends that certification not be renewed, the entity shall send the adoptive parent notice as prescribed in R6-5-6606(D).

Historical Note

Adopted effective January 18, 1978 (Supp. 78-1). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-6608. Communications with Certified Parents Awaiting Placement

- Upon request, an adoption entity shall inform a certified adoptive parent awaiting placement of a child of the following:
1. The status of the parent's case;
 2. The number of children the agency currently has available for adoption;
 3. The number of times the parent has been considered for placement of a child;
 4. The number of approved families awaiting placement of a child through the agency; and
 5. The number of placements the agency made in the prior year, the number of placements the agency has made to date in the current year, and the number of placements the agency anticipates making during the remainder of the current year.

Historical Note

Adopted effective January 18, 1978 (Supp. 78-1). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-6609. Prohibitions Regarding Birth Parents

An adoption entity shall not:

1. Promise a birth parent that the birth parent will have future contact with the child or the adoptive parent; the adoption entity may, however, explain the concepts of open adoption and semi-open adoption;
2. Promise a birth parent that the child will be placed with a specific family or type of family, except in a direct placement adoption; the adoption entity may, however, advise the parent that it will use its best efforts to honor any placement preferences the birth parent may have, to the extent that such preference is consistent with the best interests of the child;
3. Promise a birth parent any financial or other consideration prohibited by law; or
4. Do or say anything to coerce or pressure a birth parent to sign a consent.

Historical Note

Adopted effective January 18, 1978 (Supp. 78-1).
Amended effective August 15, 1980 (Supp. 80-4). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-6610. Information about Birth Parents

A. Before accepting a child for placement, the adoption entity shall make a good faith effort to obtain the information described in this Section from the child's birth parent, or person having custody of the child.

1. Information about each birth parent, including:
 - a. Name and any aliases used;
 - b. Address, phone number, and residential history;
 - c. Date and place of birth;
 - d. Social security number;
 - e. Race, citizenship, and any Native American tribal affiliation or membership;
 - f. Physical description;
 - g. Name of current employer and employment history;
 - h. Educational history;
 - i. Marital history and status;
 - j. Record of other births and children born to the birth parent;
 - k. Hobbies;
 - l. Future plans;
 - m. Record of arrests or convictions;
 - n. Medical history;
 - o. For the birth mother, history of prenatal care, gestational substance or drug abuse, pregnancy, and delivery;
 - p. Immediate family relationships; and
 - q. Significant family events.
2. An explanation of the birth parent's decision to place the child for adoption, the factors which influenced that decision, and a record of any counseling the birth parent has received concerning the decision.
3. A record of the birth parent's contact with the child.
4. A statement of the birth parent's feelings about future contact with the child.
5. A list of the birth parent's preferences regarding an adoptive home for the child.
6. Medical history on the birth parent's own parents, siblings, grandparents, aunts, uncles, and first cousins.
7. Information on the child being surrendered for adoption, as appropriate to the age of the child:
 - a. Developmental history,
 - b. Medical history,

- c. Psychosocial background,
- d. Educational history, and
- e. Membership in or affiliation with any Native American tribe.

8. A listing of the birth parent's insurance policies, including any insurance that may be available to cover the medical expenses of the birth mother or adoptive child; the listing shall specify the name of the insured, the insurance policy number, and the effective dates of coverage.

B. The adoption entity shall document all statements and information in a permanent record.

Historical Note

Adopted effective January 18, 1978 (Supp. 78-1). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-6611. Pre-consent Conferences with Birth Parents

A. The adoption entity shall have a pre-consent conference with each birth parent from whom a consent to adoption is required under A.R.S. § 8-106, to explain the following information:

1. The legal and practical consequences of executing a consent, including:
 - a. Applicable ICWA provisions; and
 - b. The fact that the consent, and all other affidavits executed in connection with an adoption, are executed under penalty of perjury;
2. The irrevocability of a consent;
3. The legal prohibition against paying the birth parent to execute a consent;
4. The fact that the birth parent has no obligation to sign the consent; and
5. The provisions of A.R.S. § 8-106(F) regarding an affidavit of potential fathers and A.R.S. § 8-548.07 regarding reimbursement to AHCCSA.

B. The Pre-consent conference shall occur:

1. No earlier than 12 hours after the birth of a child if the conference was not held before the birth, as provided in subsection (B)(2);
2. No earlier than 60 days before the anticipated due date, if the conference is held before the child's birth;
3. At least 24 hours before presenting a birth parent with the consent form for signature; and
4. At a time which takes into account the known medical and emotional condition of the birth parents.

C. The person conducting the pre-consent conference shall provide the birth parent with a sample consent form and shall convey the information described in subsection (A) in a language and form that the birth parent can understand.

D. The person conducting the pre-consent conference shall document that the information was given and understood and shall obtain the birth parent's signature on the documentation. If the conference is telephonic as prescribed in subsection (E), the person may obtain the signature later through the mail. If the conference is not held, the person shall document the reasons, as prescribed in subsection (E).

E. The pre-consent conference may be telephonic and is not required if the birth parent cannot be located or refuses to participate in the conference; however, the entity shall document the reason why the conference did not occur.

F. If required to obtain a consent from a birth father under A.R.S. § 8-106, the adoption entity shall, prior to obtaining the birth father's signature, advise the birth father of the matters listed in subsection (A), in a form and language the birth father can understand. The advice may be included on the consent form.

Historical Note

Adopted effective January 2, 1996 (Supp. 96-1).
Amended by final rulemaking at 5 A.A.R. 1006, effective
March 18, 1999 (Supp. 99-1).

R6-5-6612. Consent to Adopt; Unknown Birth Parent

- A.** A person who obtains a birth parent's signature on a consent shall not do so until the person determines:
 1. That the requirements of R6-5-6611 have been met;
 2. That the birth parent is not acting under duress;
 3. That the birth parent is physically and mentally capable of exercising informed consent; and
 4. That the birth parent has revealed all information known about the identity and location of the other birth parent.
- B.** No one shall advise a birth parent to falsely state that he or she does not know the identity or location of the other birth parent.
- C.** When a birth parent professes not to know the identity or location of the other birth parent, the person taking the consent shall explain the risks and consequences of this response, including the following:
 1. Potential invalidation of the adoption;
 2. Potential detriment to the child's social and physical well-being, due to lack of information concerning the unidentified birth parent's social and medical history; and
 3. Potential penalties for perjury.
- D.** The adoption entity shall document all action taken in compliance with this Section.
- E.** When a birth parent knows, but refuses to disclose, the identity or location of the other birth parent, the adoption entity shall advise the birth parent as provided in subsection (C) and shall also explain that the court may refuse to finalize the adoption.
- F.** The adoption entity shall give the birth parent a copy of the consent and retain a copy in the permanent adoption file.
- G.** The adoption entity shall request a search of the confidential register of information which the Arizona Department of Health Services maintains pursuant to A.R.S. § 8-106.01 if:
 1. A birth father's identity is unknown or undisclosed, and
 2. The adoption entity believes that a search of the register may prevent disruption of a placement or an adoption.

Historical Note

Adopted effective January 2, 1996 (Supp. 96-1).

R6-5-6613. Adoptable Child: Assessment and Service Plan

- A.** Prior to selecting an adoptive placement for an adoptable child, the adoption entity shall:
 1. Assess the child's medical, psychological, social, and developmental needs and shall design an adoptive family profile consistent with the child's needs and best interests;
 2. Design a written plan of developmentally appropriate preplacement and post-placement services necessary to facilitate the child's adjustment to placement;
 3. Assess whether the child is a potential candidate for an adoption subsidy.
- B.** The plan shall, at a minimum, include:
 1. Placing the child on the Registry if there is no adoptive family readily available to adopt the child;
 2. Giving the child a developmentally appropriate explanation of the adoption process.
- C.** The adoption entity shall provide the child with services in accordance with the child's plan.

Historical Note

Adopted effective January 2, 1996 (Supp. 96-1).

R6-5-6614. Placement Determination

- A.** An adoption entity shall have and follow a written policy for making placement recommendations and decisions in both direct placement and agency placement adoptions.
- B.** Except as otherwise provided in subsection (C), in an agency placement adoption, the placement decision shall be made by a team which shall, at a minimum, include:
 1. The case manager or person who assessed the adoptable child, and
 2. The case manager or person who is knowledgeable about the potential adoptive families for the adoptable child.
- C.** In international adoptions, where the case worker who assessed the child is out of the country and unavailable, the agency shall include the person who is most familiar with the adoptable child's needs.
- D.** In an agency placement adoption, an adoption entity shall place an adoptable child in the adoptive setting which best meets the child's needs. In determining who can best meet the needs, the adoption entity shall consider all relevant factors, including, without limitation:
 1. The wishes of the child's birth parent;
 2. Family relationships between the child and the adoptive family members;
 3. The racial, cultural, and ethnic background of the child and the family members;
 4. The family's ability to financially provide for the child and to meet the child's emotional, physical, mental, and social needs;
 5. The placement of the child's siblings;
 6. The availability of relatives, the adoptable child's former foster parents, or other significant persons to provide support to the adoptive family and child; and
 7. All information in the case files of the child and the adoptive family.
- E.** The adoption entity shall document the placement decision.
 1. For adoptions conducted pursuant to the ICPC, the documentation shall comply with the requirements of the ICPC regarding documentation of suitability, as prescribed in A.R.S. § 8-548.
 2. For all other adoptions, the documentation shall include the following:
 - a. The adoptive child's critical needs and characteristics that weighed most heavily in the placement determination,
 - b. The names and general family characteristics of those adoptive parents who most closely matched the child's needs and who were most seriously considered for placement, and
 - c. The reasons why the particular adoptive parent chosen for placement best matched the child's needs and characteristics.
- F.** For adoptions not covered by the ICPC, the adoption entity may document the placement decision in a file or placement log that is separate from clients' case files.

Historical Note

Adopted effective January 2, 1996 (Supp. 96-1).

R6-5-6615. Provision of Information on Placed Child

After selecting an adoptive placement for a child, and before placing the child with the chosen adoptive parent, the adoption entity shall provide the adoptive parent with all nonidentifying information available on the child, including, without limitation, the following:

1. All records concerning the child's medical, social, legal, family, and educational background;

2. All records concerning the birth parents' medical, social, legal, family, and educational background;
3. The medical and social background on the child's other immediate family members, including siblings and birth grandparents;
4. The child's plan of adoption services, as described in R6-5-6613; and
5. Advice on adoption subsidy that may be available for the child.

Historical Note

Adopted effective January 2, 1996 (Supp. 96-1).

R6-5-6616. Transportation

An adoption entity which transports adoptive children shall:

1. Ensure that any such entity or person who transports an adoptive child is informed of the child's medical needs and is capable of meeting any medical needs that are reasonably likely to arise during transport;
2. Not leave an adoptive child unattended during transportation unless the adoption entity has determined, and documented in the child's record, that the child is physically and emotionally capable of traveling alone;
3. Require all persons who provide transport to carry personal identification and a written statement from the agency describing the person's authority and responsibilities while performing transport duties;
4. Require proof of identification from any person accepting temporary or permanent responsibility for an adoptive child during the course of placement; and
5. Document all transportation plans and actual transportation events in the child's record.

Historical Note

Adopted effective January 2, 1996 (Supp. 96-1).

R6-5-6617. Expired**Historical Note**

Adopted effective January 2, 1996 (Supp. 96-1). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 1722, effective July 29, 2011 (Supp. 11-3).

R6-5-6618. Placement Services

- A. An adoption entity shall make counseling services available to the adoptive family as the entity deems reasonable and necessary to facilitate the child's acceptance into the family and to preserve stability. The adoption entity may make such services available by advising the adoptive family that such services may be beneficial and referring the adoptive family to community resources and providers.
- B. The adoption entity shall make information on adoption related educational and supportive resources available to adoptive families.

Historical Note

Adopted effective January 2, 1996 (Supp. 96-1).

R6-5-6619. Post-placement Supervision: Non-foster Parent Placements

- A. When a child is placed for adoption with a person who is not the child's foster parent, a case manager from the adoption entity shall visit the home within 30 calendar days of the date of adoptive placement to:
 1. Ensure that the adoptive parent received all available nonidentifying information on the child;
 2. Address any questions or concerns the adoptive parent or child may have about the adoption process or placement;
 3. Ensure that the family has addressed the educational needs of a school-age child; and

4. Ensure that an adoptive parent who works has made appropriate child care arrangements.

B. Following the initial placement visit described in subsection (A), a case manager from the adoption entity shall:

1. Visit the adoptive family at least once every three months until the adoption is finalized except, when the adoptive child is a child with special needs, the visits shall occur at least once a month. During the first six months following the initial placement visit, at least alternating visits shall occur at the adoptive family's home;
2. Interview all members of the adoptive family's household during the placement supervision period; and
3. Discuss the following issues with the adoptive parent if appropriate in light of the child's age and development:
 - a. How the presence of the child has changed familial relationships;
 - b. How the child and the extended family view each other;
 - c. The role each family member has assumed regarding child care and discipline;
 - d. How the parent is coping with the needs and demands of the placed child;
 - e. How the child challenges or tests the placement and how the family reacts to these episodes, including any feelings of insecurity about the propriety of the family members' response;
 - f. How the family perceives the child's sense of identity and the need to fill in gaps in the child's history; and
 - g. How the child has adjusted to the school environment; and
4. If developmentally appropriate, privately interview the child about the child's feelings about the adoption and the matters listed in subsection (B)(3), at each supervisory visit.

C. The case manager shall document all contacts and communications made pursuant to this Section.**Historical Note**

Adopted effective January 2, 1996 (Supp. 96-1).
Amended by final rulemaking at 5 A.A.R. 1006, effective March 18, 1999 (Supp. 99-1)

R6-5-6620. Post-placement Supervision: Foster Parent Placements

- A. When a foster parent plans to adopt a foster child who is age 5 or older, a case worker from the adoption entity shall privately interview the child and all members of the adoptive family household who are age 5 or older about their feelings towards the adoption, before the adoption consent is signed.
- B. When a child is placed for adoption with a person who has been a foster parent to the child, a case manager from the adoption entity shall conduct home visits at least every two months from the time legal consent for adoption has been signed until the finalization of adoption. If the adoptive child is a child with special needs, the case manager shall visit at least once a month.
- C. During such visits, the case manager shall:
 1. If developmentally appropriate, privately interview the child to discuss the child's feelings about the adoption; and
 2. Interview all members of the adoptive family household, including children, if developmentally appropriate, to discuss, at a minimum, the matters listed in R6-5-6619(B)(3).
- D. The case manager shall document all contacts and communications made pursuant to this Section.

Historical Note

Adopted effective January 2, 1996 (Supp. 96-1).

R6-5-6621. Protracted Placements

If an adoption is not finalized within two years from the date of consent, and the child is still placed in the adoptive home, the agency handling the adoption shall provide the Department with written documentation explaining the reason why the adoption has not been finalized, no later than 30 calendar days after the two-year period has ended.

Historical Note

Adopted effective January 2, 1996 (Supp. 96-1).

R6-5-6622. Finalizing the Placement

An adoption entity shall cooperate with the adoptive parent and the attorney, if any, retained by the adoptive parent, to finalize the adoption.

1. The entity shall provide all information and documents needed to finalize the adoption and shall file a final written report to the court at least 14 calendar days before the final adoption hearing, or at such other time as the Court may require. The report shall include the information listed in this subsection, unless the entity has already provided this information in an earlier report, and the information has not changed since the earlier report.
 - a. The name and age of each adoptive parent and the relationship, if any, of each adoptive parent to the child to be adopted;
 - b. The name, age, and birthplace of the child to be adopted, and whether any or all of this information is unknown to the adoptive parent;
 - c. The entity or other source from which the adoptive parent received the child to be adopted;
 - d. The circumstances surrounding the surrender of the child to the entity;
 - e. The results of the entity's evaluation of the child and of the adoptive parent, including a description of the care the child is receiving and the adjustment of the child and parent, and a summary statement of the entity's recommendation to the court regarding finalization;
 - f. A full description of any property belonging to the child to be adopted;
 - g. An itemized statement of all fees and costs the adoptive parent paid in connection with the adoption, as prescribed in R6-5-6503.
2. If developmentally appropriate, the entity shall solicit and consider the child's wishes concerning adoption.
3. The entity shall notify AHCCSA of any potential third party payors, as prescribed in A.R.S. § 36-2903.01(T), if the entity has not already done so.

Historical Note

Adopted effective January 2, 1996 (Supp. 96-1).

R6-5-6623. Placement Disruption

- A. When a placement fails, the adoption entity shall provide services, including counseling to the family and child, to help them cope with the loss and separation.
- B. An adoption entity shall have and follow written procedures for an adoptive placement disruption. The procedures shall include:
 1. Provision of counselling services to the adoptive family and child as needed; and
 2. Provision for placement of the child in another adoptive home or other developmentally appropriate living arrangement.

- C. The agency shall document the reasons for the disruption and shall take such information into account when making future placements for the adoptive parent and the child.

Historical Note

Adopted effective January 2, 1996 (Supp. 96-1).

R6-5-6624. Confidentiality

Any person who participates in an adoption or provides adoption services shall abide by the confidentiality requirements prescribed in A.R.S. §§ 8-120, 8-121, and 36-2903.01(S).

Historical Note

Adopted effective January 2, 1996 (Supp. 96-1).

ARTICLE 67. ADOPTION SUBSIDY**R6-5-6701. Definitions**

In addition to the definitions in A.R.S. § 8-141, the following definitions apply in this Article:

1. "Adoption/CPS Specialist" means the Department or private agency staff person who is responsible for managing the child's case prior to the adoption finalization.
2. "Adoption subsidy" means the same as in A.R.S. § 8-141 and may include one or more of the following:
 - a. Medical, dental, and mental health subsidy;
 - b. Maintenance subsidy;
 - c. Special services subsidy; and
 - d. Reimbursement of nonrecurring adoption expenses.
3. "Adoption Subsidy Program" means a unit within the Division of Children, Youth and Families designated to administer adoption subsidy.
4. "Adoptive parent" means an adult whom the court has certified or approved to adopt a child, or an adult who has adopted a child.
5. "Adoption subsidy supervisor" means a Department employee who is responsible for the Adoption Subsidy Program within defined geographic areas and whom the Department has authorized to approve an adoption subsidy agreement.
6. "AHCCCS" means the Arizona Health Care Cost Containment System, which is the state's program for medical assistance available under Title XIX of the Social Security Act and state public insurance statutes, A.R.S. Title 36, Chapter 29.
7. "AHCCCS hospital reimbursement system" means the payment structure that AHCCCS uses to pay for inpatient and outpatient hospital services.
8. "Complete adoption subsidy application" means a packet containing:
 - a. A Department-provided "Adoptive Family Subsidy Application" form that the adoptive parent and the Adoption/CPS Specialist and Adoption/CPS Specialist supervisor have completed and signed.
 - b. The supporting documentation and information requested in the "Adoptive Family Subsidy Application."
9. "Debilitating" means a lifelong, progressive, or fatal condition characterized by physical, mental, or developmental impairment that impedes an individual's ability to function independently.
10. "Department" or "DES" means the Arizona Department of Economic Security.
11. "Diagnose" means to identify a physical, psychological, social, educational, or developmental condition according to the accepted standards of the medical, mental health, or educational professions.

12. “Emergency situation” means a circumstance that, if unaddressed, would be detrimental to a child’s life, health, or safety.
13. “Foster Family Care payment” means a monetary payment the Department makes to a foster parent to provide substitute care for a child when the child’s own family cannot care for the child for a temporary or extended period of time.
14. “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).
15. “Qualified professional” means a practitioner licensed or certified by the state of Arizona or another state to evaluate and diagnose conditions or provide medical, dental, mental health, or educational services.
16. “Racial or ethnic factors” means Black, Hispanic, Native American, Asian, or other heritage that has been determined to be a barrier to a child being adopted.
17. “Sibling relationship” means two or more children who are related by blood or by law, and whom the same family has adopted.
18. “Special allowance” means funds provided for clothing or personal expenses, therapeutic or personal attendant care, and other specialized payments such as emergency clothing, education, and gift allowances.
19. “*Special needs*” means one or more of the following conditions which existed before the finalization of adoption:
 - a. *Physical, mental or developmental disability.*
 - b. *Emotional disturbance.*
 - c. *High risk of physical or mental disease.*
 - d. *High risk of developmental disability.*
 - e. *Age of six or more years at the time of application for an adoption subsidy.*
 - f. *Sibling relationship.*
 - g. *Racial or ethnic factors.*
 - h. *High risk of severe emotional disturbance if removed from the care of his foster parents.*
 - i. *Any combination of the special needs described in this paragraph.* (A.R.S. § 8-141)
20. “SSI” means supplemental security income, a direct government benefit available under Title XVI of the Social Security Act.
21. “Standard of care” means a medical or psychological procedure or process that is accepted as treatment for a specific illness, injury, medical or psychological condition through custom, peer review, or consensus by the professional medical or mental health community.
22. “Title IV-E” means section 473 of Title IV of the Social Security Act, 42 U.S.C. 673, which establishes the federal adoption assistance program.
23. “Title XIX” means Medicaid, as defined by Section 1900, Title XIX, of the Social Security Act, 42 U.S.C. 1396.
24. “Title XX” means the Social Services Block Grant, as defined by Section 2001, Title XX, of the Social Security Act, 42 U.S.C. 1397.
25. “Undiagnosed pre-existing special need condition” means a physical, mental or developmental disability or emotional disturbance that existed before a court finalized the child’s adoption and that a qualified professional did not confirm before the child’s adoption.

Historical Note

Adopted effective May 17, 1976 (Supp. 76-3). Amended effective June 19, 1979 (Supp. 79-3). Section repealed; new Section made by final rulemaking at 18 A.A.R. 1449, effective August 6, 2012 (Supp. 12-2).

R6-5-6702. Eligibility Criteria

- A. An Arizona child shall be eligible for adoption subsidy when the child is:
 1. In the care, custody, and control of the Department or other public or private child welfare agency licensed in Arizona, or was previously adopted and received adoption subsidy;
 2. Legally free for adoption;
 3. Legally present in the United States; and
 4. Determined to be a child with special needs as defined by Title IV-E of the Social Security Act and A.R.S. Title 8, Chapter 1, Article 2. To meet the requirements, the Department shall determine that:
 - a. The child cannot or should not be returned to the parent’s home;
 - b. The child cannot be placed with adoptive parents without adoption subsidy due to a specific factor, condition, or special need of the child; and
 - c. A reasonable but unsuccessful effort was made to place the child without an adoption subsidy, unless the Department determined that it was not in the child’s best interest to place the child with another family because of the child’s significant emotional ties with the prospective adoptive parents while in their care as a foster child.
- B. To qualify for Title IV-E adoption subsidy, a child shall also meet the additional eligibility criteria required in 42 U.S.C. 673(a)(2).

Historical Note

Adopted effective May 17, 1976 (Supp. 76-3). Section repealed; new Section made by final rulemaking at 18 A.A.R. 1449, effective August 6, 2012 (Supp. 12-2).

R6-5-6703. Eligibility Determination

- A. The adoptive parent shall submit a complete adoption subsidy application to the Department Adoption Subsidy Program prior to the finalization of the adoption. An application is complete when the Adoption Subsidy Program receives the application and all supporting documentation. Documentation may vary according to the conditions of the child and may include the recommendations of qualified professionals.
- B. The Department shall review the application and determine eligibility according to the following:
 1. The Department shall approve eligibility for adoption subsidy if a child meets the eligibility criteria listed in R6-5-6702. If the Department approves eligibility, the Department shall create an adoption subsidy agreement that the adoptive parent and the adoption subsidy supervisor or designee shall sign before the court enters the final order of adoption.
 2. The Department shall deny eligibility for adoption subsidy if a child does not meet the eligibility criteria listed in R6-5-6702. If the Department denies adoption subsidy, the Department shall send notice to the adoptive parent that explains the reason for denial, the applicant’s right to appeal, and the time-frame to file an appeal.

Historical Note

Adopted effective May 17, 1976 (Supp. 76-3). Section repealed; new Section made by final rulemaking at 18 A.A.R. 1449, effective August 6, 2012 (Supp. 12-2).

R6-5-6704. Adoption Subsidy Agreement

- A. The Department shall create an adoption subsidy agreement that lists the scope and nature of the subsidies provided, including:
 1. The child’s documented pre-existing conditions;

2. The types of subsidy approved;
 3. The amount or rates as applicable to the types of subsidy approved; and
 4. The specific terms and conditions of the agreement.
- B.** The adoption subsidy agreement shall become effective if the following occurs prior to the finalization of the adoption:
1. The adoptive parent signs the agreement and returns it to the Department Adoption Subsidy Program, and
 2. The adoption subsidy supervisor or designee signs the agreement.

Historical Note

Adopted effective May 17, 1976 (Supp. 76-3). Amended effective June 19, 1979 (Supp. 79-3). Section repealed; new Section made by final rulemaking at 18 A.A.R. 1449, effective August 6, 2012 (Supp. 12-2).

R6-5-6705. Medical, Dental, and Mental Health Subsidy

Adoption subsidy provides medical, dental, and mental health subsidy in the form of AHCCCS/Medicaid coverage to a child in the Adoption Subsidy Program who is determined eligible for AHCCCS/Medicaid. The relevant agency in the state in which the child resides determines AHCCCS/Medicaid eligibility.

Historical Note

Adopted effective May 17, 1976 (Supp. 76-3). Amended effective June 19, 1979 (Supp. 79-3). Section repealed; new Section made by final rulemaking at 18 A.A.R. 1449, effective August 6, 2012 (Supp. 12-2).

R6-5-6706. Maintenance Subsidy

- A.** Maintenance subsidy is the monthly payment paid to the custodial adoptive parent to assist with the costs directly related to meeting the adopted child's needs, including but not limited to child care, health insurance co-payments and deductibles, and supplemental educational services for the child. It is not expected to cover all the daily living expenses of the adopted child. The Department and the adoptive parent shall negotiate the amount of maintenance subsidy based on a child's current special needs and the family's circumstances.
1. As required by A.R.S. § 8-144(B), the amount of the maintenance subsidy shall not exceed the payments allowable under foster family care, not including special allowances.
 2. The Department shall deduct private or public monetary benefits, such as benefits received through Title II of the Social Security Act, paid to the child from the monthly maintenance subsidy, as allowed under state or federal law. The adoptive parents shall report the receipt of any monetary benefits for the child to the Adoption Subsidy Program.
- B.** Payment of Maintenance Subsidy
1. The Department shall not begin maintenance subsidy payments prior to the effective date of the adoption subsidy agreement.
 2. The Department shall issue maintenance subsidy payments monthly to the adoptive parent as specified in the adoption subsidy agreement.
- C.** Renegotiation of the Maintenance Rate
1. The Department or the adoptive parent may initiate a change in the maintenance subsidy rate if there are changes in the child's needs.
 2. The adoptive parent shall provide the Department with documentation supporting the requested change in the maintenance subsidy rate.
 3. If the child is in the care or custody of an agency or individual other than the adoptive parents, the Department shall request, and the adoptive parents shall provide, doc-

umentation of the adoptive parents' continued legal and financial responsibility for the child.

Historical Note

Adopted effective May 17, 1976 (Supp. 76-3). Amended effective June 19, 1979 (Supp. 79-3). Amended by final rulemaking at 18 A.A.R. 1449, effective August 6, 2012 (Supp. 12-2).

R6-5-6707. Special Services Subsidy

- A.** Special services subsidy is financial assistance for extraordinary, infrequent, or uncommon needs related to a special needs condition specified in the adoption subsidy agreement.
- B.** Special services shall be:
1. Related to a special needs condition listed in the adoption subsidy agreement;
 2. Necessary to improve or maintain the adopted child's functioning as documented by an appropriate qualified professional. The Adoption Subsidy Program shall review the documentation at least annually;
 3. Provided by a qualified professional;
 4. Provided in the least restrictive environment and as close as possible to the family's residence;
 5. In accordance with the "Standard of Care"; and
 6. Not otherwise covered by or provided through maintenance subsidy, medical subsidy, dental subsidy, mental health subsidy, or other resources for which the adopted child is eligible.
- C.** The adoptive parent shall submit the special services request to the Adoption Subsidy Program and receive approval from the Adoption Subsidy Program prior to the adoptive parent's incurring the specified expense. The request shall include:
1. Documentation from a qualified professional that the service is necessary; and
 2. Documentation that the adoptive parent had requested the service and the service provider had denied the request or documentation that the service is not available from other potential funding sources, such as AHCCCS/Medicaid, private insurance, school district, or other community resources.
- D.** Special services subsidy shall not include:
1. Payment for services to meet needs other than the pre-existing special needs conditions specifically listed in the adoption subsidy agreement;
 2. Payment for medical or dental services usually considered to be routine, such as well-child checkups, immunizations, and other services not related to the child's special needs conditions in the adoption subsidy agreement;
 3. Payment for health-related services that are not medically necessary, as determined by a qualified professional;
 4. Payment for social or recreational services such as routine child care, dance lessons, sports fees, camps, and similar services; and
 5. Payment for educational services that are not necessary to meet the special needs conditions specifically listed in the adoption subsidy agreement, or the services for which the school district is responsible.
- E.** The Department may request an independent review by a qualified professional of a special services request to determine the necessity for medical, dental, psychological, or psychiatric testing or services, or to evaluate the appropriateness of the treatment plan or placement.
- F.** The Department shall issue reimbursements to the adoptive parent for approved special services. If requested by the adoptive parent due to the adoptive parent's inability to pay, the Department may pay the service provider directly.

- G.** Special services subsidy reimbursement is limited as follows:
1. The Department shall reimburse in-state and out-of-state inpatient and outpatient hospital services according to the AHCCCS hospital reimbursement system, as required by A.R.S. § 8-142.01(A), if the adoptive parent has obtained prior approval for the service from the Department. Prior approval is not required in an emergency situation.
 2. The Department shall not reimburse special services subsidy amounts in excess of the rates allowed by the Department or AHCCCS. The Department shall use the lowest applicable rates as established by AHCCCS, the DES Comprehensive Medical and Dental Plan (CMDP), or rates established by the Adoption Subsidy Program to be customary and reasonable.
 3. The Department shall not pay for requests that the adoptive parent or provider submits more than nine months after the date of service for which the adoptive parent or provider requests payment.

Historical Note

Adopted effective May 17, 1976 (Supp. 76-3). Amended effective June 19, 1979 (Supp. 79-3). Amended by final rulemaking at 18 A.A.R. 1449, effective August 6, 2012 (Supp. 12-2).

R6-5-6708. Nonrecurring Adoption Expenses

- A.** Nonrecurring adoption expenses are reasonable and necessary expenses directly related to the legal process of adopting a child with special needs. Allowable expenses include adoption fees, court costs, attorney's fees, fingerprinting fees, home study fees, costs for physical and psychological examinations, costs for placement supervision, and travel expenses necessary to complete the adoption. The Adoption Subsidy Program does not cover expenses related to visiting and placing the child.
- B.** Reimbursement of nonrecurring adoption expenses is subject to the limitations in A.R.S. § 8-164 and to actual documented expenses not to exceed \$2000 per child.
- C.** To be eligible for reimbursement of nonrecurring adoption expenses, the child shall meet the requirements of A.R.S. § 8-163.

Historical Note

Adopted effective May 17, 1976 (Supp. 76-3). Amended effective June 19, 1979 (Supp. 79-3). Section repealed; new Section made by final rulemaking at 18 A.A.R. 1449, effective August 6, 2012 (Supp. 12-2).

R6-5-6709. Annual Review; Reporting Change

- A.** Each year, the Department shall send a review form to the adoptive parent requesting that the parent provide:
1. Information indicating that the parent remains legally and financially responsible for the child;
 2. Information on any change in benefits, such as benefits received through Title II of the Social Security Act;
 3. Information on any change in circumstances, including changes in residence, marital status, educational status, or other similar changes; and
 4. A description of any changes in the child's special needs conditions that are listed in the adoption subsidy agreement.
- B.** The adoptive parent shall provide the Department with the requested information within 30 days of the adoptive parent's receipt of the review form.
- C.** The adoptive parent shall notify the Department in writing within five calendar days when any of the following occurs:
1. The adoptive parent is no longer legally responsible for the child,

2. The adoptive parent is no longer providing support to the child,
3. The child is no longer residing in the adoptive parent's home,
4. The child has graduated from high school or obtained a general equivalency degree (GED),
5. The child has married, or
6. The child has joined the military.

Historical Note

Adopted effective May 17, 1976 (Supp. 76-3). Former Section R6-5-6709 repealed, former Section R6-5-6710 renumbered and amended as Section R6-5-6709 effective June 19, 1979 (Supp. 79-3). Section repealed; new Section made by final rulemaking at 18 A.A.R. 1449, effective August 6, 2012 (Supp. 12-2).

R6-5-6710. Termination of Adoption Subsidy

The Department shall terminate an adoption subsidy when any of the following occurs:

1. The child turns 18 years old and is not enrolled in and attending high school or a program leading to a high school diploma or general equivalency degree (GED);
2. The child is aged 18 through 21, has been continuously enrolled in school, and either drops out of school, graduates from high school, or obtains a general equivalency degree (GED);
3. The child's 22nd birthday;
4. The adoptive parent is no longer legally responsible for the child;
5. The adoptive parent is no longer providing support to the child;
6. The child marries;
7. The child joins the military;
8. The special needs conditions of the child no longer exist; or
9. The adoptive parent requests termination.

Historical Note

Adopted effective May 17, 1976 (Supp. 76-3). Former Section R6-5-6710 renumbered and amended as Section R6-5-6709, former Section R6-5-6711 renumbered and amended as Section R6-5-6710 effective June 19, 1979 (Supp. 79-3). Section repealed; new Section made by final rulemaking at 18 A.A.R. 1449, effective August 6, 2012 (Supp. 12-2).

R6-5-6711. New or Amended Adoption Subsidy Agreement

An adoptive parent may apply for a new or amended adoption subsidy agreement after the adoption is final only upon documentation of an undiagnosed pre-existing special need condition that existed before the finalization of the adoption.

1. The adoptive parent shall send the Department a written request for adoption subsidy with documentation from a qualified professional diagnosing the special need condition and confirming that it existed before the final order of adoption.
2. The adoptive parent and the Department shall follow the procedures in R6-5-6703 for processing applications and determining eligibility.
3. If the Department finds that the child has an undiagnosed pre-existing special need condition that, if diagnosed prior to the adoption, would have met the eligibility criteria listed in R6-5-6702, the Department shall grant a new subsidy or amend the adoption subsidy agreement to cover this condition.

Historical Note

Adopted effective May 17, 1976 (Supp. 76-3). Former Section R6-5-6711 renumbered and amended as Section R6-5-6710, former Section R6-5-6713 renumbered and amended as Section R6-5-6711 effective June 19, 1979 (Supp. 79-3). Section repealed; new Section made by final rulemaking at 18 A.A.R. 1449, effective August 6, 2012 (Supp. 12-2).

R6-5-6712. Appeals

- A. When the Department denies, reduces, or terminates an adoption subsidy, the Department shall send the adoptive parent written notice of the action and the parent's right to appeal.
- B. The notice shall contain:
 - 1. An explanation of the action taken and the reason for the action,
 - 2. A statement of the adoptive parent's right to appeal the action, and
 - 3. The time-frame for filing an appeal.
- C. The request for appeal shall:
 - 1. Specify the action being appealed;
 - 2. The reasons for the appeal; and
 - 3. A brief summary of why the Department's action was erroneous, unlawful, or improper.
- D. The Office of Appeals shall conduct the appeal pursuant to A.R.S. § 8-145.
- E. The rules of the Department in Article 24 of this Chapter apply to all services provided under this Article.

Historical Note

Adopted effective May 17, 1976 (Supp. 76-3). Repealed effective June 19, 1979 (Supp. 79-3). New Section made by final rulemaking at 18 A.A.R. 1449, effective August 6, 2012 (Supp. 12-2).

R6-5-6713. Renumbered**Historical Note**

Adopted effective May 17, 1976 (Supp. 76-3). Renumbered and amended as Section R6-5-6711 effective June 19, 1979 (Supp. 79-3).

ARTICLE 68. REPEALED**R6-5-6801. Repealed****Historical Note**

Adopted effective May 26, 1977 (Supp. 77-3). Repealed effective June 5, 1997 (Supp. 97-2).

R6-5-6802. Repealed**Historical Note**

Adopted effective May 26, 1977 (Supp. 77-3). Repealed effective June 5, 1997 (Supp. 97-2).

R6-5-6803. Repealed**Historical Note**

Adopted effective May 26, 1977 (Supp. 77-3). Repealed effective June 5, 1997 (Supp. 97-2).

R6-5-6804. Repealed**Historical Note**

Adopted effective May 26, 1977 (Supp. 77-3). Repealed effective June 5, 1997 (Supp. 97-2).

R6-5-6805. Repealed**Historical Note**

Adopted effective May 26, 1977 (Supp. 77-3). Repealed effective June 5, 1997 (Supp. 97-2).

R6-5-6806. Repealed**Historical Note**

Adopted effective May 26, 1977 (Supp. 77-3). Repealed effective June 5, 1997 (Supp. 97-2).

R6-5-6807. Repealed**Historical Note**

Adopted effective May 26, 1977 (Supp. 77-3). Repealed effective June 5, 1997 (Supp. 97-2).

R6-5-6808. Repealed**Historical Note**

Adopted effective May 26, 1977 (Supp. 77-3). Repealed effective June 5, 1997 (Supp. 97-2).

ARTICLE 69. CHILD PLACING AGENCY LICENSING STANDARDS**R6-5-6901. Objectives**

The objective of this Article is to establish licensing and operating standards to promote quality services for children and unmarried mothers whose needs are not adequately met in their family homes.

Historical Note

Adopted effective August 31, 1978 (Supp. 78-4).

R6-5-6902. Authority

A.R.S. §§ 8-501 through 8-520 and 46-134.

Historical Note

Adopted effective August 31, 1978 (Supp. 78-4).

R6-5-6903. Definitions

- A. "Adult." Any person 18 years of age or older.
- B. "Authorized representative." A designated employee of the Department.
- C. "Casework supervisor." A person who holds a Bachelor's degree from a university or college and has at least three years of casework experience in a certified or licensed family/child welfare agency.
- D. "Caseworker." A person who holds a Bachelor's degree from a university or college and who has training and/or experience in the field of behavioral science.
- E. "Child." Any person under 18 years of age.
- F. "Child placing agency." A child welfare agency which is authorized in its license to place children.
- G. "Department." The Arizona State Department of Economic Security.
- H. "Division." The Arizona State Department of Economic Security.
- I. "Executive Director." The person responsible for overall administration of the child placing agency; also referred to as Administrator, or Director.
- J. "Foster care." A social service which, for a planned period, provides substitute care for a child when its own family cannot care for it for a temporary or extended period of time. Foster care may be in a private family home or a group home.
- K. "Foster child." A child placed in a foster home or child welfare agency.
- L. "Foster home." A home maintained by an individual or individuals having the care or control of children, other than those related to each other by blood or marriage, or related to such individuals, or who are legal wards of such individuals (A.R.S. § 8-501(4)).
- M. "License." The legal authorization to operate a child placing agency issued by the Arizona Department of Economic Security.

- N. "Licensed medical practitioner." Any physician or surgeon licensed under the laws of this State to practice medicine pursuant to Title 32, Chapter 13 and 17 (A.R.S. § 36-501(4)).
- O. "Licensing." Includes the agency process respecting the grant, denial, renewal, revocation, suspension, annulment, withdrawal or amendment of a license.
- P. "Parent or parents." The natural or adoptive parent or parents of the child.
- Q. "Provisional license." A temporary license to operate a Child Placing Agency, issued by the Arizona Department of Economic Security for a period not to exceed six months; a provisional license is issued to an agency that is temporarily unable to conform to all licensing standards and where the deficiencies are minor, correctable and not potentially injurious to the safety or welfare of a child and the agency agrees to correct the deficiency or deficiencies, and where there is a demonstrated need for the services. A provisional license is not renewable.
- R. "Receiving foster home." A licensed foster home suitable for immediate placement of children when taken into custody or pending medical examination and court disposition which is designated as a receiving foster home and it is licensed.
- S. "Regular foster home." A licensed foster home suitable for placement of not more than five minor children.
- T. "Regular license." A license to operate a Child Placing Agency, issued by the Arizona Department of Economic Security; a regular license which may be issued following a provisional license is valid for one year from the date of issuance and must be renewed annually.
- U. "Social worker." A person who holds a Master of Social Work degree from an accredited school of social work.
- V. "Special foster home." A licensed foster home capable of handling not more than five minor children who require special care for physical, mental or emotional reasons or have been adjudicated a delinquent (A.R.S. § 8-501(10)).
- E. Licensing study
 - 1. A study will be made as required by A.R.S. § 8-505(C) by an authorized representative of the Department to evaluate the potential and actual ability of the Child Placing Agency to provide services to children according to the Standards prescribed in this Article.
 - 2. To obtain this information, the authorized representative of the Department must make at least one visit to evaluate the agency setting and interview the Director and staff.
 - 3. In addition, the authorized representative of the Department shall review documentary evidence provided by the Executive Director of the Child Placing Agency regarding agency operation and services to be provided.
- F. Provisional license
 - 1. A provisional license shall be issued to any Child Placing Agency that is temporarily unable to conform to all licensing standards, and where the deficiencies are minor, correctable and not potentially injurious to the safety or welfare of the children served, and where the agency agrees to correct the deficiencies, and where there is a demonstrated need for the services.
 - 2. A provisional license is valid for up to six months and may not be renewed.
 - 3. Prior to the expiration of the provisional license, a review of Standards will be conducted by the Department to determine eligibility for regular licensing. The Child Placing Agency must meet all licensing standards for the issuance of a regular license.
- G. Regular license
 - 1. The license is valid for one year from the date of issuance and must be renewed annually.
 - 2. Each license shall state in general terms the kind of child welfare services the licensee is authorized to undertake; and the number of children that can be received or placed and supervised in foster homes, their ages and sex, and the geographical area the agency is equipped to serve (A.R.S. § 8-505(D)).
- H. Supervision by the Department. The Department shall provide training, consultation and technical assistance to Child Placing Agencies.

Historical Note

Adopted effective August 31, 1978 (Supp. 78-4).

R6-5-6904. Licensing Requirements

- A. Consultation. Individuals, association, institutions or corporations considering the establishment of a Child Placing Agency shall consult the Social Services Bureau of the department about such plans:
 - 1. Before a specific program is developed;
 - 2. Before filing a petition for corporation; and
 - 3. Before an application is filed.
- B. Application. Individuals, associations, institutions or corporations shall make written application to the Department for a Child Placing Agency license.
- C. Fingerprints
 - 1. All members of the Child Placing Agency staff having contact with the foster children must be fingerprinted, and the fingerprints submitted to the Department for a criminal records check.
 - 2. A license for a Child Placing Agency will not be issued, or will be revoked, if any staff member, having contact with foster children has ever been convicted of a sex offense, has been involved in child abuse, child neglect, selling narcotics, or contributing to the delinquency of a minor, or has a substantial criminal record.
- D. Demonstration of need for services in the community. Evidence of need shall consist of:
 - 1. Communication from community leaders in the field of child welfare indicating a need for the services proposed by the applicant or
 - 2. Recent research data establishing a need for the services being proposed by the applicant.

Historical Note

Adopted effective August 31, 1978 (Supp. 78-4).

R6-5-6905. Denial, Suspension, or Revocation of a License

- A. The Department shall deny, suspend or revoke any license when:
 - 1. The Child Placing Agency is not in compliance with the licensing standards of the Department, Arizona state or federal statutes, city or county ordinances or codes; or
 - 2. The care and/or services needed by children are not provided.
- B. A license that has been suspended can be reinstated by the correction of the deficiency.
- C. When a license is revoked, it is necessary to correct the deficiency and make a new application.
- D. When an initial application, or an application for a renewal of a license is denied, or a license is revoked or suspended, a written notification of the action shall be forwarded by certified mail to the applicant or licensee.
 - 1. The written notice shall state the reasons for the denial, revocation or suspension with references to applicable statutes, regulations and standards.
 - 2. The Department shall notify the Child Placing Agency of the right to request a hearing within 20 days after receipt of the written notice.

3. The hearing shall be held within ten days of the request, and at that time the applicant or holder shall have the right to present testimony and confront witnesses.
4. When a hearing is requested, the denial, suspension or revocation of the license shall not become final until after the hearing decision is published.
5. The fair hearing process shall be in accordance with A.A.C. Title 6, Chapter 5, Article 24.

Historical Note

Adopted effective August 31, 1978 (Supp. 78-4).

R6-5-6906. License Renewal Requirements

- A. Every regular license shall expire one year from the date of issuance and may be renewed annually upon application of the Child Placing Agency.
 1. License renewal is not automatic.
 2. License renewal requires:
 - a. A consultation;
 - b. An application;
 - c. A written description of services provided; and
 - d. Licensing study (see R6-5-6904(E)).
 3. For license renewal, each Child Placing Agency must meet all standards for licensing as specified in this Article.
- B. An application for the renewal for a Child Placing Agency shall be made in the same manner as the original application. A licensee shall reapply when:
 1. The present license will expire within 30 days to 60 days; or
 2. There is a plan to move within 30 days from the address on the current license; or
 3. There is substantial material change in the program and/or purpose of the Child Placing Agency.

Historical Note

Adopted effective August 31, 1978 (Supp. 78-4).

R6-5-6907. Standards for Licensing and Operating a Child Placing Agency

- A. Requirements for the staff of a Child Placing Agency
 1. Executive Director. The Agency Board shall select an Executive Director.
 - a. If the Executive Director is not directly involved in supervising child placing activities, the Director shall at least have a Bachelor's degree in a field related to social work such as administration, psychology, education or other allied profession, as well as demonstrated satisfactory experience in the area of service provided by the agency.
 - b. If the Executive Director directly supervises child placing activities, he shall have a Master's degree in Social Work or at least a Bachelor's degree and a minimum of three years of experience in child welfare services in a certified or licensed family or child welfare agency.
 2. Casework supervisor. The casework supervisor shall possess above average ability in casework practice and have knowledge of and skills applicable to casework supervision. The supervisor shall have a Bachelor's degree and at least three years of casework experience in a licensed family or child welfare agency.
 3. Social worker. A person shall have a Master of Social Work degree from an accredited school of social work.
 4. Caseworker. A caseworker shall have a Bachelor's degree from a university or college and have training and/or experience in the field of behavioral science.

5. Office staff. The agency shall have sufficient clerical services to keep correspondence, records, bookkeeping, and files current and in good order.

6. Consultants

- a. The agency shall have a consulting Licensed Medical Practitioner who makes recommendations as to the medical aspects of the agency program, coordinates medical care for selected children, and advises staff regarding the health problems of specific children.
- b. Psychiatric, psychological and legal consultation and/or services shall be available to the agency.

B. Requirements for the organization of a Child Placing Agency

1. Type of organization. A Child Placing Agency shall be maintained by the state, or a political subdivision thereof, a person, firm, corporation, association, or organization.
2. Incorporation
 - a. Incorporated Child Placing Agencies shall provide the Department with a copy of the Articles of Incorporation and Bylaws and the Certificate of Incorporation issued by the Arizona Corporation Commission.
 - b. The purpose for which the agency is incorporated shall be stated in its Articles of Incorporation and the agency shall not enter any other fields of service than those provided in its Articles of Incorporation.
3. Board of Directors
 - a. All Child Placing agencies shall have a Board of Directors. The Department shall be provided a current list of all Board members, their address and office held.
 - b. Persons employed by or who receive compensation from a group care agency (see Title 6, Chapter 5, Article 74) may not be Board members of a Child Placing Agency due to a possible conflict of interest.
 - c. The Board of Directors shall:
 - i. Assume responsibility, jointly with the Executive Director, for formulating the plans and policies of the Child Placing Agency.
 - ii. Keep sufficiently informed through Board meetings and through the reports of its Executive Director and committees to ensure that the agency fulfills all of its functions in the best interest of the children.
 - iii. Meet at least quarterly. Its executive committee shall meet as needed.
 - iv. Keep minutes of each meeting which shall be made a permanent part of the records of the Child Placing Agency.
 - v. Refrain from direct administration or operation of the Child Placing Agency, either through individual members or committees, except in emergencies.
 - vi. Select and employ an Executive Director to whom the responsibility for administration of the agency shall be delegated and, when necessary, terminate such employment.
 - vii. Require and approve the Child Placing Agency's annual program and financial reports.
 - d. The Board of Directors should be composed of adult residents who have a genuine interest in child welfare, concern for social conditions in the community, and reflect equitably the ethnic and economic standing of the population served. The Board members should have sufficient time to discharge their obligations and have a variety of interests, talents and

- points of view so that no single group or profession will have a controlling voice.
- e. The names, addresses and offices held of all members of the Board of Directors shall be currently filed with the Department. All changes in composition of the Board of Directors or Officers of the Child Placing Agency must be reported to the Department in writing within 30 days of a change.
 - f. Provision should be made for replacement of members who become inactive for six months. Terms for Board members shall be overlapping and election of one-third of the Board membership annually is recommended to ensure continuity of policy, as well as the introduction of new and changing points of view. Administrators and staff of the Child Placing Agencies shall not be members of the Board of Directors. Agencies which do not have overlapping terms or which currently have administrators or staff members on their Board of Directors will have one year from the date of issuance of these standards to bring their Board of Directors into compliance.
4. Financing
 - a. Requirement for sufficient funding. The agency must furnish evidence that it has sufficient funds to pay all start-up and operating costs through the year of operation for which a license may be issued.
 - b. Budget and financial records
 - i. Child Placing Agency shall operate on a budget which has been approved by its governing board before the beginning of the fiscal year.
 - ii. A Child Placing Agency must maintain financial records of all receipts, disbursements, assets, and liabilities for at least three years. These records should be available for inspection by the Department upon request.
 - c. Solicitation of funds from the public. Each Child Placing Agency shall comply with all local and state laws relating to the solicitation of funds.
 5. Operations manual. Each agency shall compile an operations manual. It shall be available to all agency staff members, and all staff members shall be familiar with the contents. It shall contain:
 - a. The overall philosophy, which guides the agency's services.
 - b. A statement of the primary purpose, services, and goals of the agency.
 - c. A chart of organizational structure.
 - d. The agency's intake policies and procedures.
 - e. The manual of the agency's governing board.
 - f. The operational procedures, which guide the delivery of the agency's services.
 - g. Copies of the agency's forms.
 6. Records and reports
 - a. Files. Case records and financial records shall be kept in a locked, fire-resistant file. Access to records shall be limited to the staff who have need for the data, and to authorized representatives of the Department.
 - b. Case records
 - i. The agency shall maintain up-to-date, confidential and well-organized case records. Each child's record should indicate, from the point of admission to discharge, the service plan and the progress of the child.
 - ii. Records shall include the current information needed to provide services, make service plans, and evaluate each child.
 - iii. The case record should be divided into sections for easy reference, with the material filed under the following headings, as appropriate:
 - (1) Intake -- intake study, including referral material from other agencies, court, or referral sources;
 - (2) Legal -- specific verified information relative to the status of the child's legal guardianship and custody. Statements, agreements, and consents signed by parent(s) or guardian(s) pertaining to the child's placement, financial responsibility, and other data required for protection of the child;
 - (3) Medical -- medical history, including immunizations, physical defects, significant developmental history, illnesses, and hospital care and/or operations. Medical releases and/or authorizations for treatment or medical care, including the names of medical personnel involved. Records of all prescription medications consumed;
 - (4) Dental -- date of examinations, etc.;
 - (5) Psychological -- reports of psychological and/or psychiatric evaluations and examinations;
 - (6) Progress -- periodic (not less than every three months) evaluation of the child's progress, adjustment, development and future plans and goals.
 - (7) School -- school records indicating attendance and scholastic achievement;
 - (8) Correspondence -- letters received or sent concerning the child;
 - (9) Each record shall have a face sheet listing the following information which shall be kept up-to-date:
 - (a) Full name of child, including aliases;
 - (b) Date and place of birth (verified);
 - (c) Sex;
 - (d) Religion and race;
 - (e) Names, addresses of parents and siblings;
 - (f) Names, addresses and relationships of other responsible persons;
 - (g) Date referred to the agency;
 - (h) Date service was terminated;
 - (i) Other pertinent identifying information.
 - c. Reports
 - i. Each agency shall maintain and report accurate statistics on children receiving services, and staff employed, on forms provided for that purpose by the Department. These reports shall include:
 - (1) Form FC-005, "Foster Child Placement, Replacement and Discharge Central Registry Form," which must be submitted within five working days of the date action is taken.
 - (2) Form LC-008, "Child Welfare Agency Employee Central Registry," which must

- be submitted within five days of employment or discharge.
- ii. The Child Placing Agency shall report to the Department any planned change of address, change in program, or other change which significantly affects the services provided. The Department shall be notified 30 days prior to any planned changes.
- C. Requirements for the personnel of a Child Placing Agency**
1. Personnel practices. An agency shall employ an individual only after careful evaluation of the applicant which will include references as to character, skills, knowledge, and experience.
 2. Personnel policies. The agency shall maintain a manual of all personnel policies and procedures including job descriptions and all personnel forms. The written statement of personnel policies outlining personnel practices as they affect both employer and employee should include:
 - a. The conditions of employment and the conditions under which employment may be terminated.
 - b. Salary scales.
 - c. Provision for sick leave, time off, and paid vacation.
 - d. Information regarding employment benefits, such as retirement and insurance plans.
 - e. Provision for periodic assessment of work performance.
 - f. Provision for staff development through in-service training.
 3. Personnel records
 - a. A personnel record shall be maintained for each employee. This shall include identifying and qualifying information; such as, references, previous work history and education, date of employment and evaluation.
 - b. When employees resign, retire, or are discharged, the date and reason for termination shall be recorded.
- D. Placement services**
1. Foster care
 - a. Types of homes
 - i. Boarding Home. A Boarding Home provides temporary or permanent care and compensation to the foster parents for room and board. These Boarding Homes may be either Regular or Special Foster Homes.
 - ii. Free home. A free home provides temporary or permanent care without compensation other than special needs.
 - iii. Work and Wage Home
 - (1) Work and Wage Homes are those in which the child's duties within the home constitute reimbursement for room and board and for which the child may be paid an additional wage. These homes shall be used only as a resource for mature and well adjusted children from 16 to 18 years with good work skills. The Child Placing Agency shall prepare a written statement to be signed by the agency, foster parents and child which will clearly define:
 - (a) The amount of work required; and
 - (b) The remuneration the child is to receive and by whom; and
 - (c) The work schedule which shall permit the child time for school attendance, study, recreation, and other normal activities for a child in this age group.
 - (2) The Department shall not place adjudicated dependent children in Work and Wage Homes.
 - b. Foster care placement procedures
 - i. The agency shall follow the preplacement procedures set forth in A.R.S. § 8-511.
 - ii. Following the preplacement procedures outlined in A.R.S. § 8-511, if it is determined that the child should be placed in foster care, the agency shall provide appropriate counseling services to the child and his parents to prepare them for the placement.
 - (1) If the family does not explain the reason for placement and prepare the child for this experience, the representative of the Child Placing Agency should do so.
 - (2) The representative of the Child Placing Agency should explain the foster home program to the parents.
 - iii. When a child is placed in foster care, the Child Placing Agency shall comply with the requirements and procedures set forth in A.R.S. § 8-514(B) and (C).
2. Adoption. If authorized in its license to place children for adoption, the agency shall comply with all laws (including but not limited to A.R.S. Title 8, Chapter 1, Article 1) regarding the investigation of potential adoptive parent and the adoption of children. The agency shall comply with the requirements of the following rules of the Department:
 - a. Title 6, Chapter 5, Article 65, Adoption Placement;
 - b. Title 6, Chapter 5, Article 66, Adoption Study;
 - c. Title 6, Chapter 5, Article 67, Adoption Subsidy; and
 - d. Title 6, Chapter 6, Article 68, Relinquishment and Severance Services.
3. Parents
 - a. When there are social and/or emotional problems regarding the pregnancy, social services shall be given in accordance with the needs of mother during pregnancy and to help her with plans for her rehabilitation after delivery.
 - b. Unless inappropriate, the father shall be involved in planning for the mother and child.
 - c. Services to unmarried parents may also include establishing paternity and shall include making suitable plans for the child.
- E. Supervision**
1. The licensed Child Placing Agency shall supervise:
 - a. All children placed by the agency in foster homes; and
 - b. All foster homes where children are placed by the agency.
 2. The licensed Child Placing Agency's representative shall:
 - a. Visit Receiving Foster Homes at least once per month;
 - b. Visit Regular and Special Foster Homes at least once every three months; and
 - c. Prepare written reports of the visits.
 3. A Child Placing Agency may allow a child to participate in activities and functions generally accepted as usual or normal for his/her age group. Permission for a child to

participate in activities shall be given in accordance with A.R.S. § 8-513.

4. Following the initial placement, the child placed in a setting other than that of his parent's home shall have medical examinations at periodic intervals, and not less than once every year.

F. Foster home studies

1. The study. Child Placing Agencies that wish to submit foster homes for licensing shall conduct an investigation of the foster home, meeting the standards established by the Department in Title 6, Chapter 5, Article 58, Family Foster Home Licensing Standards.
2. Fingerprints. Foster parent applicants and members of the household, 18 years of age or older, must be fingerprinted, and the fingerprints submitted to the Department for a criminal records check.
3. Demonstration of health
 - a. The potential foster care application, prior to licensing, shall furnish a report of a physical examination, done within the last six months, demonstrating that the person has good health and is free from any communicable disease.
 - b. Prior to licensing, children of the foster care applicant shall have current immunizations as prescribed by the Arizona Department of Health Services.
4. Sanitation inspection. The Child Placing Agency shall request the local or state health department to conduct a sanitation inspection of the prospective foster home prior to licensing.
5. Licensing. If the foster home meets all requirements set by the Department, the Child Placing Agency shall submit an application stating the foster home's qualifications to the Department. The Child Placing Agency may also recommend the types of licensing and certification to be granted to the foster home. The Department shall review the foster home study, and issue a license for the foster home if all licensing standards have been met.
6. License renewal. Foster home license renewal is required annually by the Department.
7. Homes exempt from licensing by the Department. When a child is placed in a home by a means other than by a court order, and when the home receives no compensation from the state or any political subdivision of the state, licensing by the Department is not required.

G. Requirements of physical plant and equipment

1. Offices
 - a. There should be sufficient office space for interviewing children and families and for supervisory conferences.
 - b. The Child Placing Agency shall comply with any building, health, fire or other codes in effect in the jurisdiction where it is located.
2. Fire protection. All Child Placing Agencies shall have a written fire evacuation plan posted and should conduct fire drills at least every six months.
3. Telephone. There shall be telephone service in the Child Placing Agency.
4. Vehicle(s). The vehicle(s) for transporting children shall be in a safe operating condition and all drivers shall have a current driver's license. Persons who frequently transport children as a part of their employment shall have a chauffeur's license.
5. Insurance
 - a. The Child Placing Agency shall provide for insurance coverage for adequate protection against accidents.

- b. Insurance coverage must include liability insurance to cover acts of children or staff, and protection against damages to, or loss of, buildings and other valuable properties.
- c. There shall be liability insurance on all vehicles transporting children.

Historical Note

Adopted effective August 31, 1978 (Supp. 78-4).

R6-5-6908. Confidentiality

The rules and regulations of the Department for securing and using confidential information concerning the client shall be followed. Refer to Title 6, Chapter 5, Article 23, "Safeguarding of Records and Information."

Historical Note

Adopted effective August 31, 1978 (Supp. 78-4).

R6-5-6909. Civil Rights

The rules of the Department regarding civil rights shall be followed. Refer to Title 6, Chapter 5, Article 26, Civil Rights.

Historical Note

Adopted effective August 31, 1978 (Supp. 78-4).

R6-5-6910. Fair Labor Standards Act

The hiring and compensation policies of the Child Placing Agency shall comply with the Fair Labor Standards Act.

Historical Note

Adopted effective August 31, 1978 (Supp. 78-4).

ARTICLE 70. ADOPTION AGENCY LICENSING

R6-5-7001. Definitions

The definitions in R6-5-6501 apply in this Article.

Historical Note

Adopted as an emergency effective January 1, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 85-6). Emergency renewed effective April 1, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 86-2). Emergency expired. New Section adopted as an emergency effective October 17, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 86-5). Emergency expired. Adopted without change as a permanent rule effective January 23, 1987 (Supp. 87-1). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-7002. Who Shall Be Licensed

- A.** Only the following persons may perform the adoption services listed in subsection (B):
 1. A person licensed as an agency;
 2. An employee of or an independent contractor for an agency;
 3. A person acting under the direct supervision and control of an adoption agency; or
 4. A person or entity holding a statutory exemption from licensing pursuant to A.R.S. § 8-131, when such person is acting in the capacity described in such statutes.
- B.** Only persons listed in subsection (A) may perform the following adoption services:
 1. Recruiting a birth parent to place a child through a particular agency;
 2. Taking a birth parent's relinquishment and consent to adoption;
 3. Taking physical custody of a child for placement into an adoptive home;
 4. Placing a child in an adoptive home;

5. Monitoring, supervising, or finalizing an adoptive placement; and
 6. Providing networking or matching services for a birth parent, an adoptive parent or an adoptive child.
- C. Notwithstanding subsections (A) and (B), attorneys licensed to practice law in the state of Arizona may participate in direct placement adoptions to the extent allowed by A.R.S. Title 8, Chapter 1, Article 1.

Historical Note

Adopted as an emergency effective January 1, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 8S-6). Emergency renewed effective April 1, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 86-2). Emergency expired. New Section adopted as an emergency effective October 17, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 86-5). Emergency expired. Adopted without change as a permanent rule effective January 23, 1987 (Supp. 87-1). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-7003. Licensing: Initial Application; Fee

- A. To apply for an adoption agency license, a person shall:
1. File a completed license application form with the Department; the form shall contain the information listed in subsection (B);
 2. Submit the supporting documentation listed in subsection (C);
 3. Pay a non-refundable, initial application fee of \$400; and
 4. Obtain and provide to the Department evidence that all agency employees or personnel having direct contact with children have been fingerprinted.
- B. The application form shall contain the following information:
1. Agency name, address, and telephone number;
 2. Address of all agency offices;
 3. A written description of:
 - a. All adoption services the applicant intends to provide,
 - b. The fee the applicant will charge for each service,
 - c. The cost to the applicant of providing each service,
 - d. The time in the adoption process when the applicant will require clients to pay the fee described in subsection (B)(3)(b),
 - e. The anticipated number of clients the applicant will serve, and
 - f. The methods the applicant will use to recruit birth parents and prospective adoptive parents; and
 4. A written explanation of how the applicant will provide adoption services, including:
 - a. Number and description of staff who will provide the service, and
 - b. Staff training requirements.
- C. The applicant shall submit the following supporting documentation:
1. A current financial statement;
 2. Applicable business organization documents, including:
 - a. Articles of incorporation,
 - b. By-laws,
 - c. Partnership agreement,
 - d. Annual reports for the preceding three years, and
 - e. Financial audits for the preceding two years;
 3. Copies of all documents, forms, and notices which the applicant will use with or provide to clients, including:
 - a. Agency application for services,
 - b. Adoptive parent certification application,

- c. Fee policy and schedule as prescribed by R-5-7031(B),
 - d. Sample birth parent relinquishment and consent form,
 - e. Informational or advertising brochures,
 - f. Sample fee agreement,
 - g. Sample birth parent agreement letter,
 - h. Intake form,
 - i. Sample case file,
 - j. Court report format, and
 - k. Statistical report;
4. Copies of the applicant's internal policies and operations manual;
 5. A written plan showing how the applicant will pay start-up costs and its costs of operation during the first year; and
 6. A list of the members of the agency's governing body required by R6-5-7011, including name, address, position in the agency, and term of membership.
- D. An agency which does not have or maintain all or part of the supporting documentation listed in subsection (C) shall so indicate in a written statement filed with the application.

Historical Note

Adopted as an emergency effective January 21, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 85-6). Emergency renewed and amended effective April 1, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 86-2). Emergency expired. New Section adopted as an emergency effective October 17, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 86-5). Emergency expired. Adopted without change as a permanent rule effective January 23, 1987 (Supp. 87-1). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-7004. Licensing: Out-of-state Agencies

- A. An out-of-state agency that wishes to become licensed in Arizona as an adoption agency shall comply with all requirements of R6-5-7003.
- B. In addition to the documentation required by R6-5-7003, the out-of-state agency applicant shall file the following documents with the Department:
1. A copy of each license or authorization to perform adoption services the applicant holds in states other than Arizona or in a foreign country;
 2. A consent allowing any out-of-state or foreign licensing authority to release information on the applicant to the Department; and
 3. A written description of any license suspension or revocation proceedings pending or filed, or brought against:
 - a. The applicant;
 - b. The applicant's owner, if the applicant is acting as an individual or a sole proprietor;
 - c. The partners of the applicant, if the applicant is a partnership; and
 - d. The directors, officers, and shareholders holding more than a 10% ownership interest in the applicant if the applicant is a corporation.

Historical Note

Adopted as an emergency effective January 1, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 85-6). Emergency renewed and amended effective April 1, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 86-2). Emergency expired. New Section adopted as an emergency effective October 17, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 86-5). Emergency expired. Adopted without change as a permanent rule effective January 23, 1987 (Supp. 87-1). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

86-5). Emergency expired. Adopted without change as a permanent rule effective January 23, 1987 (Supp. 87-1). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-7005. Department Procedures for Processing License Applications

- A.** In this Section, a complete application package means:
1. For an initial license, the items listed in R6-5-7003; and
 2. For a renewal license, the items listed in R6-5-7008.
- B.** Within 14 days of receiving an initial or renewal license application package, the Department shall notify the applicant that the package is either complete or incomplete, as required by A.R.S. § 41-1074(A). If the package is incomplete, the notice shall specify what information is missing, as required by A.R.S. § 41-1074(B).
- C.** An applicant with an incomplete package shall supply the missing information within 60 days from the date of the notice. If the applicant fails to do so, the Department may close the file. An applicant whose file has been closed and who later wishes to become licensed shall reapply.
- D.** Upon receipt of all missing information within 60 days, as specified in subsection (B), the Department shall notify the applicant that the application package is complete.
- E.** The Department shall not process an application for licensing, as described in R6-5-7006(A), until the applicant has fully complied with the requirements of R6-5-7003 or R6-5-7008, as applicable.
- F.** The Department shall issue a licensing decision no later than 90 days after receipt of a completed application package. The date of receipt is the postmark date of the notice advising the applicant that the package is complete.
- G.** For the purpose of A.R.S. § 41-1073, the Department establishes the following licensing time-frames for both initial and renewal licenses:
1. Administrative completeness review time-frame: 15 days;
 2. Substantive review time-frame: 90 days; and
 3. Overall time-frame: 105 days.

Historical Note

Adopted as an emergency effective January 1, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 85-6). Emergency renewed effective April 1, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 86-2). Emergency expired. New Section adopted as an emergency effective October 17, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 86-5). Emergency expired. Adopted without change as a permanent rule effective January 23, 1987 (Supp. 87-1). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1). Amended by final rulemaking at 5 A.A.R. 1006, effective March 18, 1999 (Supp. 99-1).

R6-5-7006. License: Issuance; Denial

- A.** Prior to issuing a license to an applicant, the Department shall:
1. Review the application package;
 2. Inspect the applicant's place of business, books of record, books of accounting, and system for client files;
 3. Interview the applicant's staff, as necessary to familiarize the Department representative with the applicant's operations; and
 4. As to out-of-state agency applicants, verify that the applicant is licensed out-of-state and investigate any complaints asserted against the applicant in other states.
- B.** Prior to issuing a license, the Department may submit the applicant's written fiscal plan for audit verification.
- C.** The Department may issue a license to an applicant who:

1. Has complied with all application and inspection requirements; and
 2. Demonstrates that it:
 - a. Has sufficient capital to pay all start-up costs; and
 - b. Has sufficient capital, personnel, expertise, facilities, and equipment to provide the services it plans to offer;
 - c. Does not intend to charge unreasonable fees; and
 - d. Complies with the requirements of this Article and Article 66.
- D.** The Department may deny a license to:
1. An applicant which had a license revoked by another state or foreign country,
 2. An applicant which employs personnel whose fingerprint background check shows that the employee has been convicted of or is awaiting trial on an offense listed in A.R.S. § 46-141,
 3. An applicant which does not comply with one or more of the standards listed in subsection (C),
 4. An applicant which has intentionally or recklessly jeopardized the well-being of a client,
 5. An applicant which has a history or pattern of violations of applicable adoption statutes or rules, or
 6. An applicant which violates the ICPC or ICWA during a licensing year.
- E.** When the Department denies a license, the Department shall send the applicant written notice explaining the reason for denial and the applicant's right to seek a fair hearing.

Historical Note

Adopted as an emergency effective January 1, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 85-6). Emergency renewed effective April 1, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 86-2). Emergency expired. New Section adopted as an emergency effective October 17, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 86-5). Emergency expired. Adopted without change as a permanent rule effective January 23, 1987 (Supp. 87-1). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-7007. License: Term; Nontransferability

- A.** The Department shall issue a license only to the agency for which application is made and for the location shown on the application.
- B.** A license expires one year from the date of issuance.
- C.** A license shall not be transferred or assigned and shall expire upon a change in agency ownership.
- D.** For the purpose of this Section, a change in ownership shall include the following events:
1. Sale or transfer of the agency,
 2. Bulk sale or transfer of the agency's assets or liabilities,
 3. Placement of the agency in the control of a court appointed receiver or trustee,
 4. Bankruptcy of the agency,
 5. Change in the composition of the partners or joint venturers of an agency organized as a partnership,
 6. Sale or transfer of a controlling interest in the stock of a corporate agency, or
 7. Loss of an agency's nonprofit status.

Historical Note

Adopted as an emergency effective October 17, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 86-5). Emergency expired. Adopted without change as a permanent rule effective January 23, 1987

(Supp. 87-1). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-7008. Application for License Renewal; Fee

- A. No earlier than 90 and no later than 45 days prior to the expiration date of a license, an agency may apply to the Department for license renewal.
- B. The renewal application shall be on a Department form containing the information listed in R6-5-7003(B), except that the agency shall obtain additional fingerprint clearance on continuing personnel every third year following original clearance.
- C. An agency shall submit copies of the supporting documents listed in R6-5-7003(C) if the agency has changed, amended, or updated such documents since the agency last renewed its license.
- D. With a renewal application, the agency shall also submit a renewal fee of \$225 and the following documentation:
 1. A current financial statement;
 2. A copy of the agency's current budget required by R6-5-7022, and most recent audit report required by R6-5-7023;
 3. Copies of any written complaints the agency has received about its performance during the expiring license year; and
 4. A written description of any changes in program services or locations, or the population served by the agency.

Historical Note

Adopted as an emergency effective October 17, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 86-5). Emergency expired. Adopted without change as a permanent rule effective January 23, 1987 (Supp. 87-1). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-7009. Renewal License: Issuance

- A. The Department shall process a renewal application package pursuant to the procedures described in R6-5-7005 and R6-5-7006.
- B. In addition to conducting an investigation as prescribed in R6-5-7006(A) and (B), the Department may:
 1. Interview agency clients and references,
 2. Observe agency staffings, and
 3. Conduct field visits to agency branch offices.
- C. In determining whether to renew a license, the Department may consider the licensee's past history from other licensing periods, and shall consider a repetitive pattern of violations of applicable adoption statutes or rules as evidence that the agency is unable to meet the standards for obtaining a license.
- D. The Department may renew an agency's license when the agency:
 1. Demonstrates that it meets the standards described in this Article,
 2. Has complied with the requirements of this Article and Article 66 during the expiring period of licensure, and
 3. Has corrected any prior circumstances which resulted in non-compliance status.

Historical Note

Adopted as an emergency effective October 17, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 86-5). Emergency expired. Adopted without change as a permanent rule effective January 23, 1987 (Supp. 87-1). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-7010. Amended License

- A. An agency which seeks to change its name, address, or offices, without a change in ownership, shall apply to the Department for an amended license at least 14 days prior to the effective date of the change.
- B. The application shall be in writing and shall specify the information to be changed.
- C. So long as the change does not cause the agency to fall out of compliance with the standards listed in this Article and Article 66, the Department shall issue an amended license which shall expire at the end of the agency's current licensing year.

Historical Note

Adopted as an emergency effective October 17, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 86-5). Emergency expired. Amended and adopted as a permanent rule effective January 23, 1987 (Supp. 87-1). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-7011. Governing Body

- A. The adoption agency shall have a governing body, which shall:
 1. Establish the agency's policies and oversee the implementation of those policies;
 2. Ensure that the agency has the capital, physical facilities, staff, and equipment to effectively implement the agency's policies and adoption program;
 3. Ensure that the agency complies with:
 - a. All legal agreements to which the agency is a party; and
 - b. All relevant federal, state, and local laws;
 4. Review and approve the agency's annual budget required by R6-5-7022 and the annual audit required by R6-5-7023; and
 5. Notify the Department before making any substantial changes to the adoptions program set out in the agency's operations manual.
- B. The agency shall advise the Department in writing of any changes in composition of the governing body within 30 days of the change.

Historical Note

Adopted as an emergency effective October 17, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 86-5). Emergency expired. Adopted without change as a permanent rule effective January 23, 1987 (Supp. 87-1). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-7012. Agency Administrator

- A. The agency shall have an administrator who is responsible for the agency's business operations.
- B. The Administrator shall have the education and experience described in this subsection.
 1. A bachelor's degree from an accredited college or university and two years of professional experience in the human services field, one year of which shall have been in a supervisory or administrative position; or
 2. A master's or doctorate degree from an accredited graduate school in business or public administration or in one of the areas of study in the human services field, and one year of professional experience in the human services field.
 3. Five years of experience as the administrator of an adoption agency may substitute for only the degree that is required in subsections (B)(1) or (B)(2).
- C. The Administrator shall:

1. Oversee development and implementation of the agency's policy and procedures for program and fiscal operations;
 2. Ensure that the agency achieves and maintains compliance with the requirements of this Article;
 3. Oversee hiring, evaluation, and discharge of agency personnel in accordance with the agency's established personnel policies and this Article;
 4. Establish and supervise working relationships with other social service agencies within the community.
- D.** An Administrator who directly supervises adoption activities shall also meet the requirements for a social services director prescribed in R6-5-7013.

Historical Note

Adopted as an emergency effective October 17, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 86-5). Emergency expired. Adopted without change as a permanent rule effective January 23, 1987 (Supp. 87-1). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-7013. Social Services Director

- A.** The agency shall have a social services director who is responsible for the agency's casework and family services.
- B.** The social services director shall have the following education and experience:
1. A bachelor's degree in social work or a related human services field from an accredited college or university and three years of professional experience in services to children and families, two years of which shall be in adoption services; or
 2. A master's degree in social work or a related human services field from an accredited college or university and a minimum of two years of professional experience in services to children and families.
- C.** The social services director shall, either personally or through a designee:
1. Supervise, manage, train, and evaluate all social work staff members and consultants;
 2. Approve decisions regarding family and child eligibility for service, maternity and child care, transportation and placement arrangements, finalization, and any other changes in a child's legal status; and
 3. Implement the agency's adoption program and services.
- D.** If the social services director delegates responsibility as prescribed in subsection (C), the social services director shall personally supervise the designee and shall oversee the performance of the duties described in subsection (C).
- E.** If the social services director performs the duties of an administrator, the director shall also meet the requirements for an administrator prescribed in R6-5-7012.

Historical Note

Adopted as an emergency effective October 17, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 86-5). Emergency expired. Adopted without change as a permanent rule effective January 23, 1987 (Supp. 87-1). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-7014. Social Workers

- A.** The agency shall have social workers sufficient to meet the ratio requirements prescribed in R6-5-7020.
- B.** A social worker shall have the following qualifications:
1. A bachelor's degree in social work or a related human services field from an accredited college or university and

two years of professional experience in a human services field; or

2. A master's degree in social work or in a related human services field from an accredited college or university.
- C.** A social worker shall:
1. Maintain up-to-date case records on cases assigned to the worker;
 2. Prepare certification and placement reports and home studies for adoptive applicants and parents, and such other reports as the court may require;
 3. Provide preplacement, placement, post-placement, or post-adoption services to clients.

Historical Note

Adopted as an emergency effective October 17, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 86-5). Emergency expired. Adopted without change as a permanent rule effective January 23, 1987 (Supp. 87-1). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-7015. Agency Employees: Hiring; References; Fingerprinting

- A.** An agency shall obtain an application for employment or a resume from each employee. The application or resume shall contain, at a minimum, the following information on the applicant:
1. Name and current address and telephone number;
 2. Educational history;
 3. Degrees or certifications held;
 4. Work history for five years prior to the date of the application, and the reasons for leaving each prior job;
 5. A summary of all prior experience the applicant has had in the area for which the applicant is seeking employment;
 6. A minimum of three professional references;
 7. A minimum of three personal references; and
 8. A list of any criminal convictions, excluding minor traffic violations.
- B.** An agency shall not hire an applicant for employment until:
1. The agency has personally contacted at least two of the applicant's professional references and one of the applicant's personal references;
 2. The agency has verified that the applicant has the skills and training necessary to perform the task for which the agency is hiring the applicant; and
 3. The applicant has submitted to a fingerprint and criminal records check as required by A.R.S. § 46-141.
- C.** The agency shall not knowingly hire or retain any staff member who is awaiting trial on, or has been charged with, been convicted of, pled guilty to, or entered into a plea agreement regarding an offense listed in A.R.S. § 46-141.
- D.** The agency shall have written job descriptions for all employee and volunteer positions in the agency. The job descriptions shall include the essential functions of the job and any minimum qualifications or training required for the position.

Historical Note

Adopted as an emergency effective October 17, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 86-5). Emergency expired. Adopted without change as a permanent rule effective January 23, 1987 (Supp. 87-1). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-7016. Agency Volunteers; Interns

An agency which uses volunteers or student interns shall follow the requirements of this Section.

1. An appropriate employee shall directly supervise each volunteer or intern. As used in this subsection, the term “appropriate” shall mean agency personnel with skills and training to guide the volunteer or intern in the performance of the designated tasks.
2. The agency shall subject each volunteer or intern who renders direct services to clients, to the same fingerprinting and reference checks the agency performs on agency employees.
3. For each volunteer or intern, the agency shall maintain a record of fingerprint clearance, reference check information, and any training provided. The agency shall retain the record for three years following the volunteer or intern’s termination with the agency.

Historical Note

Adopted as an emergency effective October 17, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 86-5). Emergency expired. Adopted without change as a permanent rule effective January 23, 1987 (Supp. 87-1). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-7017. Personnel Records

- A. The agency shall maintain a personnel file for each agency employee. The file shall contain:
 1. The employee’s resume or written application for employment;
 2. Documentation of the reference checks required by R6-5-7015(B);
 3. Evidence of fingerprint and criminal records clearance;
 4. A record of the expiration date and number of the employee’s driver’s or chauffeur’s license, if the employee transports clients;
 5. Copies of the employee’s professional credentials or certifications, if relevant to the employee’s job functions;
 6. Documentation of initial and ongoing training the employee has received;
 7. Periodic job performance evaluations; and
 8. Dates of employment and separation, and reasons for separation.
- B. The agency shall maintain employee personnel records for at least three years following the employee’s separation from the agency.

Historical Note

Adopted as an emergency effective October 17, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 86-5). Emergency expired. Adopted without change as a permanent rule effective January 23, 1987 (Supp. 87-1). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-7018. Training Requirements

- A. An agency shall provide initial and ongoing training for professional employees.
 1. Initial training shall include orientation to the agency and any of the agency’s policies and procedures that are relevant to the employee’s job.
 2. Ongoing training shall include a minimum of 14 hours of annual training in the following, or related, subject areas:
 - a. Adoption statutes and rules,
 - b. Agency policies and procedures,
 - c. Confidentiality, and
 - d. The specific subject matter of employee’s job.

- B. The agency shall document all training in the employee’s personnel file.
- C. As used in this Section, “professional employee” shall mean any person who renders services directly to clients.

Historical Note

Adopted as an emergency effective October 17, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 86-5). Emergency expired. Adopted without change as a permanent rule effective January 23, 1987 (Supp. 87-1). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-7019. Contracted Services

- A. When an agency provides adoption services through persons who are not agency employees, volunteers, or interns, the agency shall retain only external professionals or consultants who are certified, licensed, or otherwise meet the qualifications described in Articles 66 and 70, to provide such services.
- B. The agency shall not require clients to use medical, legal, psychological, psychiatric, or other professionals or consultants used or recommended by the agency. The agency may use consultants or persons selected by the agency’s client, so long as the consultant designated by the client has the education, experience, or certification required to render the service.

Historical Note

Adopted as an emergency effective October 17, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 86-5). Emergency expired. Adopted without change as a permanent rule effective January 23, 1987 (Supp. 87-1). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-7020. Staffing Ratios

- A. An agency shall have sufficient staff to satisfy:
 1. All statutory requirements for provision of adoption services;
 2. All applicable requirements of this Article and Article 66; and
 3. All requirements included in the agency’s own operating and procedural manuals, policies, or guidance documents.
- B. To determine sufficiency under subsection (A), the Department shall consider:
 1. Complaints made against the agency;
 2. The complexity of the individual needs of the clients served by the agency;
 3. The professional training and experience of the agency’s staff;
 4. The specific functions assigned to individual agency staff;
 5. The geographic area served by the agency and any travel time required for agency staff;
 6. The respective amounts of time staff devote to various functions and responsibilities, including provision of services, court appearances, case documentation, professional training and development, and administrative tasks; and
 7. Other similar factors bearing on caseload distribution.
- C. Notwithstanding any other provision of this Article, a case manager whose caseload is predominantly a caseload of children with special needs shall not have a caseload in excess of 20 children.

Historical Note

Adopted as an emergency effective October 17, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 86-5). Emergency expired. Adopted without

change as a permanent rule effective January 23, 1987 (Supp. 87-1). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-7021. Operations Manual

- A.** An agency shall have a written operations manual which shall include:
1. A statement of the agency's purpose, philosophy, and program;
 2. A list of any eligibility requirements for clients;
 3. A description of services provided to clients and the name of any person or entity providing the service, if different from the agency and its employees;
 4. An organizational chart explaining the agency's lines of authority;
 5. Intake policies and procedures;
 6. The operational procedures the agency follows for delivery of services;
 7. Confidentiality policies and procedures;
 8. Staff training policy;
 9. Policy for use of volunteers;
 10. Policy on student and intern placement;
 11. Policy and procedures to be followed in the event of adoptive placement disruption; and
 12. Policy for recruitment and selection of adoptive families.
- B.** The agency shall make the operations manual available to all agency personnel and shall ensure that personnel are familiar with and trained in those policies and procedures relevant to their job functions.
- C.** The agency shall make the operations manual available for review by clients, upon request.

Historical Note

Adopted as an emergency effective October 17, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 96-5). Emergency expired. Adopted without change as a permanent rule effective January 23, 1987 (Supp. 87-1). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-7022. Agency Operations Budget; Financial Records

- A.** Before the start of the agency's fiscal year, the Governing Body shall adopt a budget which shall reflect sufficient funds to pay the costs of the agency's program and shall be based on the audit report prepared in compliance with R6-5-7023.
- B.** The agency shall operate within the budget adopted by the Governing Body.
- C.** The agency shall maintain financial records of receipts, disbursements, assets, and liabilities. The agency shall maintain its financial records in accordance with generally accepted accounting principles; the records shall accurately reflect the agency's financial position.
- D.** The agency shall maintain records showing the following information:
1. Each adoptive parent's original contract date with the agency,
 2. Fees that each adoptive parent has paid to the agency and the date of such payments, and
 3. Fees that the agency has charged to the adoptive parent.
- E.** The agency shall make all records described in this Section available for inspection by the Department at periodic inspections, or at other reasonable times upon Department request.
- F.** The agency shall retain financial records for five years, except for records involved in an audit, which records the agency shall retain for five years following completion of the audit.

Historical Note

Adopted as an emergency effective October 17, 1986, pursuant to A.F.S. §§ 41-1003, valid for only 90 days (Supp. 86-5). Emergency expired. Adopted without change as a permanent rule effective January 23, 1987 (Supp. 87-1). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-7023. Annual Financial Audit

- A.** An agency shall obtain an annual, fiscal year-end, financial audit by an independent certified public accountant. The accountant shall conduct the audit in accordance with generally accepted auditing standards.
- B.** The agency shall obtain from the auditor a written audit report which shall include the following financial information:
1. Income statement,
 2. Balance sheet,
 3. Statement of cash flows,
 4. Statement of monies or other benefits the agency has paid or transferred to other business entities or individuals affiliated with the agency, and
 5. A record of any financial transactions between the agency and any other agency.

Historical Note

Adopted as an emergency effective October 17, 1986, pursuant to A.P.S. §§ 41-1003, valid for only 90 days (Supp. 86-5). Emergency expired. Adopted without change as a permanent rule effective January 23, 1987 (Supp. 87-1). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-7024. Insurance Coverage

An agency shall provide evidence that it maintains a blanket liability insurance policy for protection against financial loss, accidents, errors, and omissions in the minimum amount of \$100,000 per person; \$300,000 per accident.

Historical Note

Adopted as an emergency effective October 17, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 86-5). Emergency expired. Adopted without change as a permanent rule effective January 23, 1987 (Supp. 87-1). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-7025. Protecting Confidentiality of Adoption Records

The agency shall have and follow a written policy for the maintenance and security of adoption records. The policy shall be consistent with A.R.S. §§ 8-120, 8-121, and 36-2903.01(S) and shall specify:

1. The personnel responsible for supervision and maintenance of records,
2. The persons who shall and may have access to the records,
3. The procedures for release of records.

Historical Note

Adopted as an emergency effective October 17, 1986, pursuant to A.P.S. §§ 41-1003, valid for only 90 days (Supp. 96-5). Emergency expired. Adopted without change as a permanent rule effective January 23, 1987 (Supp. 87-1). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-7026. Recordkeeping Requirements: Adoptive Children

The agency shall maintain a case record for each adoptive child. Except as otherwise provided in A.R.S. § 8-129(A), the record shall be divided into two sections as follows:

1. Non-identifying information as required by A.R.S. § 8-129; and
2. Identifying information which shall include:
 - a. Tapes, videos, or photos of the adoptive child or birth parent;
 - b. Legal documents and reports required for adoption;
 - c. Social, physical, mental, and educational history of the child's birth family;
 - d. Social, physical, mental, and educational history of the adoptive child; and
 - e. A summary of all action taken to prepare the child for placement in the adoptive home.

Historical Note

Adopted as an emergency effective October 17, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 86-5). Emergency expired. Adopted without change as a permanent rule effective January 23, 1987 (Supp. 87-1). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-7027. Recordkeeping Requirements: Adoptive Parents

The agency shall maintain a case record for each adoptive parent. If the adoptive parent is a member of the same family as another adoptive parent, the agency can maintain one file for the adoptive family. The file shall include:

1. Documentation showing that the adoptive parent received the orientation described in R6-5-6603,
2. The adoptive parent's application for certification,
3. The parent's certification report and any recertification reports,
4. A copy or description of the nonidentifying information the agency has provided to the adoptive parent pursuant to A.R.S. § 8-129(A), and
5. A summary of the adoptive placement decision and the preplacement and post-placement contacts with the family and the adoptive child.

Historical Note

Adopted as an emergency effective October 17, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 96-5). Emergency expired. Amended and adopted as a permanent rule effective January 23, 1987 (Supp. 87-1). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-7028. Reporting Requirements: Abuse; Unauthorized Practice; Changes; Registry Information

- A. During the period of time that an agency is providing services to an adoptive child or family, the agency shall:
 1. Immediately report any suspected or alleged incident of maltreatment of an adoptive child to Child Protective Services; and
 2. Immediately notify a Department licensing representative if an adoptive child dies or suffers a serious illness, bodily injury, or psychiatric episode.
- B. An agency shall notify the Department orally of any of the following changes or events within 24 hours after the agency learns of their occurrence and shall submit written notification to the Department within five working days:
 1. Permanent or temporary closure of the agency or any part thereof;
 2. A criminal conviction or plea agreement involving any agency staff member, excluding minor traffic violations;
 3. Filing of a lawsuit against the agency;
 4. Filing of a lawsuit against agency personnel when the lawsuit relates to or is likely to adversely affect the provision of adoption services;

5. Damage to agency facilities which substantially disrupts the program or the agency's accessibility to clients; and
 6. Knowledge of any child placement which the agency reasonably believes is not permitted by law.
- C. The agency shall notify the Department in writing at least 30 calendar days prior to any of the following proposed changes and events, if known:
 1. Any plans to reorganize the adoption program that would involve changes in target population, geographic area, services, or eligibility, and the reasons for the changes;
 2. Any change in the identity of the agency administrator or social director; or
 3. Any change in ownership as described in R6-5-7007(D).
 - D. When there is a change in the adoptive circumstances of a child or family listed on the Registry, the agency shall notify the Department of the change within five work days of receipt of information about the changed circumstances. For the purpose of this subsection, a change in adoptive circumstances shall include the following events:
 1. Placement of a child,
 2. Loss or renewal of certification, and
 3. Disruption or failure of a placement.

Historical Note

Adopted as an emergency effective October 17, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 86-5). Emergency expired. Adopted without change as a permanent rule effective January 23, 1987 (Supp. 87-1). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-7029. Birth Parent: Service Agreement; Prohibitions

- A. Before providing services to a birth parent, an agency shall enter into a signed written agreement with the birth parent. The agreement shall:
 1. Describe all services the agency will provide to the birth parent;
 2. Explain, with an itemized statement of costs, any expense which the agency will require the birth parent to reimburse to the agency, and the circumstances giving rise to reimbursement;
 3. Contain an itemized statement describing the nature, purpose, and amount of any payments the birth parent will receive from the adoptive parent; if the actual amount is not known, the agency shall describe how the amount will be calculated; and
 4. Contain an itemized statement of all consideration the birth parent will receive in connection with the birth or adoption of a child, if not already described pursuant to subsection (A)(3).
- B. Before or at the time of entering into a birth parent agreement with a birth mother, the adoption entity shall advise the birth mother of her obligations under A.R.S. § 8-106(F).
- C. Before providing services to a birth parent, the adoption agency shall advise the birth parent of the Department's responsibility for licensing and monitoring agencies, and the public's right to register a complaint about an agency as prescribed in R6-5-7034.

Historical Note

Adopted as an emergency effective October 17, 1996, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 86-5). Emergency expired. Adopted without change as a permanent rule effective January 23, 1987 (Supp. 87-1). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-7030. Adoption Fees; Reasonableness

- A.** An agency shall not charge clients more than a reasonable fee for services.
- B.** An agency shall establish, maintain, and follow a written policy on the fees it charges clients for adoption services. The fee policy shall include all of the agency's practices and procedures regarding fees, including the following:
 - 1. A schedule of fees the agency charges for each specific service the agency offers, and the time in the adoption process when the client is required to pay the fee, broken down, at a minimum, as follows:
 - a. Preregistration and registration fees,
 - b. Application and orientation fees,
 - c. Certification application fee,
 - d. Certification investigation,
 - e. Certification report,
 - f. Certification renewal fees,
 - g. Placement services,
 - h. Placement investigation and report,
 - i. Foreign adoption services,
 - j. Post-placement services, and
 - k. Fees incurred when a child has special needs;
 - 2. An explanation of any practice the agency may have for assessing fees based on pooled or averaged costs;
 - 3. An explanation of the circumstances or conditions which would cause the agency to reduce, waive, suspend, or refund a fee, which circumstances may include:
 - a. Adjustment made for the well-being of an adoptive child, and
 - b. Adjustments made to accommodate an adoptive parent's limited ability to pay;
 - 4. An explanation of the circumstances which would cause the agency to increase its fees; and
 - 5. The procedures the agency follows to collect its fees.
- C.** An agency shall advise prospective and existing clients of its fee policy and shall make a copy of the policy available to clients upon request.
- D.** An agency shall not:
 - 1. Condition a client's eligibility for, or receipt of, adoption services on the client's donation or agreement to donate money, goods, services, or other things of value, other than the regular scheduled adoption fees, to the agency or to an agency affiliate;
 - 2. Obstruct or withhold finalization of a placement or adoption solely for nonpayment of fees;
 - 3. Charge a client for any fee which the agency has not listed in the fee schedule, included in its fee policy, and disclosed to the client in the client's fee agreement letter; or
 - 4. Charge a prospective adoptive parent advance fees contrary to R6-5-6603(C).
- E.** The Department may audit, or designate a certified public accountant to audit, an agency's fee structure.
- F.** The agency shall provide the Department and the agency's current adult clients with a copy of any changes made to the agency's fee policy, no less than 14 days prior to the effective date of the change.
- G.** An agency shall refund to a client any fees the client paid for services the agency failed to perform. Against any such refund, the agency may offset any amount due from the client for services the agency has performed and for which the client agreed to pay but has not paid.

Historical Note

Adopted as an emergency effective October 17, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days

(Supp. 96-5). Emergency expired. Adopted without change as a permanent rule effective January 23, 1987 (Supp. 87-1). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-7031. Adoption Fee Agreement

- A.** Before providing services to an adoptive parent, the agency shall enter into a written fee agreement with the adoptive parent. Both the adoptive parent and an authorized representative of the agency shall sign and date the agreement. The agency shall retain the original agreement in the adoptive parent's file and provide a copy to the adoptive parent.
- B.** The fee agreement shall include the following terms:
 - 1. A description of all services the agency will provide to the adoptive parent and the fee for each service; the agreement shall specify how much of the fee is being allocated to cover medical expenses, including the cost of prenatal care and delivery;
 - 2. A general description of any adoption services the agency is not providing but which are required to finalize the adoption, with an estimate of the costs of such services;
 - 3. The terms of payment, including payment due dates and amounts;
 - 4. A statement advising the client of the client's right to receive a copy of the agency's fee policy.
- C.** An agency shall not charge a fee, other than a certification application fee, or enter into an adoption fee agreement until after the potential client has received the orientation described in R6-5-6603.

Historical Note

Adopted as an emergency effective October 17, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 96-5). Emergency expired. Adopted without change as a permanent rule effective January 23, 1987 (Supp. 87-1). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-7032. AHCCCS Reimbursement; Disclosure of Third-party Coverage

- A.** This Section applies to placements made pursuant to the ICPC.
- B.** When an agency has collected fees to cover the medical expenses of a birth mother or an adoptive child whose medical expenses were paid by AHCCCSA, the agency shall reimburse AHCCCSA for the monies AHCCCSA has expended on behalf of the birth mother or child for prenatal care and delivery of the child. The reimbursement amount shall not exceed the amount AHCCCSA has paid for capitation, reinsurance and fee-for-service costs.
- C.** An agency shall determine whether an adoptive parent has insurance that will cover the medical expenses of a birth mother or adoptive child whose medical expenses were paid for by AHCCCSA. If insurance is available, the agency shall provide AHCCCSA with information about the adoptive parent's insurance.
- D.** The Department shall provide AHCCCSA with a copy of the verified accounting form required by A.R.S. § 8-114.01 and A.A.C. R6-5-6503.01.

Historical Note

Adopted as an emergency effective October 17, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 86-5). Emergency expired. Adopted without change as a permanent rule effective January 23, 1987 (Supp. 87-1). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-7033. Monitoring: Inspections and Interviews; Compliance Audit

- A. The Department shall monitor the ongoing operations of each agency.
- B. Monitoring activities may include the following:
 1. At least one announced and one unannounced onsite inspection of each agency during the licensing year;
 2. Interviews of agency personnel and clients;
 3. A review of the agency's books, records, and sample client files; and
 4. A compliance audit of the agency, as described in subsection (C).
- C. Upon receipt of a complaint against an agency, or in response to observed deficiencies, the Department may conduct a compliance audit of the agency to assess the agency's compliance with applicable adoption licensing and adoption services statutes and rules.
- D. An agency shall facilitate the Department's monitoring functions or compliance audit by:
 1. Making the agency's books, files, records, manuals, premises, and facilities available to Department staff for inspection;
 2. Allowing Department staff to interview agency personnel and employees; and
 3. Enabling the Department to conduct interviews with agency clients.

Historical Note

Adopted as an emergency effective October 17, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 86-5). Emergency expired. Adopted without change as a permanent rule effective January 23, 1987 (Supp. 87-1). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-7034. Complaints; Investigations

- A. Any person may register a complaint about an adoption agency with the Department. The Department shall ask persons making oral complaints to put the complaint in writing.
- B. Upon receipt of a complaint, or in response to deficiencies observed by Department staff, the Department shall investigate the allegations of the complaint.
- C. The Department's investigation may include:
 1. Interviews with the complaining party, agency staff members, and agency clients;
 2. Inspections of agency records, files, or other documents related to the issues raised in the complaint; and
 3. Any other activities necessary to substantiate or refute the allegations.
- D. Upon completion of its investigation, the Department shall:
 1. Find that the complaint is unsubstantiated and close the investigation;
 2. Find that the complaint is substantiated and take appropriate disciplinary action against the agency, as described in this Article; or
 3. Find that the complaint cannot be substantiated or refuted based on the available evidence.
- E. The Department shall maintain a file on all complaints against an agency and shall make information on substantiated complaints available to the general public, upon request, and to the extent permitted by confidentiality laws.

Historical Note

Adopted as an emergency effective October 17, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 86-5). Emergency expired. Adopted without change as a permanent rule effective January 23, 1987

(Supp. 87-1). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-7035. Noncompliance Status

- A. The Department shall place an agency in noncompliance status when a Department representative observes or the Department receives and substantiates a complaint in an area which does not endanger the health, safety, or well-being of a client.
- B. The Department shall mail the agency written notice of the noncompliance status and the reason for that status and recommendations for changes the agency can make to cure the identified problem.
- C. No later than 10 working days following the postmark date of the noncompliance notice, the agency shall provide the Department with a written plan showing how the agency will correct the problem which resulted in the noncompliance status, with an estimated time-frame in which the agency shall implement the corrective action. The Department may extend the 10-day time-frame when the agency has demonstrated a good faith effort to address and resolve the identified problem.
- D. Imposition of noncompliance status is not an adverse action and is not appealable.

Historical Note

Adopted as an emergency effective October 17, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 86-5). Emergency expired. Adopted without change as a permanent rule effective January 23, 1987 (Supp. 87-1). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-7036. Suspension

- A. The Department may suspend an agency's license for violations of the statutes or rules governing adoptions, or for any activity which may threaten the health, safety, or welfare of any agency client, including the following:
 1. When the Department receives a CPS report of abuse or neglect alleged to have been committed by agency staff against a child, and the agency fails to take protective measures pending an investigative finding;
 2. Conduct that causes disruption of a placement or adoption;
 3. When an agency permits an employee who has failed to comply with fingerprinting requirements or who has been denied fingerprint clearance to continue providing services to children;
 4. When an agency refuses to cooperate with Department requests for information which the Department requires for determining compliance with the statutes and rules governing provision of adoption services;
 5. When an agency refuses to provide the Department with information the Department has requested during the course of a complaint investigation; or
 6. When an agency fails to correct a problem which resulted in imposition of noncompliance status, within the time provided in the agency's corrective action plan.
- B. The Department shall mail the agency written notice of the suspension, the reason for the suspension, and an explanation of the agency's right to appeal the suspension.
- C. Except as otherwise provided in subsection (D), an agency may continue to place adoptable children who become available for placement and to finalize adoptions of placed children and adoptees during a period of suspension; the agency shall not recruit, accept, or register any new birth parents or adoptive parents.
- D. When the Department finds that the physical or emotional health or safety of a client is in imminent danger, the Depart-

ment may take immediate action to eliminate the danger. For the purpose of this subsection,

1. A situation involving imminent danger shall be those situations identified in A.R.S. § 8-223(C)(2) which would justify removal of a child;
2. Immediate action may include:
 - a. Removal of children,
 - b. Transfer of clients to another agency, or
 - c. Other protective action designed to eliminate the danger or risk of harm.

- E. If the agency does not correct the situation which led to suspension of its license, the Department shall initiate license revocation proceedings against the agency.

Historical Note

Adopted as an emergency effective October 17, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 86-5). Emergency expired. Adopted without change as a permanent rule effective January 23, 1987 (Supp. 87-1). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-7037. Revocation

- A. The Department may revoke a license for any of the following reasons:
1. When the agency violates a statute or rule governing provision of adoption services;
 2. When the agency commits any activity which may threaten the health, safety, or welfare of any agency client, including, but not limited to the circumstances justifying license suspension, as prescribed in R6-5-7036;
 3. When the agency commits fraud or intentional misrepresentation in obtaining or renewing its license;
 4. When the agency commits fraud or intentional misrepresentation in dealing with its clients;
 5. When the agency has obtained a birth parent's relinquishment and consent to adoption through duress, coercion, extortion, or intimidation;
 6. When the agency knowingly fails to advise an adoptive parent that the adoptive child has been abused while in the agency's care or control; or
 7. When the agency violates its agreement with a client for provision of services.
- B. The Department shall mail the agency written notice of the revocation, the reason for the revocation, and an explanation of the agency's right to appeal the revocation.
- C. A revocation is effective:
1. Twenty-one days after the postmark date of the revocation notice; or
 2. In cases where the agency appeals the revocation, when an administrative hearing officer issues a decision affirming the revocation. If an agency further appeals a hearing officer's decision affirming a decision to revoke the agency's license, the revocation is effective until there is a higher administrative or judicial decision reversing or vacating the hearing officer's decision.
- D. An agency which has had its license revoked shall perform no adoption services after the effective date of the revocation and shall surrender its license to the Department.
- E. An agency which has had its license revoked shall cooperate with the Department to transfer all its clients to another agency.

Historical Note

Adopted as an emergency effective October 17, 1986, pursuant to A.P.S. §§ 41-1003, valid for only 90 days (Supp. 86-5). Emergency expired. Adopted without change as a permanent rule effective January 23, 1987

(Supp. 87-1). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-7038. Adverse Action: Procedures

- A. When the Department takes adverse action against a license applicant or adoption agency, the Department shall give the affected party written notice of such adverse action by first-class or registered mail.
- B. For the purpose of this Section, the following are adverse actions:
1. Denial of an initial or renewal license, and
 2. Suspension or revocation of a license.
- C. The adverse action notice shall specify:
1. The action taken,
 2. All reasons supporting such action, and
 3. The procedures by which affected parties may contest the action taken.

Historical Note

Adopted as an emergency effective October 17, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 86-5). Emergency expired. Adopted without change as a permanent rule effective January 23, 1987 (Supp. 87-1). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

R6-5-7039. Appeals

- A. An applicant or agency may appeal an adverse action other than imposition of noncompliance status, by filing a written notice of appeal with the Department's Adoptions Licensing Office no later than 20 days from the postmark date of the adverse action notice.
- B. The notice of appeal shall specify the action being appealed, the reasons for the appeal, and a brief summary of why the Department's action was erroneous, unlawful, or improper.
- C. The Department shall conduct an appeal from an adverse action as prescribed in 6 A.A.C. 5, Article 75.
- D. The Department shall conduct an appeal from the decision of a hearing officer as prescribed in A.R.S. §§ 41-1992(D) and 41-1993 and R6-5-7518 through R6-5-7520.

Historical Note

Adopted as an emergency effective October 17, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 86-5). Emergency expired. Adopted without change as a permanent rule effective January 23, 1987 (Supp. 87-1). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1). Amended effective June 4, 1998 (Supp. 98-2).

R6-5-7040. International Adoptions

- A. An agency shall not accept a foreign child for adoptive placement in the United States unless the government of the foreign child's country of origin authorized the placement.
- B. The agency shall provide the Department with evidence of its authority from or agreements with a foreign country or placing organization. If the evidence of authority is not written in English, the agency shall provide an English language translation of the documentation.
- C. The agency shall advise the adoptive parents of the need to have the child naturalized in the United States.
- D. The agency shall provide adoptive parents with information about the child's foreign culture of origin.

Historical Note

Adopted as an emergency effective October 17, 1996, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 86-5). Emergency expired. Adopted without change as a permanent rule effective January 23, 1987

(Supp. 87-1). Section repealed, new Section adopted effective January 2, 1996 (Supp. 96-1).

ARTICLE 71. REPEALED

R6-5-7101. Repealed

Historical Note

Adopted as an emergency effective January 1, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 85-6). Emergency renewed effective April 1, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 86-2). Emergency expired. Permanent rule adopted effective July 11, 1986 (Supp. 86-4). Repealed effective April 9, 1998 (Supp. 98-2).

R6-5-7102. Repealed

Historical Note

Adopted as an emergency effective January 1, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 85-6). Emergency renewed effective April 1, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 86-2). Emergency expired. Permanent rule adopted effective July 11, 1986 (Supp. 86-4). Repealed effective April 9, 1998 (Supp. 98-2).

R6-5-7103. Repealed

Historical Note

Adopted as an emergency effective January 1, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 85-6). Emergency renewed effective April 1, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 86-2). Emergency expired. Permanent rule adopted effective July 11, 1986 (Supp. 86-4). Repealed effective April 9, 1998 (Supp. 98-2).

R6-5-7104. Repealed

Historical Note

Adopted as an emergency effective January 1, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 85-6). Emergency renewed effective April 1, 1986, pursuant to A.R.S. §§ 41-1003, valid for only 90 days (Supp. 86-2). Emergency expired. Permanent rule adopted effective July 11, 1986 (Supp. 86-4). Repealed effective April 9, 1998 (Supp. 98-2).

ARTICLE 72. REPEALED

Former Article 72 consisting of Sections R6-5-7201 through R6-5-7214 repealed effective July 12, 1984.

ARTICLE 73. REPEALED & RENUMBERED

Editor's Note: Article 73 was repealed except for Sections R6-5-7307 and R6-5-7308 which were both renumbered, effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7301. Repealed

Historical Note

Adopted effective January 21, 1985 (Supp. 85-1). Repealed effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7302. Repealed

Historical Note

Adopted effective January 21, 1985 (Supp. 85-1). Repealed effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7303. Repealed

Historical Note

Adopted effective January 21, 1985 (Supp. 85-1). Repealed effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7304. Repealed

Historical Note

Adopted effective January 21, 1985 (Supp. 85-1). Repealed effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7305. Repealed

Historical Note

Adopted effective January 21, 1985 (Supp. 85-1). Repealed effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7306. Repealed

Historical Note

Adopted effective January 21, 1985 (Supp. 85-1). Repealed effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7307. Renumbered

Historical Note

Adopted effective January 21, 1985 (Supp. 85-1). Section R6-5-7307 renumbered to R6-5-7470 and amended effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7308. Renumbered

Historical Note

Adopted effective January 21, 1985 (Supp. 85-1). Section R6-5-7308 renumbered to R6-5-7471 and amended effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7309. Repealed

Historical Note

Adopted effective January 21, 1985 (Supp. 85-1). Repealed effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

ARTICLE 74. LICENSING PROCESS AND LICENSING REQUIREMENTS FOR CHILD WELFARE AGENCIES OPERATING RESIDENTIAL GROUP CARE FACILITIES AND OUTDOOR EXPERIENCE PROGRAMS

R6-5-7401. Definitions

In addition to the definitions contained in A.R.S. § 8-501, the following definitions apply in this Article:

1. "Abandonment" has the same meaning ascribed to "abandoned" in A.R.S. § 8-531(1).
2. "Abuse" means the infliction or allowing of physical injury, impairment of bodily function or disfigurement or the infliction of or allowing another person to cause serious emotional damage as evidenced by severe anxiety, depression, withdrawal or untoward aggressive behavior and which emotional damage is diagnosed by a medical doctor or psychologist pursuant to § 8-821 and which is caused by the acts or omissions of an individual having care, [physical] custody and control of a child. Abuse includes:
 - (a) Inflicting or allowing sexual abuse pursuant to § 13-1404, sexual conduct with a minor pursuant to § 13-1405, sexual assault pursuant to § 13-1406, moles-

- tation of a child pursuant to § 13-1410, commercial sexual exploitation of a minor pursuant to § 13-3552, sexual exploitation of a minor pursuant to § 13-3553, incest pursuant to § 13-3608 or child prostitution pursuant to § 13-3212.*
- (b) *Physical injury to a child that results from abuse as described in § 13-3623, subsection C. A.R.S. § 8-201(2).*
3. “Accredited” means the approval and recognition of an institution of learning as maintaining those standards requisite for its graduates to gain admission to other institutions of higher learning or to achieve credentials for professional practice. An example of an accrediting body is the North Central Association of Colleges and Universities.
 4. “Administrative completeness review time frame” means the number of days from [the Licensing Authority’s] receipt of an application for a license until [the Licensing Authority] determines that the application contains all components required by statute or rule, including all information required to be submitted by other government agencies. The administrative completeness review time frame does not include the period of time during which an agency provides public notice of the license application or performs a substantive review of the application. A.R.S. § 41-1072(1).
 5. “Adverse action” means suspension or revocation of a license, denial of a renewal license, or making a material change in licensing status.
 6. “After-care” means services provided to a child after the child is discharged from a licensee’s care and may also include services for the child’s family.
 7. “Applicant” means a person who submits a written application to the Licensing Authority to become licensed or to renew a license to operate a child welfare agency or a residential group care facility.
 8. “Barracks” means a building that:
 - a. Is designed and constructed or remodeled for the specific purpose of housing large numbers of children of the same gender;
 - b. Has wide, open sleeping areas for children, under one roof;
 - c. Is identified and described as a barracks or dormitory in the agency’s promotional and organizational materials; and
 - d. Is made known as a barracks or dormitory to placing agencies and persons considering placement of a child.
 9. “Behavior management” means the policies, procedures, and techniques a licensee uses to control conduct as prescribed in R6-5-7456.
 10. “Child placing agency” means a person or entity that is licensed or authorized to receive children for care, maintenance, or placement in a foster home, because:
 - a. The Department has licensed the person or entity as a child welfare agency pursuant to A.R.S. § 8-505; or
 - b. It is an entity with statutory authorization to place children.
 11. “Child welfare agency” or “agency”
 - a. Means:
 - i. *Any agency or institution maintained by a person, firm, corporation, association, or organization to receive children for care and maintenance or for 24-hour social, emotional, or educational supervised care or who have been adjudicated as a delinquent or dependent child.*
 - ii. *Any institution that provides care for unmarried mothers and their children.*
 - iii. *Any agency maintained by the state, or a political subdivision thereof, person, firm, corporation, association, or organization to place children or unmarried mothers in a foster home.*
 - b. *Does not include state operated institutions or facilities, detention facilities for children established by law, health care institutions that are licensed by the department of health services pursuant to Title 36, Chapter 4 or private agencies that exclusively provide children with social enrichment or recreational opportunities and that do not use restrictive behavior management techniques. A.R.S. § 8-501(A)(1).*
 12. “Corrective action” means a specific course of conduct an agency will follow to remedy violations of the licensing requirements prescribed in this Article, within a specified period of time.
 13. “Corrective action plan” means a written document describing an agency’s corrective action, as prescribed in R6-5-7418.
 14. “CPS” means Child Protective Services, a Department program responsible for investigating reports of child maltreatment.
 15. “CPSCR” means the Child Protective Services Central Registry, a computerized database, which CPS maintains according to A.R.S. § 8-804.
 16. “De-escalation” means a method of verbal communication or non-verbal signals and actions, or a combination of signals and actions, that interrupt a child’s behavior crisis and calm the child.
 17. “Department” or “DES” means the Department of Economic Security.
 18. “Developmentally appropriate” means an action that takes into account:
 - a. A child’s age and family background;
 - b. The predictable changes that occur in a child’s physical, emotional, social, cultural, and cognitive development; and
 - c. A child’s individual pattern and timing of growth, personality, and learning style.
 19. “DHS” means the Department of Health Services.
 20. “Direct care staff” means the facility staff who provide primary personal care, guidance, and supervision to children in care.
 21. “Discharge plan” means:
 - a. A written description of:
 - i. A program of action to prepare a child for release from a facility; and
 - ii. After-care;
 - b. That is developed by a licensee in cooperation with a child’s service team.
 22. “Discipline” means a teaching process through which a child learns to develop and maintain the self-control, self-reliance, self-esteem, and orderly conduct necessary to assume responsibilities, make daily living decisions, and live according to accepted levels of social behavior.
 23. “Document” means to make and retain a permanent written or electronic record of a fact, event, circumstance, observation, contact, or communication.
 24. “Exploitation” means the act of taking advantage of, or to make use of a child selfishly, unethically, or unjustly, for one’s own advantage or profit, in a manner contrary to the

- best interests of the child, such as having a child handle, steal, or perform other illegal activities.
25. “Facility” or “residential group care facility” means a living environment operated by a child welfare agency, where children are in the care of adults unrelated to the children, 24 hours per day.
 - a. “Facility” does not include a program licensed as a behavioral health service agency by the Department of Health Services under A.R.S. § 36-405 and 9 A.A.C. 20.
 - b. “Facility” does include an outdoor experience program.
 - c. When used in reference to an outdoor experience program, “facility” means the campsite at which or the mobile equipment in which children are housed.
 26. “File” means a place where information is stored through written, electronic, or computerized means.
 27. “Foot candles” means a unit of luminous intensity that can be measured with a light meter.
 28. “Governing body” means an individual or group of individuals responsible for the policies, activities, and operations of a facility, as prescribed in R6-5-7424.
 29. “Individual education plan” or “IEP” means a written document that describes educational goals for a particular child and the services the child needs to attain those goals.
 30. “Institution” as used in A.R.S. § 8-501(A)(1) means an entity meeting two or more of the following criteria:
 - a. Solicits charitable contributions;
 - b. Is organized as a profit or non-profit corporation with a board of directors and officers;
 - c. Publishes and distributes information or promotional materials about its program or operations;
 - d. Requires residents to formally apply for residency through use of application forms or other similar paperwork;
 - e. Operates a structured program of care pursuant to written policies, procedures, guidelines, or rules; or
 - f. Advertises itself or holds itself out in the community as an institution that provides care or social services.
 31. “Institution for Unwed Mothers and Children” means a child welfare agency, as described in A.R.S. § 8-501(A)(1)(a)(ii), that is licensed to care for unmarried mothers who are under age 18 at the time of admission to the agency and the children of those mothers.
 32. “License” means a document issued by the Licensing Authority to an individual or non-governmental business, which authorizes the individual or business to operate a child welfare agency in compliance with this Article.
 33. “Licensee” means the person or entity holding a license. When used in reference to a duty, task, or obligation, the term “licensee” includes the staff who work at an agency or facility and who are responsible for doing the acts necessary to fulfill the requirements of this Article.
 34. “Licensed medical practitioner” means a person who holds a current license as a physician, surgeon, nurse practitioner, or physician’s assistant pursuant to A.R.S. §§ 32-1401 et seq., Medicine and Surgery; A.R.S. §§ 32-1800 et seq., Osteopathic Physicians and Surgeons; A.R.S. §§ 32-2501 et seq., Physician Assistants; and A.R.S. §§ 32-1601 et seq., Nursing and R4-19-501(A)(1), Registered Nurse Practitioner, respectively.
 35. “Licensing Authority” means the Department administrative unit that monitors and makes licensing determinations for agencies and facilities, including issuance, denial, suspension, and revocation of a license or operating certificate, and imposition of corrective action.
 36. “Licensing representative” means a person employed by the Licensing Authority to investigate and monitor applicants and licensees.
 37. “Licensing year” means a one-year time period that begins on the date an agency obtains its initial license to operate, and ends one year later.
 38. “Living unit” means a specific grouping of children who are assigned to and share a distinct and common physical space within a facility.
 39. “Maltreatment” means abuse, neglect, abandonment, or exploitation, of a child.
 40. “Material change in licensing status” means, for the purpose of A.R.S. § 8-506.01,
 - a. Any of the following actions:
 - i. Denial, suspension, or revocation of an operating certificate;
 - ii. At any time following issuance of an initial license, imposition of provisional license status, in lieu of a regular license as prescribed in R6-5-7419; or
 - iii. A change in a term appearing on the face of a license or operating certificate, including: a.) Geographic area served; b.) Age, number, or gender of children served; or c.) Type of services offered;
 - b. But does not include the act of placing an agency on a corrective action plan to bring the agency into compliance with licensing requirements as prescribed in R6-5-7418.
 41. “Mechanical restraint” means:
 - a. An article, device, or garment that:
 - i. Restricts a child’s freedom of movement or a portion of a child’s body;
 - ii. Cannot be removed by the child; and
 - iii. Is used for the purpose of limiting the child’s mobility;
 - b. But does not include an orthopedic, surgical, or medical device that allows a child to heal from a medical condition or to participate in a treatment program.
 42. “Medication” means an agent, such as a drug or remedy, used to prevent or treat disease, illness or injury, including both prescribed and over-the-counter agents.
 43. “Mobile dwelling” means a structure, such as a trailer or recreational vehicle as defined in A.R.S. § 41-2142(30). Mobile dwelling does not mean a mobile, manufactured, prefabricated, or modular home as defined in A.R.S. § 41-2142(14), (24), or (26).
 44. “Neglect” has the same meaning as A.R.S. § 8-201(21).
 45. “Non-ambulatory child” means a child who cannot walk due to a physical disability or impairment, rather than as a result of the child’s normal age and developmental level.
 46. “Onsite” means located on the physical property operated by the licensee for the purpose of the licensee’s residential program and includes the contiguous area within:
 - a. A single structure;
 - b. A cluster of structures;
 - c. A complex containing single or multiple family dwelling units with or without separate entrances for each unit;
 - d. A campus containing any combination of the residences listed in subsections (a)-(c), as approved by the Licensing Authority.

47. "Operating certificate" means a document that the Licensing Authority issues to a particular facility that is run by an agency holding a license, as prescribed in R6-5-7409.
48. "Outdoor experience program" means a child welfare agency that is located in a cabin or portable structure such as a tent or covered wagon and primarily uses the outdoors to provide recreational and educational experiences in group living, either in a fixed campsite or in a program with an unfixed site, such as a wagon train or wilderness hike.
49. "Out-of-home placement" means the placing of a child in the custody of an individual or agency other than with the child's parent or legal guardian and includes placement in temporary custody pursuant to § 8-821, subsection A or B, voluntary placement pursuant to 8-806 or placement due to dependency actions. A.R.S. § 8-501(A)(7).
50. "Overall time frame" means the number of days after receipt of an application for a license during which [the licensing authority] determines whether to grant or deny a license. The overall time frame consists of both the administrative completeness review time frame and the substantive review time frame. A.R.S. § 41-1072(2).
51. Paid staff means:
 - a. A licensee's paid employees who work at a facility;
 - b. Any temporary worker or independent contractor the licensee uses as a temporary replacement for an employee who is sick, on leave, or unavailable; and
 - c. Any independent contractor that the licensee retains to provide children in care with direct services at the facility.
52. "Parent or parents" means the natural or adoptive mother or father of a child. A.R.S. § 8-501(A)(8).
53. "Person" means an individual, partnership, joint stock company, business trust, voluntary association, corporation, or other form of business enterprise, including non-profit or governmental organizations.
54. "Personally identifiable information" means any information which, when considered alone, or in combination with other information, identifies, or permits another person to readily identify the person who is the subject of the information, and includes:
 - a. Name, address, and telephone number;
 - b. Date of birth;
 - c. Photograph;
 - d. Fingerprints;
 - e. Physical description;
 - f. School;
 - g. Place of employment; and
 - h. Unique identifying number, including:
 - i. Social Security number;
 - ii. Driver's license number;
 - iii. License number; and
 - iv. Court case number.
55. "Physical restraint" means the use of bodily force to restrict a child's freedom of movement, but does not include holding a child firmly enough to prevent the child from harming himself or herself, or others, but gently enough so that the child is not harmed by being held.
56. "Placing agency or person" means the child placing agency, parent, or guardian, having legal custody of a child and who makes the decision to send the child to reside at a particular agency.
57. "Potentially hazardous food" means a food that is:
 - a. Natural or synthetic and capable of rapid and progressive growth of infectious or toxigenic microorganisms or the growth and production of *Clostridium botulinum*;
 - b. Of animal origin and is raw or has been heated;
 - c. Of plant origin and is heated or consists of raw seed sprouts;
 - d. A cut melon; or
 - e. A garlic and oil mixture.
58. "Program director" means a person who meets the qualifications listed in R6-5-7432(B).
59. "Relative" means a grandparent, great grandparent, brother or sister of whole or half blood, aunt, uncle, or first cousin. A.R.S. § 8-501(A)(12).
60. "Residential environment" means a facility building or any portion of a facility building that is used for living, sleeping, counseling, dining, or academic purposes.
61. "Restrictive behavior management" means a form of behavior control that is subject to limitations as prescribed in R6-5-7456(D)-(F).
62. "Safeguard" means to use reasonable and developmentally appropriate measures to minimize the risk of harm to a child in care and to ensure that a child in care will not be harmed by a particular object, substance, or activity. Where a specific method is not otherwise prescribed in this Article, safeguarding may include:
 - a. Locking up a particular substance or item;
 - b. Putting a substance or item beyond the reach of a child who is not mobile;
 - c. Erecting a barrier that prevents a child from reaching a particular place, item, or substance;
 - d. Mandating the use of protective safety devices;
 - e. Providing staff supervision; or
 - f. Providing a young adult with safety information and generalized instruction necessary to promote the safe and appropriate use of potentially dangerous objects.
63. "Seclusion" means placing a child alone in a room with closed, locked doors that cannot be opened from the inside as prohibited by R6-5-7456(C)(6).
64. "Service plan," which is sometimes described as a "case plan," means a goal-oriented, time-limited individualized program of action that:
 - a. Describes the plans for treating and providing services to a child and the child's family, and
 - b. Is developed by a licensee in cooperation with a child's service team.
65. "Service team" means the group of persons listed in R6-5-7441(D)(1) who participate in development and review of a child's service plan and discharge plan.
66. "Shelter care facility" means an agency facility that receives children for temporary out-of-home care, 24 hours per day, when children request care, or are placed in care by a placing agency, a law enforcement agency, a parent, a guardian, or a court.
67. "Significant person" means a person who is important or influential in a child's life and may include a family member or close friend.
68. "Sleeping area" means a single bedroom, or a cluster of two or more bedrooms, located in an adjacent area of a dwelling.
69. "Social worker" means a person with a bachelor's, master's, or doctoral degree in a field of organized work called social work, which is intended to advance the social conditions of a community through provision of counseling, guidance, and assistance, especially in the form of social services to individuals.
70. "Staff" means a licensee's paid staff and unpaid staff.

71. “Substantive review time frame” means the number of days after the completion of the administrative completeness review time frame during which [the licensing authority] determines whether an application or applicant for a license meets all substantive criteria required by statute or rule. Any public notice and hearings required by law shall fall within the substantive review time frame. A.R.S. § 41-1072(3).
72. “Swimming pool” means any on-grounds, natural or man-made body of water that is used for the purposes of swimming, recreation, or physical therapy, and includes spas and hot tubs.
73. “Threat” means an expression of intent to hurt, destroy, or take action prohibited by this Article or the licensee’s policies, but does not include an expression of intent to impose a planned consequence for misbehavior if the consequence is not prohibited by this Article or the licensee’s policies.
74. “Transitional program” means services provided to a child who is being emancipated as an adult, or a person who has reached the age of 18 and is considered an adult as a matter of law, in order to assist the child or person in becoming independent.
75. “Unpaid staff” means a licensee’s volunteers, students, and interns who work, train, or assist at a facility.
76. “Unusual incident” means one or more of the events listed in R6-5-7434(C), (D), (E), or (G).
77. “Work day” means 8:00 a.m. to 5:00 p.m., Monday through Friday, excluding Arizona state holidays.
78. “Young adult” means an individual, age 16 to 21, who has been assessed and determined to be appropriate for preparation for adult self-sufficiency. The assessment or determination shall be made by:
 - a. The placing agency, if the young adult is in the care, custody, and control of the state of Arizona;
 - b. A parent or legal guardian of the young adult, if subsection (a) does not apply;
 - c. The licensee, if subsections (a) and (b) do not apply.

Historical Note

Adopted effective May 19, 1977 (Supp. 77-3). Former Section R6-5-7401 repealed; new Section R6-5-7401 filed with the Secretary of State’s Office May 15, 1997; adopted effective July 1, 1997 (Supp. 97-2). Amended by emergency rulemaking at 12 A.A.R. 2233, effective June 1, 2006 for 180 days (Supp. 06-2). Emergency renewed at 12 A.A.R. 4732, effective November 28, 2006 for 180 days (Supp. 06-4). Amended by final rulemaking at 13 A.A.R. 2049, effective May 21, 2007 (Supp. 07-2).

R6-5-7402. Request for Initial Application - New Applicant

- A. A person who wants to operate a residential group care facility shall initiate the licensing process by contacting the Licensing Authority to request an application for a child welfare agency license.
- B. Upon request, the Licensing Authority shall send the prospective applicant an application package containing:
 1. A cover letter outlining the licensing process and requesting a responsive letter of intent,
 2. An application form,
 3. A statement of requirements for licensure, and
 4. A form the applicant can use to obtain city or county zoning clearance.

Historical Note

Adopted effective May 19, 1977 (Supp. 77-3). Former Section R6-5-7402 repealed; new Section R6-5-7402

filed with the Secretary of State’s Office May 15, 1997; adopted effective July 1, 1997 (Supp. 97-2).

R6-5-7403. Letter of Intent - New Applicant

- A. The prospective applicant shall prepare a responsive letter of intent to proceed with licensure, and return it to the Licensing Authority. The letter of intent shall include the following information:
 1. The applicant’s name, address, and telephone and telefacsimile numbers;
 2. The name of the applicant’s chief executive officer or administrator, with a description of that person’s qualifications to operate the agency;
 3. A description of community or statewide need for the service or program the applicant intends to provide;
 4. A plan for financing the proposed agency during the first year of operation;
 5. A statement that the applicant has conferred with the school district where the facility will be located to advise the district of any special needs that children likely to be in care at the facility may have; and
 6. A description of the proposed agency’s program and services, which shall address the following areas, if applicable:
 - a. Any organization from which the applicant will seek accreditation;
 - b. The form of on-campus educational programs the applicant will offer;
 - c. The characteristics of the children the applicant plans to serve;
 - d. The applicant’s primary source of referrals;
 - e. The frequency and method by which the applicant will provide or offer psychiatric, psychological, or counseling services;
 - f. Whether the applicant will employ behavioral health practitioners, or contract for behavioral health services; and
 - g. A general description of the number and qualifications of the applicant’s professional staff.
- B. Within 10 work days of receiving a letter of intent, a licensing representative shall contact the applicant.
 1. If the Licensing Authority determines that an applicant may require licensure as a behavioral health service agency under A.R.S. § 36-405 and 9 A.A.C. 20, the Licensing Authority shall refer the applicant to the Department of Health Services for evaluation. In determining whether to refer an applicant to DHS, the Licensing Authority shall consider the factors set forth on Appendix 1.
 2. For all other applicants, the representative shall schedule an appointment for a licensing consultation. The appointment shall occur within 45 calendar days of the date the Licensing Authority receives the letter of intent, unless the applicant requests a later consultation.
 3. If DHS declines to license an applicant as a behavioral health service agency, and refers an applicant to the Department for licensure as a child welfare agency, the applicant shall contact the Licensing Authority to request a licensing consultation. The Licensing Authority shall schedule the consultation within 45 calendar days of the date of the request, unless the applicant requests a later consultation.

Historical Note

Adopted effective May 19, 1977 (Supp. 77-3). Amended subsection (O), paragraph (1) effective January 21, 1985 (Supp. 85-1). Former Section R6-5-7403 repealed; new

Section R6-5-7403 filed with the Secretary of State's Office May 15, 1997; adopted effective July 1, 1997 (Supp. 97-2).

R6-5-7404. The Licensing Consultation; Time for Completion of Application

- A. At the licensing consultation, a licensing representative shall review the licensing application form with the applicant. The licensing representative shall explain the requirements for licensure and shall advise the applicant about:
1. The information and documentation the applicant must provide to complete the application or licensing process, as set forth in R6-5-7405;
 2. The fingerprinting and background checks required by A.R.S. § 46-141 and R6-5-7431;
 3. The need for a DHS health and safety inspection of the agency and each facility, and the process for scheduling the inspection;
 4. The need to obtain a fire inspection and zoning clearance for the each facility;
 5. The need to confer with the local school district to discuss any special educational needs that the children to be served may present;
 6. The timelines for submission of application information; and
 7. The need for the Licensing Authority to conduct a site inspection as prescribed in R6-5-7406.
- B. No later than 60 days after the licensing consultation, the applicant shall provide the Licensing Authority with a complete application package, as prescribed in R6-5-7405(A).
- C. If the applicant cannot provide the information within 60 days, the applicant shall contact the Licensing Authority to request an extension of time. The Licensing Authority shall allow an extension for a fixed period of time, which shall not exceed 120 days past the original 60 days.
- D. If the applicant fails to provide the information within the time periods specified in subsections (B) and (C), the Licensing Authority shall close the applicant's file and send the applicant a written notice of closure. An applicant whose file has been closed shall reapply.
- E. For an initial application, the administrative completeness review time-frame described in A.R.S. § 41-1072(1) begins when the applicant submits the application form and the required documentation listed in R6-5-7405(A).

Historical Note

Adopted effective May 19, 1977 (Supp. 77-3). Former Section R6-5-7404 repealed; new Section R6-5-7404 filed with the Secretary of State's Office May 15, 1997; adopted effective July 1, 1997 (Supp. 97-2).

R6-5-7405. Complete Application; Initial License - New Applicant

- A. A complete application package for an initial license of a new agency shall contain the information and supporting documentation listed in this subsection.
1. Identification and background information: agency, facility, administrators.
 - a. Name, address, and telephone and telefacsimile numbers for the agency and all facilities operated by the agency;
 - b. Name, title, business address, and telephone and telefacsimile numbers of:
 - i. The person who serves as the chief executive officer (CEO) as prescribed in R6-5-7432(A);
 - ii. The person who serves as the program director as prescribed in R6-5-7432(B);

- iii. The person with delegated authority to act when the CEO is absent;
 - iv. The person in charge of each separate facility as prescribed in R6-5-7432(C);
 - v. Persons holding at least a 10% ownership interest in the applicant; and
 - vi. The agency and facility medical directors, if applicable;
- c. The educational qualifications and work history for each person identified in subsection (A)(1)(b), with that person's attached resume, employment application, or curriculum vitae;
 - d. A list of the members of the agency's governing body described in R6-5-7424, including: name, address, position in the agency, term of membership, and any relationship to the applicant;
 - e. A list of licenses or certificates for provision of medical or social services, currently or previously held by the applicant or persons listed in subsection (A)(1)(b), including those held in this state or another state or country;
 - f. A written description of any proceedings for denial, suspension or revocation of a license or certificate for provision of medical, psychological, behavioral health, or social services, pending or filed, or brought against the applicant or a person listed in subsection (A)(1)(b), including those held in this state or another state or country; and
 - g. A written description of any litigation in which the applicant or a person listed in subsection (A)(1)(b) has been a party, including, without limitation, collection matters and bankruptcy proceedings during the 10 years preceding the date of application.
2. Business organization.
 - a. An organizational chart for the agency and each separate facility, showing administrative structure and staffing, and lines of authority;
 - b. Business organization documents appropriate to the applicant, including:
 - i. Articles of incorporation, by-laws, annual reports for the preceding three years; or
 - ii. Partnership or joint venture agreement;
 - c. For corporations, a certificate of good standing from the Arizona Corporation Commission or comparable entity from a foreign state; and
 - d. A statement as to whether the applicant is for-profit or not-for-profit if not explained in other documents already provided.
 3. Staff.
 - a. A list of the applicant's paid staff, including:
 - i. Name;
 - ii. Position or title;
 - iii. Degrees, certificates, or licenses held;
 - iii. Business address;
 - iv. Date of hire;
 - v. Date of last physical; and
 - vi. Date of submission for fingerprinting and background clearance;
 - b. Evidence that staff have submitted fingerprints and criminal background information, as prescribed in A.R.S. § 46-141 and R6-5-7431 and obtained a physical exam as prescribed in R6-5-7431(F); and
 - c. For any staff whose primary residence is the facility,
 - i. The name and date of birth of any persons residing with the staff member;

- ii. Evidence that any adult residing with the staff member has submitted fingerprints and criminal background information as prescribed in R6-5-7431 and is free from communicable diseases posing a danger to children in care, as prescribed in R6-5-7431(H); and
 - iii. Evidence that the staff member's children who reside at the facility have current immunizations.
- 4. Financial Stability.
 - a. A written, proposed operating budget for start up and the first year of operation;
 - b. Verifiable documentation of funds available to pay start-up costs; the funds shall be in the form of cash or written authorization for a line of credit;
 - c. Verifiable documentation of funds available to pay operating expenses for the first three months of operations; the funds shall be in the form of cash or written authorization for a line of credit;
 - d. Verifiable documentation of financial resources to operate in accordance with the proposed operating budget for the remaining nine months of the licensing year; the resources may include:
 - i. Cash;
 - ii. Contracts for placement;
 - iii. Donations;
 - iv. Grants; and
 - v. Authorization for a line of credit;
 - e. If the applicant or one of the persons listed in subsection (A)(1)(b) has operated any child welfare agency in this state or any other state during the past 10 years, the most recent financial statement and financial audit for that agency, unless the most recent statement or audit is more than 10 years old; and
 - f. A certificate of insurance, or letter of commitment from an insurer, showing that the applicant has insurance coverage as prescribed in R6-5-7426.
- 5. Program.
 - a. Informational or advertising material about the agency and its facility;
 - b. For each facility, a written description of:
 - i. All services the applicant intends to provide;
 - ii. The number and type of children the applicant will serve, including: age, gender, special needs, or particular behavior problems;
 - iii. The anticipated sources of placement and referral;
 - iv. Number and qualifications of paid staff who will provide services, including the staff-child ratio, per living unit, during a 24-hour day, for a seven-day week; and
 - c. Program description, including:
 - i. Goals and objectives;
 - ii. Educational activities, with attached copy of Arizona Department of Education approval, if applicable;
 - iii. Recreational activities;
 - iv. Food and nutrition, with sample menus;
 - v. Behavior management practices;
 - vi. Religious practices, if any; and
 - vii. Medical services.
- 6. Documentation, Forms, and Notices. Samples of all documents, forms, and notices which the applicant will use with or provide to children placed with the agency, the parents and guardians of those children, and the persons and entities who place children, including:
 - a. Agency application for services;
 - b. Agency placement agreement;
 - c. Intake form;
 - d. Child's case file and medical record;
 - e. Forms for reports to courts and placing agencies;
 - f. Statement of client rights;
 - g. Unusual incident reports; and
 - h. Sample medication logs.
- 7. Policies and Procedures. The applicant's internal policies, procedures, and operations manual.
- 8. Physical site and environment.
 - a. The floor plan for each facility;
 - b. A DHS health and safety inspection report for each facility;
 - c. Documentation showing that the local zoning authority verifies that each agency facility complies with all applicable zoning requirements;
 - d. Fire safety inspection report from the state fire marshal or a local fire department inspector for each facility;
 - e. Any water supply report as prescribed in R6-5-7458(D);
 - f. Gas equipment inspection report as prescribed in R6-5-7465(D)(1); and
 - g. Any other inspection certificates or reports prescribed in this Article, and any building occupancy certificates.
- 9. Miscellaneous.
 - a. A statement authorizing the Department to investigate the applicant;
 - b. The signature, under penalty of perjury, of the agency administrator or person submitting the application, attesting to the truthfulness of the information contained in the application; and
 - c. The date of application.
- B.** If an applicant has attached a copy of a policy or procedure which describes the applicant's practice or procedure on a particular issue, the applicant need not separately describe the policy or procedure on the application form, but shall indicate that the description is contained in a particular identified and attached policy.
- C.** If the Licensing Authority needs additional information to determine the applicant's fitness to hold a license or an operating certificate, ability to perform the duties of a licensee as prescribed in this Article, or ability to fulfill the requirements prescribed in the applicant's policies, procedures, and program description, the Licensing Authority may require the applicant to provide additional information, including a signed form permitting a specifically named person or entity to release information to the Licensing Authority.
- D.** An agency which does not have or is unable to obtain all or part of the information or supporting documentation listed in subsection (A) shall so indicate in a written statement filed with the application. The written statement shall explain why the information or documentation is unavailable.

Historical Note

Adopted effective May 19, 1977 (Supp. 77-3). Former Section R6-5-7405 repealed; new Section R6-5-7405 filed with the Secretary of State's Office May 15, 1997; adopted effective July 1, 1997 (Supp. 97-2).

R6-5-7406. Site Inspection

- A.** After receiving a complete application package, the Licensing Authority shall notify the applicant that the application is com-

plete, and shall schedule the applicant for a site inspection, which may require more than one visit to a site.

- B. The site inspection shall begin no later than 45 days after the Licensing Authority receives the applicant's completed application package.
- C. During the site inspection, the licensing representative shall:
 1. Inspect the facility to ensure that any deficiencies identified in the DHS inspection report have been remedied;
 2. Verify that the facility meets the requirements of this Article;
 3. Review the applicant's policies and procedures;
 4. Review model client files;
 5. Review personnel files;
 6. Inspect the applicant's books, records, and proposed forms;
 7. Interview one or more of the applicant's governing board members, incorporators or organizers, and a representative sampling of staff who have been hired; and
 8. Inspect the applicant's computer security system and review the applicant's confidentiality safeguards.
- D. For an initial application, the administrative completeness review time-frame described in A.R.S. § 41-1072(1) is 75 days. Before expiration of the time-frame, the Licensing Authority shall send the applicant written notice of administrative completeness or deficiency as prescribed in A.R.S. § 41-1074(A).
- E. If the applicant does not supply the missing information, as prescribed in the notice, within 60 days of the notice date, the Licensing Authority may close the file. An applicant whose file has been closed, who later wishes to become licensed, may reapply.

Historical Note

Adopted effective May 19, 1977 (Supp. 77-3). Former Section R6-5-7406 repealed; new Section R6-5-7406 filed with the Secretary of State's Office May 15, 1997; adopted effective July 1, 1997 (Supp. 97-2).

R6-5-7407. Licensing Study

- A. The licensing representative shall summarize the results of the site visit, and other information gathered during the licensing process in a written licensing study, which shall be the basis for the licensing decision.
- B. The licensing study shall describe whether the applicant has:
 1. Complied with all application and inspection requirements; and
 2. Demonstrated that it has:
 - a. The capital to pay all start-up costs and the financial ability to meet one year's operating expenses, as prescribed in R6-5-7405(A)(4);
 - b. The staff, expertise, facilities, and equipment to provide the services it plans to offer; and
 - c. The ability and intent to comply with the standards and requirements of this Article.
- C. The applicant may obtain a copy of the licensing study, upon request.

Historical Note

Adopted effective May 19, 1977 (Supp. 77-3). Former Section R6-5-7407 repealed; new Section R6-5-7407 filed with the Secretary of State's Office May 15, 1997; adopted effective July 1, 1997 (Supp. 97-2).

R6-5-7408. Licensing Decision: Issuance; Denial; Time-Frames

- A. The Licensing Authority shall issue a written licensing decision within 30 days of concluding the applicant's final site

visit. This 30 day period is the substantive review time-frame required by A.R.S. § 41-1072(3).

- B. The licensing decision shall explain whether the Licensing Authority will grant or deny a license, and the terms of the license.
 1. If the Licensing Authority grants a license, the Licensing Authority shall send the license and any operating certificates with the notification letter.
 2. If the Licensing Authority issues a provisional license as prescribed in R6-5-7419 or denies a license, the Licensing Authority shall send the notice by certified mail. The notice shall contain the information listed in R6-5-7421(B) for a notice of adverse action.
- C. The overall time-frame for an initial license is 105 days.

Historical Note

Adopted effective May 19, 1977 (Supp. 77-3). Former Section R6-5-7408 repealed; new Section R6-5-7408 filed with the Secretary of State's Office May 15, 1997; adopted effective July 1, 1997 (Supp. 97-2).

R6-5-7409. Licenses and Operating Certificates: Form; Term; Nontransferability

- A. If an agency's administrative office is located separately from an agency facility, the Licensing Authority shall issue a license to the agency and an operating certificate to each facility the agency operates. If the agency and facility occupy the same location, the Licensing Authority shall issue only a license, with the information required for an operating certificate.
 1. A license shall:
 - a. Identify the agency name, and the geographic area in which the agency is licensed to operate;
 - b. List each facility the agency operates, and the total number of children the agency is authorized to serve; and
 - c. Require the agency to operate each facility in accordance with the operating certificate issued to the particular facility.
 2. An operating certificate shall:
 - a. Identify the agency operating the facility;
 - b. Identify the facility name, if different from the agency name, and the geographical area in which the facility is authorized to operate;
 - c. List the type of service or program to be offered at the facility; and
 - d. Specify the number, gender, and ages of children the facility may receive for care.
- B. An operating certificate is not valid unless it has been issued in the name of an agency holding a license. Except as otherwise prescribed in subsection (A) for an agency and facility at the same location, a facility cannot operate without a current operating certificate.
- C. A license and an operating certificate expire one year from the date of issuance, except as otherwise provided in R6-5-7410 for satellite facilities and in R6-5-7419 for provisional licenses.
- D. An agency shall post its current license in the agency, in a conspicuous location, visible to the public. The agency shall post a facility's current operating certificate in a conspicuous location within the facility.
- E. A license and an operating certificate cannot be transferred or assigned, and shall expire upon a change in ownership. For the purpose of this Section, a "change in ownership" includes any of the following events:
 1. Sale or transfer of the agency or facility;
 2. Bulk sale or transfer of the agency's or facility's assets or liabilities;

3. Placement of the agency or facility in the control of a court appointed receiver or trustee;
4. Bankruptcy of the agency or facility;
5. Change in the composition of the partners or joint venturers of an agency or facility organized as a partnership;
6. Sale or transfer of a controlling interest in the stock of a corporate agency or facility; or
7. Loss of an agency's or facility's nonprofit status.

Historical Note

Adopted effective May 19, 1977 (Supp. 77-3). Amended effective May 25, 1979 (Supp. 79-3). Amended subsection (H) effective January 2, 1981 (Supp. 81-1). Former Section R6-5-7409 repealed; new Section R6-5-7409 filed with the Secretary of State's Office May 15, 1997; adopted effective July 1, 1997 (Supp. 97-2).

R6-5-7410. Licensed Agency: Application for an Operating Certificate for an Additional Satellite Facility

- A. A currently licensed agency that wishes to obtain an operating certificate for an additional satellite facility shall send the Licensing Authority a letter of intent. The letter of intent shall include the following information:
 1. The applicant's name, address, and telephone and telefacsimile numbers;
 2. The name of the applicant's chief executive officer or administrator;
 3. The name, address, and telephone and telefacsimile numbers of the additional facility;
 4. A request that the Licensing Authority schedule the additional facility for a DHS health and safety inspection;
 5. The name of the person who will be in charge of the additional facility, with a description of that person's qualifications;
 6. A description of program and services to be offered at the proposed facility, including any policy or procedures unique to the facility;
 7. A statement as prescribed in R6-5-7403(A)(5) for the applicable school district; and
 8. All of the information listed in R6-5-7405(A) that differs from the information already on file for the agency, including:
 - a. Floor plan,
 - b. Fire inspection,
 - c. Zoning clearance letter,
 - d. Certificate of insurance,
 - e. Evidence of financial stability,
 - f. List of paid staff with the information required by R6-5-7405(A)(3), and
 - g. Facility staffing schedule.
- B. Upon receipt of all information listed in subsection (A), and a report of the DHS health and safety inspection, the Licensing Authority shall schedule the facility for a site inspection, as provided in R6-5-7406.
- C. The Licensing Authority shall prepare a licensing study and issue a licensing decision on the application for the additional operating certificate as prescribed in R6-5-7407 through R6-5-7408. In determining whether to grant an additional operating certificate to an agency operating under a provisional license, the Licensing Authority shall also consider:
 1. The nature and extent of the problems giving rise to the deficiency that caused the agency to be placed on provisional license status; and
 2. The agency's progress on its corrective action to resolve the problems.
- D. An operating certificate for an additional satellite facility expires at the end of an agency's regular licensing year.

Historical Note

Adopted effective May 19, 1977 (Supp. 77-3). Former Section R6-5-7410 repealed; new Section R6-5-7410 filed with the Secretary of State's Office May 15, 1997; adopted effective July 1, 1997 (Supp. 97-2).

R6-5-7411. Application for Renewal of License and Operating Certificates

- A. No earlier than 90 and no later than 60 days prior to the expiration date of a license, an agency may apply to the Licensing Authority for renewal of its license and any operating certificates. The Licensing Authority does not have a duty to notify the agency of license expiration. The agency shall contact the Licensing Authority to request a renewal application and to schedule a DHS health and safety inspection. The agency shall schedule its own fire inspection. Failure to timely apply or obtain inspections may result in suspension of the agency's license until the renewal process is completed.
- B. An agency shall apply for renewal on a Department application form containing the information required in this Section.
- C. An agency shall submit copies of the completed renewal application and supporting documents to the Licensing Authority. If the agency has not amended, changed or updated the information or documentation since the agency last applied for or renewed its license, the agency shall indicate "no change" on the documents submitted with the renewal application.
- D. With a renewal application, the agency shall also submit the following documentation:
 1. A current financial statement prepared by an independent certified public accountant who is not employed by the agency;
 2. A certificate of current insurance coverage as prescribed in R6-5-7426;
 3. A copy of the agency's current budget and the agency's audit report for its preceding fiscal year;
 4. Identification of and the following background information on the agency, facility, and administrators:
 - a. Name, address, and telephone and telefacsimile numbers for the agency and all facilities operated by the agency;
 - b. Name, title, business address, and telephone and telefacsimile number of:
 - i. The person who serves as the chief executive officer (CEO) as prescribed in R6-5-7432(A);
 - ii. The person who serves as the program director as prescribed in R6-5-7432(B);
 - iii. The person with delegated authority to act when the CEO is absent;
 - iv. The person in charge of each separate facility as prescribed in R6-5-7432(C);
 - v. Persons holding at least 10% ownership interest in the applicant; and
 - vi. The agency and facility medical directors, if applicable;
 - c. The educational qualifications and work history for each person listed in subsection (D)(4)(b), with that person's attached resume, employment application, or curriculum vitae;
 - d. A list of the members of the agency's governing body described in R6-5-7424, including name, address, position in the agency, term of membership, and any relationship to the applicant;
 - e. A list of licenses or certificates for provision of medical or social services currently or previously held by the applicant or persons listed in subsection (D)(4)(b), including those held in this state or

- another state or country; the list shall include the dates the person held the license or certificate;
- f. A written description of any proceedings for denial, suspension, or revocation of a license or certificate for provision of medical, psychological, behavioral health, or social services, pending or filed, or brought against the applicant or a person listed in subsection (D)(4)(b), including those held in this state or another state or country; and
 - g. A written description of any litigation in which the applicant or a person listed in subsection (D)(4)(b) has been a party during the 10 years preceding the date of application, including, collection matters and bankruptcy proceedings.
5. An organizational chart for the agency and each separate facility, showing administrative structure and staffing, and lines of authority.
 6. The following information on staff:
 - a. A list of applicant's paid staff, including:
 - i. Name;
 - ii. Position or titles;
 - iii. Degrees, certificates, or licenses held;
 - iv. Business address;
 - v. Date of hire;
 - vi. Date of last physical; and
 - vii. Date of submission for fingerprinting and background clearance;
 - b. For any staff whose primary residence is the facility:
 - i. The name and date of birth of any persons residing with a staff member;
 - ii. Evidence that any adult residing with a staff member has submitted fingerprints and criminal background information as prescribed in R6-5-7431 and is free from communicable diseases posing a danger to children in care, as prescribed in R6-5-7431(H); and
 - iii. Evidence that the staff member's children who reside at the facility have current immunizations.
 7. Copies of any written complaints the agency has received about its performance at its facilities during the expiring license year and the agency's response to the complaints; and
 8. A written description of any changes in program services or locations, or the children served by the agency.
- E. For a renewal application, the administrative completeness review time-frame described in A.R.S. § 41-1072(1) begins when the applicant submits a renewal application form and the required documentation listed in this Section.

Historical Note

Adopted effective May 19, 1977 (Supp. 77-3). Former Section R6-5-7411 repealed; new Section R6-5-7411 filed with the Secretary of State's Office May 15, 1997; adopted effective July 1, 1997 (Supp. 97-2). Amended by final rulemaking at 6 A.A.R. 4032, effective September 29, 2000 (Supp. 00-3).

R6-5-7412. Renewal of License and Operating Certificates: Site Inspection; Time-frames; Standard for Issuance

- A. Upon receipt of a complete renewal application, the Licensing Authority shall schedule the renewal applicant for a DHS health and safety inspection.
- B. Upon receipt of the DHS inspection report and a complete renewal application package, the Licensing Authority shall schedule the applicant for a site inspection of the agency and each agency facility.

- C. At the renewal site inspection, the licensing representative shall investigate the agency and facilities as prescribed in R6-5-7406, and may also:
 1. Interview staff,
 2. Interview clients and references,
 3. Observe staffings,
 4. Review a random sample of client and staff files,
 5. Conduct field visits to agency branch offices and facilities.
- D. For a renewal application, the administrative completeness review time-frame described in A.R.S. § 41-1072(1) is 45 days. Before expiration of the time-frame, the Licensing Authority shall send the applicant written notice of administrative completeness or deficiency as prescribed in A.R.S. § 41-1074(A).
- E. If the applicant does not supply the missing information, as prescribed in the notice, within 60 days of the notice date, the Licensing Authority may close the file. An applicant whose file has been closed, who later wishes to become licensed, may reapply.
- F. The Licensing Authority shall issue a licensing decision within 25 calendar days of concluding the applicant's final site visit. This 25-day period is the substantive review time-frame under A.R.S. § 41-1072(3). The overall time-frame for a issuance of a renewal license is 70 days.
- G. The Licensing Authority may renew an agency's license and any operating certificate for its facility when the agency and facility:
 1. Demonstrate compliance with the standards set forth in applicable statutes and this Article;
 2. Have complied with applicable statutes and the requirements of this Article during the expiring period of license; and
 3. Have corrected any problems that resulted in imposition of a provisional license.
- H. The Licensing Authority shall issue a renewal licensing decision as prescribed in R6-5-7408(B).

Historical Note

Adopted effective May 19, 1977 (Supp. 77-3). Former Section R6-5-7412 repealed; new Section R6-5-7412 filed with the Secretary of State's Office May 15, 1997; adopted effective July 1, 1997 (Supp. 97-2).

R6-5-7413. Notification to Licensing Authority of Changes Affecting License; Staff Changes

- A. A licensee shall send the Licensing Authority written notification of any planned change in the licensee's name, ownership, agency location, facility location, governing board member, chief executive officer, or program director, at least one month before the change. If the change occurs without sufficient time for prior written notice, the licensee shall orally notify the Licensing Authority as soon as the change is known, and shall send the Licensing Authority written confirmation within 48 hours of giving oral notice.
- B. If a licensee wishes to make a substantial change as described in subsection (C), the licensee shall:
 1. Provide the Licensing Authority with prior written notice of the change at least one month before the effective date of the change; and
 2. Apply for an amended license as prescribed in R6-5-7414.
- C. As used in subsection (B), "substantial change" means any of the following:
 1. An event that will cause the licensee to be out of compliance with:

- a. The terms stated on the face of the license or an operating certificate; or
 - b. A standard prescribed in this Article;
- 2. A change in a building or a physical site at the agency or facility if that change will alter the level or nature of care provided to children; or
- 3. Substantive revision of the policies and procedures required by this Article.
- D. Within five work days of a paid staff member's hiring or separation, the licensee shall complete and send the Licensing Authority a Department form LC-008, "Child Welfare Agency Employee Central Registry," with the following information on the paid staff member:
 - 1. Name,
 - 2. Date of birth,
 - 3. Social security number,
 - 4. Date fingerprinted and fingerprinting results,
 - 5. Position held,
 - 6. Date of and reason for separation from employment, and
 - 7. Opportunity for rehire.

Historical Note

Adopted effective May 19, 1977 (Supp. 77-3). Former Section R6-5-7413 repealed; new Section R6-5-7413 filed with the Secretary of State's Office May 15, 1997; adopted effective July 1, 1997 (Supp. 97-2).

R6-5-7414. Amended License or Operating Certificate

- A. The Licensing Authority may issue an amended license or operating certificate to reflect a change in an agency or facility name or the terms of a license or an operating certificate if the change does not cause the agency or facility to fall out of compliance with applicable statutes and this Article.
- B. The Licensing Authority shall not issue a license for an agency or an operating certificate for a facility that has moved to a new location until the agency or facility has:
 - 1. Provided the information listed in R6-5-7405(A)(8),
 - 2. Passed a DHS health and safety inspection,
 - 3. Passed a fire inspection,
 - 4. Passed a Licensing Authority site inspection, and
 - 5. Submitted any new staff and household members for fingerprinting and criminal background checks as prescribed in A.R.S. § 46-141 and R6-5-7431.
- C. An amended license or operating certificate expires at the end of the agency or facility's regular licensing year.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7415. Alternative Method of Compliance

- A. The Licensing Authority, with the approval of the Attorney General's Office, may permit a licensee to substitute an alternative method of compliance for a licensing requirement or objective prescribed in this Article and not otherwise required by law, if the following conditions are met:
 - 1. The licensee seeking to achieve compliance through an alternative methodology proposes, to the satisfaction of the Licensing Authority, that the licensee can satisfy the objective of the requirement through the alternative methodology; and
 - 2. Allowing the licensee to achieve compliance through an alternative method will not jeopardize the health, safety, or well-being of children who are or may be placed in the licensee's care.
- B. Approval of an alternative methodology expires as prescribed in the written letter authorizing the alternative, or at the end of the licensing year, and must be annually renewed.

- C. The Licensing Authority is not obligated to permit an alternative method of compliance or to renew approval of the alternative methodology.
- D. The Licensing Authority shall document the alternative and the findings required by subsection (A) in the licensing file.
- E. The Licensing Authority may revoke the licensee's permission to comply through an alternative method if the Licensing Authority finds that a condition listed in subsection (A)(1) or (2) is not met.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7416. Monitoring

- A. The Licensing Authority shall monitor the ongoing operations of agencies and facilities.
- B. Monitoring activities may include the following:
 - 1. Announced and unannounced inspections of an agency or a facility, including both physical premises and internal operations, books, records, policies, procedures, logs, manuals, files, inspection reports, certificates, and any other document prescribed by this Article;
 - 2. Interviews with clients, staff, or other persons with information about the agency; and
 - 3. Observation of program activities.
- C. A licensee shall cooperate with the Licensing Authority's monitoring functions. Cooperation includes:
 - 1. Making the agency, facility, and program activities available to licensing representatives for inspection and observation;
 - 2. Providing the Licensing Authority with information or documentation requested;
 - 3. Making staff available for interview; and
 - 4. Allowing children in care to be interviewed.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7417. Complaints; Investigations

- A. If the Licensing Authority receives an oral complaint about a licensee, agency, or facility, the Licensing Authority shall ask the complaining party to submit the complaint in writing, but shall investigate complaints as prescribed in this Section even if the complaining party does not put the complaint in writing.
- B. The Licensing Authority shall refer all complaints involving allegations of child maltreatment to CPS as required by A.R.S. § 13-3620 for investigation as prescribed in A.R.S. § 8-546.01(C).
- C. The Licensing Authority shall investigate complaints about a licensee through one or more of the following methods:
 - 1. Telephone contact with the licensee,
 - 2. Interviews with the complaining party,
 - 3. Interviews with the licensee's staff,
 - 4. Interviews with the licensee's clients,
 - 5. Interviews of witnesses to the matters at issue,
 - 6. Inspections of records and documents related to the issues raised in the complaint,
 - 7. Announced and unannounced inspections of the agency or a facility,
 - 8. Evaluation of a law enforcement or CPS report for evidence of a licensing violation, and
 - 9. Any other activity necessary to validate or refute the allegations.
- D. A licensee shall cooperate in any Department investigation as prescribed in R6-5-7416(C).

- E. Upon completion of an investigation as described in subsection (C), the Licensing Authority shall:
1. Find that the complaint is invalid, document the findings in the agency's licensing file, and close the investigation;
 2. Find that the complaint is valid and take disciplinary action against the licensee as prescribed in R6-5-7419 and R6-5-7420, or require corrective action as prescribed in R6-5-7418; or
 3. Find that the complaint cannot be validated or refuted based on the available evidence and document the finding in the licensing file.
- F. The Licensing Authority shall provide the licensee with an oral report of any findings made under subsection (E) and, upon the licensee's request, a copy of the written findings placed in the licensee's file. At the time of giving the oral report, the licensing representative shall advise the licensee of the opportunity to obtain a copy of the written findings.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7418. Corrective Action

- A. If a deficiency is correctable within a specified period of time and does not jeopardize the health or safety of a child, the Licensing Authority may place the agency on a corrective action plan to cure the deficiency in lieu of the disciplinary measures prescribed in R6-5-7419 and R6-5-7420.
- B. In determining whether to require corrective action in lieu of other disciplinary action, the Licensing Authority shall consider the following criteria:
1. The nature of the deficiency;
 2. Whether the deficiency can be corrected;
 3. Whether the licensee and its affected staff understand the deficiency and show a willingness and ability to participate in corrective action;
 4. The length of time required to implement corrective action;
 5. Whether the same or similar deficiencies have occurred on prior occasions;
 6. Whether the licensee has had prior corrective action plans, and, if so, the licensee's success in achieving the required goals of the plan;
 7. The licensee's history in providing care; and
 8. Other similar or comparable factors demonstrating the licensee's ability and willingness to follow through with a corrective action plan and avoid future deficiencies.
- C. The agency shall prepare a corrective action plan for the review and approval of the Licensing Authority.
1. The plan shall explain:
 - a. How the agency will remedy the non-compliance;
 - b. The time periods for completing all corrective action; and
 - c. The agency staff responsible for carrying out the corrective action plan.
 2. The plan shall provide for the agency to send the Licensing Authority periodic reports on the agency's progress, and a final report when all corrective action is completed.
 3. An authorized representative of the agency shall sign and date the corrective action plan.
- D. In deciding whether to approve a plan, the Licensing Authority shall ensure that the plan:
1. Will correct the identified deficiency within a specified period of time;
 2. Identifies persons responsible for executing the steps listed in the plan; and

3. Permits the Licensing Authority to monitor the Licensee's progress in completing the plan.

- E. The Licensing Authority may conduct announced and unannounced inspections of the agency or facility to monitor implementation of a corrective action plan. The licensee shall cooperate in any monitoring inspection as prescribed in R6-5-7416(C).

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7419. Provisional License

- A. If an agency or a facility is temporarily unable to conform to the standards prescribed in this Article, the Licensing Authority may issue a provisional license to the agency, or convert a regular license to provisional status, as prescribed in A.R.S. § 8-505(C). For the purpose of this Section, "temporarily unable" means a time period of six months or less.
- B. The Licensing Authority may impose provisional license status on an agency operating multiple facilities even though less than all facilities are out of compliance.
- C. The Licensing Authority may issue a provisional license only when:
1. The non-compliance is correctable; and
 2. The non-compliance does not jeopardize the health, safety, or well-being of children in care.
- D. If the Licensing Authority issues a provisional license, the agency shall cooperate with the Licensing Authority to develop a written corrective action plan that meets the requirements of R6-5-7418(C) and (D) and shall comply with the terms of the plan.
- E. If an agency receives a provisional license at the time of annual renewal and the license is later converted to a regular license during the agency's licensing year, the regular license expires one year from the date the provisional license was issued.
- F. If an agency receives a regular license at the time of annual renewal, and the license is converted to a provisional license during the agency's licensing year, the agency's license expires one year from the date the regular license was issued.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7420. Denial, Suspension, and Revocation of a License or Operating Certificate

- A. The Licensing Authority may deny, suspend, or revoke a license or operating certificate when:
1. An applicant or licensee has violated or is not in compliance with licensing rules and standards, Arizona state or federal statutes, or city or county ordinances or codes;
 2. An applicant or licensee refuses to cooperate with the Licensing Authority in providing information required by these rules or any information required to determine compliance with these rules;
 3. An applicant or licensee misrepresents or fails to disclose information to the Department regarding qualifications, experience, or performance of duties;
 4. A licensee fails to cooperate in developing a corrective action plan after a request by the Licensing Authority, or fails to comply with a corrective action plan; or
 5. An applicant or licensee is unable or unwilling to meet the physical, emotional, social, educational, or psychological needs of children in care.
- B. In determining whether to deny a license, to take disciplinary action against a licensee, or to renew a license, the Licensing

Authority may consider the licensee's past history from other licensing periods, both in Arizona and in other jurisdictions, and shall consider a pattern of violations of applicable child welfare statutes or rules, as evidence that an applicant or licensee is unable or unwilling to meet the physical, emotional, social, educational, or psychological needs of children.

- C. The Licensing Authority shall deny, suspend, or revoke a license when an individual applicant or licensee has been convicted of or is awaiting trial on the criminal offenses listed in A.R.S. § 46-141.
- D. The Licensing Authority shall deny, suspend, or revoke a license when an agency or facility:
 1. Retains staff who have been convicted of or are awaiting trial on the criminal offenses listed in A.R.S. § 46-141;
 2. Allows an adult other than those described in subsection (D)(1), who has been convicted of or is awaiting trial on the offenses listed in A.R.S. § 46-141, to reside at a facility; or
 3. Allows any staff or other adult at the facility, who has committed an offense listed in A.R.S. § 46-141(D), to have contact with children in care.
- E. The Licensing Authority may deny, suspend, or revoke a license when an applicant or licensee, any staff member, or any other adult who resides at the facility, has been convicted of or found by a court to have committed, or is awaiting trial on any criminal offense, other than those listed in A.R.S. § 46-141. In determining whether a person's criminal history affects an applicant's or licensee's fitness to hold a license, the Licensing Authority shall consider all relevant factors, including the following:
 1. The extent of the person's criminal record, if any;
 2. The length of time which has elapsed since the offense was committed;
 3. The nature of the offense and whether the offense was originally classified as a felony or a misdemeanor;
 4. The circumstances surrounding the offense;
 5. The degree to which the person participated in committing the offense;
 6. The extent of the person's rehabilitation; and
 7. The person's role within the agency or facility.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7421. Adverse Action; Procedures; Effective Date

- A. When the Licensing Authority plans to take adverse action against a licensee, the Licensing Authority shall give the licensee written notice of the adverse action by certified mail.
- B. The notice shall specify:
 1. The action taken;
 2. All reasons supporting the action;
 3. The sections of law justifying the action;
 4. The procedures by which an applicant or licensee may contest the action taken, and the time periods for doing so;
 5. An explanation of the applicant or licensee's right to request an informal settlement conference as prescribed in A.R.S. § 41-1092.03(A); and
 6. If the Licensing Authority summarily suspends a license as provided in A.R.S. § 41-1064(C), the required finding of emergency.
- C. The following actions are not appealable adverse actions:
 1. Imposition of a corrective action plan to bring the licensee into compliance with licensing requirements, absent any material change in licensing status;

2. Denial or revocation of permission for an alternate method of compliance or operation of a barracks facility as prescribed in R6-5-7461(B) and R6-5-7462(B); and
 3. A staff member's failure to clear the criminal history check prescribed in R6-5-7431(B).
- D. Except as otherwise provided in A.R.S. § 41-1064 for emergency suspensions, adverse action is effective:
 1. If a licensee does not appeal the adverse action, 31 days after the postmark date of the notice prescribed in subsection (A); or
 2. If the licensee appeals the adverse action, when there is a final administrative decision, as prescribed in A.R.S. § 41-1092.08(D), affirming the adverse action.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7422. Appeals

- A. An applicant may appeal the denial of a license and a licensee may appeal adverse action under A.R.S. § 8-506.01 and A.R.S. Title 41, Chapter 6, Article 10.
- B. The applicant or licensee shall file a notice of appeal with the Licensing Authority. The notice shall contain the information required by A.R.S. § 41-1092.03(B).

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7423. Statement of Purpose; Program Description and Evaluation; Compliance With Adopted Policies; Client Rights; Single Category of Care

- A. A licensee shall have a written statement which describes its philosophy, purpose, and program for children in care, and the nature and extent of any family involvement in the program.
- B. A licensee shall have a written description of all services each facility provides to children in care and their families and the methods of service delivery.
- C. A licensee shall follow all plans, policies, and procedures the licensee adopts in accordance with this Article.
- D. A licensee shall annually evaluate whether a facility is achieving the objectives described in R6-5-7405(A)(5)(c)(i). The licensee shall make a written report of the evaluation and provide a copy to the Licensing Authority at the time of license renewal.
- E. A licensee shall have a statement of client rights.
- F. A licensee shall not combine its child welfare program, as defined pursuant to subsection (A), with other forms of care or programming such as child care, nursing or convalescent care for adults, or adult developmental care unless the licensee:
 1. Physically separates children in the child welfare program from persons in other programs, and
 2. Prevents interaction between children in the child welfare program and persons in other programs.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7424. Governing Body

- A. A licensee shall have a governing body to oversee the operations, policies, and practices of the agency and its facilities. The governing body shall be:
 1. The board of directors for an agency that is a non-profit corporation, or
 2. The board of directors or individual owner of an agency that is a for-profit organization.
- B. The governing body shall:

1. Ensure that the licensee provides the services described in the licensee's statement of purpose;
 2. Adopt an annual budget of anticipated income and expenditures necessary to provide the services described in the licensee's statement of purpose;
 3. Approve the licensee's annual financial audit report;
 4. Establish a policy and procedure for selection and retention of staff sufficient to operate the agency and its facilities in accordance with this Article;
 5. Unless the licensee is a sole proprietorship, meet at least four times each year, and maintain records of attendance and minutes of the meetings;
 6. Develop criteria and written procedures for selection of the governing body members, and the chief executive officer as required by R6-5-7432(A);
 7. Employ a chief executive officer who meets the qualifications prescribed in R6-5-7432(A), to whom the governing body shall delegate responsibility for the daily administration and operation of the agency;
 8. Regularly evaluate the chief executive officer's performance; and
 9. Review and approve the agency's policies and procedures, and any amendments to them.
- C.** A licensee shall maintain a list of the governing body's members; the list shall include each member's the name, address, term of membership, and relationship to the licensee, if any.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7425. Business and Fiscal Management; Annual Audit

- A.** A licensee shall maintain complete and accurate accounts, books, and records as prescribed in this Article, and in accordance with generally accepted accounting practice.
- B.** A licensee shall operate on the annual budget approved by its governing board.
- C.** A licensee shall regularly record its financial transactions and maintain, for five years, its financial records including receipts, disbursements, assets, and liabilities.
- D.** A licensee shall have an annual, fiscal year-end, financial audit by an independent certified public accountant who shall conduct the audit in accordance with generally accepted auditing standards. The audit report shall include the following financial information:
1. Income statement,
 2. Balance sheet,
 3. Statement of cash flow,
 4. A statement showing monies or other benefits the licensee has paid or transferred to any of the following:
 - a. Business entities affiliated with the licensee,
 - b. The licensee's directors or officers,
 - c. The licensee's chief executive officer or program director,
 - d. The family member of a person listed in subsections (D)(2)(e)(ii) or (iii), or
 - e. Another agency.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7426. Insurance Coverage

A licensee shall have insurance coverage that provides protection against financial loss as prescribed in this Section.

1. The licensee shall carry liability insurance covering accidents, injuries, errors and omissions in the minimum

amount of \$100,000 per person, and \$300,000 per accident or event.

2. The licensee shall ensure that any vehicle the licensee owns or uses to transport children in care has the following insurance coverage:
 - a. Injury per person: \$100,000,
 - b. Injury per accident: \$300,000, and
 - c. Property damage: \$25,000.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7427. Confidentiality

- A.** Except as otherwise allowed by law, a licensee's records concerning children in care and their families are confidential, and the licensee shall not disclose or knowingly permit the disclosure of confidential information.
- B.** A licensee shall have written policies and procedures for keeping records secure, in a manner that preserves confidentiality and prevents loss, tampering, or unauthorized use. The policies and procedures shall:
1. Be consistent with any laws applicable to the specific records at issue; and
 2. Cover the following:
 - a. The form in which children's records are maintained and stored;
 - b. Identification of the staff who:
 - i. Supervise the maintenance of records,
 - ii. Have custody of records, and
 - iii. Have access to records;
 - c. The persons to whom records may be released and under what circumstances records may be released, including release of information to custodial and non-custodial parents and guardians;
 - d. Photography, audio or audio-visual recording, and public identification of children; and
 - e. Participation of children or use of children's records in data research.
- C.** Before using personally identifiable information for publicity, fundraising, or research, a licensee shall obtain:
1. A written consent to release, as prescribed in subsection (E), from the child who is the subject of the information, if developmentally appropriate; and
 2. A written consent to release, as prescribed in subsection (E), from the child's placing agency or person; or
 3. Written authorization from the court, if the child is a ward of the court.
- D.** A licensee may release personally identifiable information about a child or family to persons who require the information to treat or provide services to the child unless the release is prohibited by law.
- E.** A consent to release shall include the following information:
1. The name of the person or agency to whom the information is to be released;
 2. A description of the information to be disclosed;
 3. The reason for disclosure;
 4. The expiration date of the consent, not to exceed six months from date of signature; and
 5. The dated signature of the person authorizing the release.
- F.** Notwithstanding any other provision of this Article, in a medical emergency, the licensee shall promptly release information from a child's record to persons who require the information to treat the child.
- G.** A licensee may withhold information if, in the judgment of the professional person treating the child, or the agency's program

director, the release of information would be contrary to the child's best interests, unless the release is:

1. Ordered by a court,
2. Mandated by federal or state law,
3. Required by the licensee's agreement with the placing agency or person, or
4. Required by the Department to assess the licensee's compliance with the law.

H. If a licensee withholds information pursuant to subsection (G), the licensee shall:

1. Document, in the child's record, the reason for withholding the information;
2. Advise the person who requested the information that the person may grieve the withholding pursuant to the licensee's internal grievance process adopted in accordance with R6-5-7429.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7428. Children's Records: Contents, Maintenance, Destruction

A. A licensee shall maintain a current, separate case record for each child in care. The record shall be readily accessible to persons providing services to the child and shall include at least the following information:

1. The name, gender, race, religion, birthdate, and birthplace of the child;
2. The name, address, telephone number, and marital status of the child's parents;
3. The date of admission and source of referral;
4. The name, address, telephone number, and relationship to the child of the person with whom the child was living prior to admission, if other than the child's parent;
5. All documents related to the child's referral and admission of the child to the facility;
6. Documentation of the current custody and legal guardianship of the child;
7. The child's court status, if applicable;
8. Consent forms signed by the placing agency or person at the time of placement, allowing the licensee to authorize necessary medical care, medications, routine tests, and immunizations;
9. Service plans and all reviews, revisions, notes, and updates reflecting the child's and family's goals, and progress towards achievement of goals;
10. A plan for permanent placement of the child;
11. Education records and reports;
12. Vocational training and employment records, if applicable;
13. Treatment and clinical records and reports; and
14. The discharge summary required by R6-5-7442(B).

B. A licensee shall have the medical records required by R6-5-7455. While the child is in care, the licensee may keep the child's medical records in a location separate from the records described in this Section. If the licensee keeps medical records in a separate location, the child's main record shall identify the location of the medical record.

C. All record entries shall be made in permanent ink or electronically. The licensee shall require personnel to date and legibly sign entries in a child's records.

D. If a licensee maintains a child's records in more than one place, the licensee shall:

1. Identify, in one location that is readily accessible to inspection by the Licensing Authority, the location of all parts of the record; and

2. Consolidate all records and notes into one case file, at one location, within 15 days following either:
 - a. A request for consolidation from the Licensing Authority; or
 - b. The date of the child's discharge from the facility.

E. A licensee shall maintain a child's record for the longest of the following time periods:

1. At least five years after the child's last discharge from the licensee's care;
2. At least three years after the child's 18th birthday; or
3. Another time period specified by applicable law or contract.

F. A licensee shall dispose of expired records in a manner that maintains confidentiality.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7429. Grievances

A. A licensee shall have a written policy and written procedures governing the receipt, consideration, and resolution of grievances brought to the licensee by children in care and their parents, regarding the licensee's program and care of children. The procedures shall:

1. Be written in a clear and simple manner that is developmentally appropriate for children in care;
2. Prohibit reprisal or retaliation against an individual who brings a grievance for the act of bringing the grievance;
3. Describe a process for fair and expeditious resolution of a grievance; and
4. Provide a means to tell the grievant about the action taken in response to the grievance.

B. A licensee shall maintain written records of grievance decisions for at least 12 months after the resolution.

C. The licensee shall maintain a log of grievances filed against the licensee. The licensee may keep a centralized agency log, or can maintain a separate log for each facility. The log shall include the following information:

1. Name of grievant;
2. Date grievance filed;
3. Description of the substance of the grievance;
4. Summary of the grievance resolution;
5. A copy of the grievance decision required by subsection (B), or a description of where the Licensing Authority can find the decision.

D. Copies of the grievance decisions may serve as the grievance log if:

1. The copies are kept in one central location that is readily accessible to the Licensing Authority,
2. The grievance decisions contain all the information listed in subsection (C), and
3. The licensee retains the decisions for at least three years following the date of grievance resolution.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2). Numbering for subsections (C) and (D) amended to correct typographical errors (Supp. 00-3).

R6-5-7430. Staff Management and Staff Records

A. A licensee shall have written staff policies and procedures which shall describe:

1. How the licensee recruits, screens, hires, supervises, trains, retains, develops, evaluates, disciplines, and terminates staff;
2. How the licensee handles staff resignations;

3. A job title, description and minimum qualifications for each position within the agency and all facilities;
 4. The duties assigned to each position;
 5. How the licensee handles staff grievances;
 6. An organizational chart for the agency and all facilities; and
 7. A method to assure privacy of staff records.
- B.** The licensee shall give all staff a copy of the person's own job description and allow staff access to the licensee's staff policies and procedures.
- C.** A licensee shall maintain a personnel record for all paid staff. The record shall include the following information, if applicable:
1. Application for employment including previous employment history and educational background;
 2. Reference letters and documentation of phone notes on references that are dated and signed;
 3. Documentation of the highest level of education achieved; the documentation may include a copy of a diploma, equivalence certificate, or record of notes of calls to educational institutions;
 4. Medical examination reports on paid staff as required by R6-5-7431(F);
 5. Medical examination reports on any other adult residing at the facility showing that the adult is free from communicable diseases as required by R6-5-7431(H);
 6. Medical and immunization records on children who reside at the facility but are not in care, as required by R6-5-7431(H);
 7. Copies of applicable professional licenses, credentials, and certifications, as required by R6-5-7431(A);
 8. Documentation of fingerprinting and criminal records clearance as required by A.R.S. § 46-141 and R6-5-7431(B);
 9. Record of all orientation and training received during employment;
 10. Documentation showing that the paid staff member has read and agrees to abide by the facility's behavior management policies and procedures which shall include the dated signature of the paid staff member and a witness;
 11. Documentation showing that the paid staff member has a valid driver's license if the paid staff member transports children;
 12. Reports of all performance evaluations;
 13. Documentation of any personnel actions or investigations that result in a written report;
 14. Dates the paid staff member started and separated from employment; and
 15. Reason for separation from employment.
- D.** A licensee shall maintain a personnel record on unpaid staff. The record shall include the following information, if applicable:
1. Application for work or study, including previous employment history and educational background;
 2. Reference letters and documentation of phone notes on references that are dated and signed;
 3. Medical examination reports, as required by R6-5-7431(F);
 4. Copies of applicable professional licenses, credentials, and certifications, as required by R6-5-7431(A);
 5. Documentation of fingerprinting and criminal records clearance as required by A.R.S. § 46-141 and R6-5-7431(B);
 6. Record of all orientation and training received while affiliated with the licensee;
 7. Documentation showing that the person has read and agrees to abide by the facility's behavior management policies and procedures which shall include the dated signature of the person and a witness;
 8. Documentation showing that the person has a valid driver's license if the person transports children;
 9. Reports of all performance evaluations;
 10. Documentation of any personnel actions or investigations that result in a written report;
 11. Dates the person began and ended affiliation with the licensee; and
 12. Reason for ending affiliation with the licensee.
- E.** The licensee shall keep personnel records for at least three years after the staff member's separation from the licensee.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7431. General Qualifications for Staff

- A.** A licensee shall ensure that all staff providing services to children and their families under the licensee's program are currently certified, registered, or licensed as required by state law.
- B.** As prescribed in A.R.S. § 46-141, all staff having direct contact with children, and any persons age 18 or older who live at a facility, excluding children in care, shall be fingerprinted and shall certify on notarized forms provided by the Department whether they:
1. Are awaiting trial on or have ever been convicted of the following criminal offenses in this state or similar offenses in another state or jurisdiction:
 - a. Sexual abuse of a minor;
 - b. Incest;
 - c. First or second degree murder;
 - d. Kidnapping;
 - e. Arson;
 - f. Sexual assault;
 - g. Sexual exploitation of a minor;
 - h. Contributing to the delinquency of a minor;
 - i. Commercial sexual exploitation of a minor;
 - j. Felony offenses involving distribution of marijuana or dangerous or narcotic drugs;
 - k. Burglary;
 - l. Robbery;
 - m. A dangerous crime against children as defined in A.R.S. § 13-604.01;
 - n. Child abuse;
 - o. Sexual conduct with a minor;
 - p. Molestation of a child;
 - q. Manslaughter;
 - r. Aggravated assault; and
 2. Have ever committed any of the acts listed in subsections (B)(1)(a), (g), (i), (m), (n), (o), and (p).
- C.** A licensee shall not knowingly employ, retain, or allow to reside at a facility, any staff, or person age 18 or above, who is awaiting trial on or has been convicted of any of the criminal offenses listed in subsection (B), or the same or similar offenses in another state or jurisdiction. A licensee shall not knowingly allow a person who has committed any of the offenses listed in subsection (B)(2) to have contact with children in care.
- D.** For all staff, a licensee shall:
1. Verify at least two years immediate, or most recent, past employment through reference checks;
 2. Obtain at least three references from persons not related to the staff member by blood or marriage, who can attest to the staff member's character, knowledge, and skill.

- E. The licensee shall document verification of the reference information required in subsection (D).
- F. A licensee shall have staff providing direct care to children obtain a physical examination by a licensed medical practitioner before beginning assigned duties and at least every two years while working.
- G. All staff shall be free from any communicable disease that poses a danger to children in care and shall have the capacity to perform the essential functions of that person's job.
- H. Other adults who reside at the facility shall be free from communicable disease that poses a danger to children in care. Children who reside at the facility but are not in care shall have current immunizations and be free from communicable disease that poses a danger to children in care.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7432. Qualifications for Specific Positions or Tasks; Exclusions

- A. Chief Executive Officer "CEO": A licensee shall have a chief executive officer for the agency. The CEO:
 - 1. Is responsible for general management, administration, and operation of the agency in accordance with this Article;
 - 2. Ensures that:
 - a. Each child in care receives necessary professional services;
 - b. Appropriately qualified staff render services to children in care; and
 - c. The services are coordinated;
 - 3. Shall have management experience and meet any other qualifications prescribed by the Governing Body;
 - 4. Shall reside in Arizona;
 - 5. Shall be accessible to staff, representatives of the Licensing Authority, and other governmental agencies; as used in this subsection, "accessible" means readily available to answer questions and to handle problems or emergencies that arise, either personally or through a chain of command; and
 - 6. Shall designate a qualified person to perform administrative responsibilities whenever the CEO is inaccessible.
- B. Program Director: A licensee shall have at least one person who is responsible for development, implementation, and supervision of an agency's programs and services. This person shall have at least:
 - 1. A master's degree in social work or a related area of study from an accredited school and at least one year experience in the child welfare or child care services field; or
 - 2. A bachelor's degree in social work or a related area of study from an accredited school and two years of experience in the child welfare or child care services field.
- C. Facility Supervisor: If a licensee operates more than one facility, the licensee shall designate a person to supervise the operations of each facility.
- D. Supervisors: Any staff member who supervises, evaluates, or monitors the work of the direct care staff shall have at least six months paid child care experience and at least 3 1/2 years of any combination of the following:
 - 1. Paid child care or related experience; or
 - 2. Post-high school education in social work or a related field.
- E. Direct Care Staff: A person who supervises, nurtures, or cares for a child in care shall have at least:

- 1. A high school diploma or equivalency degree and one year experience in working with children; or
- 2. One year post-high school education in a program leading to a degree in the field of child welfare or human services.

- F. Program Instructors: A person who supervises, trains, or teaches children in the performance of a physical activity that poses an unusually high risk of harm, such as archery, river rafting, rock climbing, caving, rappelling, and hang gliding, shall:
 - 1. Be currently certified to perform the activity, if applicable;
 - 2. Have at least three years of experience related to the activity; or
 - 3. Have at least three letters of reference attesting to skill and experience in the activity.
- G. CPR and First Aid Certification: A licensee shall ensure that:
 - 1. Direct care staff are certified in pediatric cardiopulmonary resuscitation (CPR) and in first aid by the American Red Cross, the American Heart Association, or the Arizona Chapter of the National Safety Council within three months of being hired and before caring alone for children in care.
 - 2. At least one staff member per shift, per facility is currently certified in CPR and first aid.
- H. Multiple Functions: A licensee may allow one person to perform multiple functions or fill more than one position so long as:
 - 1. The person performing multiple functions is qualified for the jobs held; and
 - 2. The licensee does not violate the requirements of this Article, including R6-5-7437 governing staff-child ratios.
- I. Exclusions: The educational requirements set forth in this Section do not apply to persons employed with a licensee on the effective date of this Article. These requirements do apply to:
 - 1. Persons hired as employees after the effective date of this Article; and
 - 2. Persons who:
 - a. Are employed with a licensee on the effective date of this Article;
 - b. Subsequently separate from that employment; and
 - c. Later seek employment with the same or a different licensee.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2). Amended by final rulemaking at 6 A.A.R. 4032, effective September 29, 2000 (Supp. 00-3).

R6-5-7433. Orientation and Training for Staff

- A. A licensee shall have a written plan for orientation and training of all staff. The plan shall include a method for the licensee to evaluate whether the person has actually learned the information that was the subject of orientation or training.
- B. All staff shall receive initial orientation and training before assignment to solo supervision of children. The initial orientation and training shall include:
 - 1. Acquainting staff with the licensee's philosophy, organization, program, practices, and goals;
 - 2. Familiarizing staff with the licensee's policies and procedures, including those on confidentiality, client and family rights, grievances, emergencies and evacuations, behavior management, preventing and reporting child maltreatment, recordkeeping, medications, infection control, and treatment philosophy;

3. Training staff in cardiopulmonary resuscitation (CPR) and first aid according to American Red Cross guidelines as prescribed in R6-5-7432(G);
 4. Training staff to do the initial health screening prescribed in R6-5-7438(E)(9); the licensee shall have a licensed medical practitioner provide this training;
 5. Training staff in de-escalation and any physical restraint practices used at the facility by an instructor qualified under this subsection. An instructor is qualified to train staff in de-escalation and physical restraint practices if:
 - a. The instructor has a written curriculum that conforms to the requirements of this Article and state law.
 - b. The classroom instruction provided conforms to the requirements of this Article and state law.
 6. Familiarizing staff with the specific child care responsibilities outlined in the person's job description;
 7. Training staff to recognize expected responses to and side effects of medications commonly prescribed for children in care; and
 8. Training staff in the licensee's emergency admissions process if applicable to the licensee's services.
- C.** The licensee's training plan for ongoing training shall satisfy the requirements of this subsection.
1. A full-time support staff member shall receive at least four hours of annual training.
 2. A full-time direct care staff member shall receive at least 24 hours of annual training.
 3. The training shall cover matters related to the person's job responsibilities, and at least the following subjects, as appropriate to the characteristics of the children in care at the facility:
 - a. Child management techniques;
 - b. Discipline, crisis intervention, and behavior management techniques;
 - c. A review of the licensee's policies;
 - d. Health care issues and procedures;
 - e. Maintenance of current certification in CPR and first aid;
 - f. Attachment and separation issues for children and families;
 - g. Sensitivity towards and skills related to cultural and ethnic differences;
 - h. Self-awareness, values, and professional ethics; and
 - i. Children's need for permanency and how the agency works to fulfill this need.
 7. Time of the incident;
 8. Description of the incident; and
 9. Licensee's response to the incident.
- B.** The licensee shall maintain a record of all unusual incidents occurring at the facility in a separate log or place, which shall permit the Licensing Authority to easily locate the incident reporting form if the licensee maintains the form in a location separate from the log.
- C.** When a child in care dies, the licensee shall notify the child's placing agency or person, and the Licensing Authority within two hours of knowledge of the death.
- D.** When a child in care suffers a serious illness, serious injury, or a severe psychiatric episode requiring hospitalization, the licensee shall notify the child's placing agency or person within 24 hours of knowledge of the occurrence.
- E.** A licensee shall comply with the statutory obligation to report child maltreatment, as prescribed in A.R.S. § 13-3620.
- F.** A licensee shall comply with any reporting requirements set forth in the licensee's contracts with placing agencies or persons.
- G.** No later than 5:00 p.m. on the next business day, the licensee shall notify the Licensing Authority when any of the following occurs:
1. Fire or a natural disaster affecting the licensee;
 2. Law enforcement involvement in which a formal complaint is filed by or against the licensee, but excluding incidents of children cited solely for absence without leave from the facility;
 3. Any incident of alleged child maltreatment of a child in care;
 4. When a child in care or any other person suffers any injury from use of restrictive behavior management, and which requires treatment by a licensed medical practitioner;
 5. When a child in care suffers any physical injury from an incident involving another child in care and requires treatment by a licensed medical practitioner;
 6. When a child in care suffers an injury or psychiatric episode that is severe enough to require hospitalization or external medical intervention for the child; and
 7. When a child in care requires external emergency services including a suicide watch.
- H.** Within five calendar days, a licensee shall give the Licensing Authority written documentation of an event listed in subsection (G) above. The documentation shall contain at least the information required by subsection (A), and may be a copy of the licensee's unusual incident reporting form.
- I.** If a child in care dies, a licensee shall notify the local law enforcement authority and cooperate in any arrangements for examination, autopsy, and burial.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2). Amended by final rulemaking at 6 A.A.R. 4032, effective September 29, 2000 (Supp. 00-3).

R6-5-7434. Notification of Unusual Incidents and Other Occurrences

- A.** A licensee shall make a record of any unusual incident on an incident reporting form which shall include the following information:
1. Location of the unusual incident;
 2. Name and address of any child involved in or observing the incident;
 3. Name of the agency if different from the facility;
 4. Name, title, and address of any staff involved in or observing the incident;
 5. Name and address of any other person involved in or observing the incident;
 6. Date of the incident;

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7435. Investigations of Child Maltreatment

- A.** A licensee shall have written procedures for handling alleged and suspected incidents of child maltreatment, including at least the following provisions:
1. Reporting suspected incidents of maltreatment to law enforcement or Child Protective Services as required by A.R.S. § 13-3620;
 2. Notifying the Licensing Authority, and notifying the child's placing agency or person if so requested;
 3. Taking precautions to prevent further risk to the child who allegedly suffered the maltreatment and potential risk to other children in care;

4. Evaluating the retention of any staff who commit or allow child maltreatment; and
 5. If the licensee internally investigates incidents, conducting the internal investigation.
- B.** A licensee shall require all staff to read and sign a statement describing the duty to report child maltreatment as prescribed in A.R.S. § 13-3620.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7436. Runaways and Missing Children

A licensee shall have a written policy and procedures for handling runaways and missing children. The policy shall include at least the following:

1. Procedures for making staff who provide services to a child with a history of or potential for running away, aware of that child's history or potential;
2. Procedures for immediately notifying the designated administrator of the child's facility or that person's designee when a child is discovered to be missing;
3. Procedures for notifying the local law enforcement agency, the child's placing agency or person, and others as necessary;
4. Procedures to prevent runaways; and
5. Procedures for submitting a written report to the child's placing agency or person within five days or the time specified in the placement agreement.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7437. Staff Coverage; Staff-child Ratios

- A.** A licensee shall have a written plan to minimize the risk of harm to children. The written plan shall describe the staffing for each facility, for 24 hours per day, seven days per week. The staffing plan shall explain:
1. How staff coverage is assured:
 - a. When assigned staff are absent due to illness, vacation, or other leaves of absence; and
 - b. During emergencies when only one staff member is on duty; and
 2. The methods the licensee uses to assure adequate communication and support among staff to provide continuity of services to children.
- B.** A licensee shall also have a written staffing schedule for each facility shift; the schedule shall document the staff actually on duty during each shift. The licensee shall retain the schedules in one designated location for at least two years.
- C.** A licensee shall have at least the paid staff to child ratios prescribed in this subsection.
1. Age 12 and above:
 - a. At least one paid staff member for each 10 children when children are under the licensee's direct supervision and awake.
 - b. During sleep hours, at least one paid staff member in each building where children in care are sleeping.
 2. Age 6 through 11:
 - a. At least one paid staff member for each eight children when children are under the licensee's direct supervision and awake.
 - b. During sleep hours, at least one paid staff member in each building where children in care are sleeping.
 3. Age 3 through 5:

- a. At least one paid staff member for each six children when children are under the licensee's direct supervision and awake.
 - b. At least one paid staff member in each building where children in care are sleeping.
4. Under age 3:
- a. At least one paid staff member for each five children when children are under the licensee's direct supervision and awake.
 - b. At least one paid staff member for each six children when children are sleeping.
5. Nonambulatory children, under age 6: At least one paid staff member for each four children at all times.
6. Young adults:
- a. At least one paid staff member onsite for each 10 young adults when young adults are under the licensee's direct supervision and awake.
 - b. During sleep hours, at least one paid staff member onsite for each 20 young adults.
- D.** For the purpose of the paid staff-child ratios in subsection (C):
1. Students and volunteers do not count as staff;
 2. A child who lives at the facility is counted as a child, unless the child is not in the care, custody, and control of the state of Arizona, and the child's parent is:
 - a. In care, residing in the same facility; and
 - b. Determined to be the child's primary caregiver by:
 - i. The placing agency;
 - ii. A court; or
 - iii. The licensee, when subsections (i) and (ii) do not apply;
 3. When a child resides with a parent in a facility licensed under this Article, the licensee shall provide, at the Department's request, documentation of:
 - a. The custodial relationship between parent and child; and
 - b. If applicable, the determination that the parent is an acceptable primary caregiver for the child.
 4. Any paid staff member counted in the ratio shall be someone who is qualified to provide direct child care as prescribed in R6-5-7432(E).
- E.** A licensee shall not fall below the minimum paid staff-child ratios specified in subsection (C), and shall, notwithstanding those ratios, have paid staff:
1. Sufficient to care for children as prescribed in this Article and in the licensee's own program description, statement of purpose, and policies;
 2. That take into account the following factors:
 - a. The ages, capabilities, developmental levels, and service plans of the children in care;
 - b. The time of day and the size and nature of the facility; and
 - c. The facility's history and the frequency and severity of unusual incidents, including runaways, sexual acting-out behavior, disciplinary problems, and injuries.
- F.** A licensee shall have sufficient numbers of qualified staff to perform the fiscal, clerical, food service, housekeeping, and maintenance functions prescribed in this Article and in the licensee's own policies.
- G.** A licensee shall make a good faith effort to employ staff who reflect the cultural and ethnic characteristics of the children in care.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2). Amended by final rulemaking at 6 A.A.R. 4032, effective September

ber 29, 2000 (Supp. 00-3). Amended by emergency rulemaking at 12 A.A.R. 2233, effective June 1, 2006 for 180 days (Supp. 06-2). Emergency renewed at 12 A.A.R. 4732, effective November 28, 2006 for 180 days (Supp. 06-4). Amended by final rulemaking at 13 A.A.R. 2049, effective May 21, 2007 (Supp. 07-2).

R6-5-7438. Admission and Intake; Criteria; Process; Restrictions

A. Admissions: A licensee shall have a written admissions policy, which shall:

1. Describe the licensee's admission criteria, including:
 - a. Population to be served, including age range, gender, physical development, social behavior, and custody and guardianship status;
 - b. Geographic area of service;
 - c. The needs, problems, and child-related issues best served at the licensee's facility; and
 - d. The method used to assign a child to a particular living unit;
2. Contain an acknowledgment that the licensee abides by the Interstate Compact on the Placement of Children, the Indian Child Welfare Act, and the Interstate Compact on Juveniles; and
3. Provide that the licensee shall not refuse admission to any child on the grounds of race, religion, or ethnic origin.

B. Age Limit; Continuing Care for Persons in High School: A licensee shall not admit a person who is age 18 or older, except a licensee may continue to care for an individual under age 22 who was a child in care and turned age 18 while in care, as long as the individual is currently enrolled in and regularly attending a high school program or vocational training program. A licensee shall not allow an individual to remain in care after the individual receives a high school degree or certificate of equivalency, or completes the vocational training program.

C. Admissions Outside of Criteria: A licensee shall not accept a child who is not within the licensee's admission criteria unless:

1. The placing agency or person specifically authorizes the admission after reviewing the agency's program description;
2. The admission is consistent with the terms of the agency's license and will not result in a violation of this Article; and
3. The child's individual service plan explains:
 - a. The reasons for acceptance, and
 - b. How the facility will meet the child's needs.

D. Intake Assessment:

1. A licensee shall not accept a child into care unless:
 - a. The child has a current intake assessment covering the child's social, health, educational, legal, family, behavioral, psychological, and developmental history; or
 - b. The licensee completes such an assessment within seven days following the child's admission.
2. In this subsection, "current" means within the six months prior to admission.

E. Admission and Intake Process and Requirements: The licensee shall have a written policy and procedures describing the process and requirements for both regular and emergency admissions and intake. The policy shall include the provisions listed in this subsection.

1. The licensee shall have a method to allow a child to participate in admission and intake decisions, including selection of a living unit, if developmentally appropriate and consistent with the licensee's program.

2. The licensee shall provide the placing agency or person with a reasonable opportunity to participate in admission and intake decisions.

3. Except for emergency admissions as prescribed in subsection (F), the licensee shall not admit a child unless the licensee has, at the time of or prior to admission:

- a. A written agreement with the child's placing agency;
- b. A court order; or
- c. The written consent of the child's custodial parent or guardian.

4. The licensee shall obtain any available medical information about the child before or at the time of the child's admission. The information may include:

- a. A report of a medical examination of the child performed within 45 days prior to admission;
- b. A report of a dental examination of the child performed within six months prior to admission; and
- c. The child's and family's medical history.

5. If the information described in subsection (D)(4) is not available, the licensee shall comply with the requirements of R6-5-7452 to obtain an examination.

6. At the time of or prior to admission, the licensee shall obtain written consent from the child's placing agency or person for the licensee to authorize routine medical and dental procedures for the child.

7. If a child is taking medication at the time of admission, the licensee shall:

- a. If the medication is in its original container, labeled by the dispensing pharmacist with a fill date, prescribing physician, and instructions for administration, document the receipt of the medication as prescribed in subsection (E)(7)(c); or
- b. If the medication is not in its original container, or if the container is not labeled as described in subsection (E)(7)(a), contact the prescribing physician to verify the medication administration schedule and reason for the medication; and
- c. Document the contact in the child's medical record required by R6-5-7455 and the medication administration schedule as prescribed in R6-5-7453(B).

8. A licensee shall not refill a prescription that a child brings at admission without having a licensed medical practitioner determine the child's need for the medication and documenting the need as prescribed in subsection (E)(7)(c).

9. Within 24 hours of a child's admission, a direct care staff member who has the training prescribed in R6-5-7433(B)(4), or a licensed medical practitioner, shall assess the child's general health, by:

- a. Looking at the child for signs of obvious physical injury and symptoms of disease or illness;
- b. Assessing the child for evidence of apparent vision and hearing problems; and
- c. Documenting any conditions or problems and referring the child for immediate or further assessment or treatment, if indicated.

F. Emergency Admissions: In an emergency situation requiring immediate placement, a licensee shall:

1. Gather as much information as possible about the child and the circumstances requiring placement;
2. Record this information in the child's record, within two days of admission, as an emergency admission notation; and
3. Keep an emergency admission record, which shall include at least the following information about the child:
 - a. Physical health,

- b. Family history,
- c. Educational background,
- d. Legal status, and
- e. A statement explaining the need for care.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7439. Information and Services Provided to the Placing Agency or Person

- A.** No later than the date of a child's admission, a licensee shall provide information about the following subjects to the placing agency or person.
 - 1. The licensee's statement of purpose and program description prescribed in R6-5-7423(A) and (B);
 - 2. Daily routines at the facility where the child is or will be placed;
 - 3. The behavior management policies and procedures prescribed in R6-5-7456;
 - 4. Services and treatment strategies provided or used at the facility;
 - 5. The visitation and communications policy prescribed by R6-5-7448;
 - 6. The education program or method for providing a child with education;
 - 7. Any religious practices observed by the licensee or religious observances required of children.
- B.** The licensee may provide the information in summary form or orally, but shall:
 - 1. Convey the information in a language or form that the placing agency or person can understand;
 - 2. Advise the placing agency or person that the licensee will provide a copy of the licensee's policies or procedures, upon request.
 - 3. Provide the name and telephone number of a staff person that the placing agency or person may contact to obtain information about the program, facility, or child.
- C.** The licensee shall provide the placing agency or person with a copy of the licensee's grievance procedures required by R6-5-7429 and the statement of client rights required by R6-5-7423(C).
- D.** The licensee shall obtain the dated signature of the placing agency or person indicating receipt of the information listed in subsections (A) through (C).
- E.** Before obtaining the signature of a child's parent or guardian on a contract, consent, or release, the licensee shall explain the contents of the documents.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7440. Orientation Process for a Child In Care

- A.** A licensee shall provide a child admitted into care with the orientation described in this Section in a language and manner that the child can understand and to the extent developmentally appropriate to the child.
- B.** During the first full day of a child's placement, a licensee shall:
 - 1. Explain the facility's emergency procedures,
 - 2. Show the child where emergency exits are located,
 - 3. Take the child on a tour of the facility, and
 - 4. Introduce the child to staff and other residents.
- C.** During the first week following a child's admission and as part of each child's orientation, a licensee shall:
 - 1. Familiarize the child with the licensee's program;

- 2. Explain the licensee's expectations and requirements for behavior;
 - 3. Explain the criteria for successful participation in and completion of or emancipation from the program;
 - 4. Make available a copy of the behavioral rules prescribed by R6-5-7456(A)(3)(a), (b), (c), (d), and (h);
 - 5. Make available a copy of the visitation and communication policy prescribed by R6-5-7448; and
 - 6. Describe and, upon request, make available a copy of the grievance procedures prescribed by R6-5-7429 and the statement of client rights prescribed by R6-5-7423(E).
- D.** The licensee shall document the orientation and other information given to a child in the child's case record.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7441. Child's Service Plan: Preparation; Review; Planning Participants

- A.** Service Plan Contents: A child in care shall have a personalized service plan tailored to the child's unique background, needs, strengths, weaknesses, and problems. The plan shall include at least the following information:
 - 1. A description of services the child is to receive while in care, including services to ready the child for discharge or emancipation from the program;
 - 2. Goals and objectives for the child;
 - 3. Timelines for achieving each goal and objective;
 - 4. Recommendations for any after-care;
 - 5. Identification of persons invited to participate in service planning;
 - 6. The names and, if available, signatures of the persons who participated in service planning;
 - 7. Identification of persons responsible for implementing the service plan, with an explanation of each person's role; and
- B.** Timing for Plan Development and Review:
 - 1. If a child has an existing service plan at the time of admission, the licensee shall:
 - a. Review the plan before or at the time of the child's admission, and
 - b. Assess the existing plan and make any necessary changes to conform to the requirements of this Section.
 - 2. If a child does not have a service plan at the time of admission, the licensee shall initiate service planning at the time of admission.
 - 3. Within seven days of a child's admission, a licensee shall document all interim planning efforts identifying the child's needs and initial plans for service.
 - 4. No later than 30 days after the child's admission to a facility, the licensee shall complete the child's initial service plan and any initial modifications to an existing plan.
- C.** Plan Review: The licensee shall review and update a child's service plan at least every 90 days following completion of the child's service plan described in subsection (B)(4).
- D.** Planning Participants:
 - 1. The licensee shall invite, or delegate the responsibility for inviting, at least the following persons to participate in development of the service plan and periodic review:
 - a. A representative of the facility;
 - b. A representative of the placing agency, if applicable;
 - c. The child, if the child's presence is developmentally appropriate; and
 - d. The child's parent or guardian.

2. At least one participant on the service team shall have the qualifications listed in R6-5-7432(B)(1) or (2).
- E. Methods of Participation: The licensee shall allow service team members to participate in service planning through the following methods:
 1. Attendance at a planning meeting,
 2. Submission of a written report or documentation,
 3. Review and approval of the plan through signing and dating, or
 4. Audio or audio-visual teleconference.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7442. Discharge; Discharge Summary

- A. Policy and Procedure: A licensee shall have written policy and procedures for planned and unplanned discharges of children.
 1. Before a child's planned discharge, the licensee shall explain the discharge plan to the child and help the child understand the plan.
 2. The licensee shall also explain the discharge plan to the person removing the child.
 3. Before discharging a child to another out-of-home placement, the licensee shall make a reasonable effort to:
 - a. Arrange for the service team to meet or communicate with a representative from the new placement to share information about the child; and
 - b. Arrange for the child to visit the new placement.
- B. Discharge Summary: Within 15 days of the date a child is discharged, the licensee shall complete a written discharge summary which shall include the following information:
 1. The name, address, telephone number, and relationship of the person to whom the child was discharged;
 2. The planned and actual discharge dates;
 3. A summary of the contacts between the licensee and the facility or person to whom the child was discharged about the child's pending discharge;
 4. A summary of services provided during care;
 5. A list of medication provided during care, with a summary of the reasons for prescribing the medication and any outcomes of the medication;
 6. A summary of progress toward service plan goals;
 7. An assessment of the child's unmet needs and alternative services which might meet those needs;
 8. Any after-care plan and identification of any person or agency responsible for follow-up services and after-care; and
 9. For an unplanned discharge, a description of the circumstances surrounding the unplanned discharge, including the licensee's actions.
- C. Notice of Unplanned Discharge: When a child's placing agency or person has not participated in the decision to discharge the child, the licensee shall notify the placing agency or person within one hour of discharge, or document attempts at notification.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7443. Personal Care of Children

- A. A licensee shall provide children in care with:
 1. Developmentally appropriate supervision, assistance, and instruction in, good habits of personal care and hygiene and culturally appropriate grooming;
 2. Necessary toiletry items; and

3. The opportunity to have a daily shower or tub bath in private, as developmentally appropriate, or as otherwise prescribed in program policy.

- B. A licensee shall not allow community use of grooming and hygiene articles such as towels, toothbrushes, soap, hairbrushes, and deodorants.
- C. If a licensee restricts personal care or grooming practices, the licensee shall have a policy describing the restrictions and the reasons for the restrictions.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7444. Children's Clothing and Personal Belongings

- A. A child may bring clothing and personal belongings to the facility and acquire belongings while in care, in accordance with the child's service plan and the facility's policy.
- B. If a licensee limits a child's right to have, wear, or display certain clothes or personal belongings, the licensee shall:
 1. Have a written policy explaining the limitations and the reasons for the limitations; and
 2. Explain the limitations to the child in a form and manner that the child can understand.
- C. When a child is admitted, the licensee shall inventory the child's clothing and personal belongings; the licensee shall provide a copy of the inventory to the placing agency or person and keep a copy in the child's file.
- D. The licensee shall either store any restricted possessions or return the possessions to the child's placing agency or person.
- E. The licensee shall ensure that each child has a personal supply of clean and seasonable clothing as required for health, comfort, and physical well-being and as appropriate to the child's age, gender, size, and individual needs.
- F. The licensee shall allow a child to help select his or her own clothing when developmentally appropriate and allowed by programmatic requirements.
- G. The licensee shall have a policy governing retention, return, and disposal of the clothes and personal belongings of a child who has had an unplanned discharge. At the time of a child's planned discharge, the licensee shall allow the child to take clothing and personal belongings.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7445. Children's Money; Restitution

The licensee shall provide opportunities for children to develop a sense of the value of money through allowances, earnings, spending, giving, and saving. Any practices regarding children's money shall comply with this Section.

1. The licensee shall have a written policy regarding allowances.
2. The licensee shall treat a child's money as that child's personal property.
3. The licensee may limit the amount of money to which a child may have access when the limitations are:
 - a. In the child's best interest and explained in the child's service plan; or
 - b. In accordance with the facility's program description.
4. The licensee shall not deduct sums from a child's allowance as restitution for damages caused by the child unless:
 - a. The licensee has discussed restitution with the child; and
 - b. The deduction is:

- i. Reasonable in amount,
 - ii. Consistent with the child's ability to pay,
 - iii. In accordance with the licensee's policy, and
 - iv. Explained in the child's service plan.
5. The licensee shall maintain individual accounting records for the money of each child.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7446. Nutrition, Menus, and Food Service

- A. A licensee shall have a written, dated menu of planned meals. The menu shall be available at the facility at least one week before meals are served. The licensee shall post the weekly menu in the dining area or in a location where children may review it. The licensee shall keep a copy of the menu and any menu substitutions on file for one year.
- B. The licensee shall prepare and serve meals in compliance with the written, dated menus.
- C. A registered nutritionist or dietitian shall either prepare or approve the licensee's menus. The licensee shall maintain a record of any approvals for one year, and keep the record in a central location at the agency or facility.
- D. A licensee shall develop and follow a specialized menu for a child with special nutritional needs. The licensee shall make special menus available to nutritional staff, but shall not post special menus in an area that is readily seen by other children in care.
- E. Menus shall reflect the religious, ethnic, and cultural differences of children in care.
- F. When developmentally appropriate, a licensee shall allow children to make menu suggestions.
- G. A licensee shall provide each child with at least three meals daily, with no more than 14 hours between the evening and morning meals. Between meal snacks shall not replace regular meals.
- H. A licensee shall provide meal portions that are consistent with each child's caloric needs.
- I. A licensee shall serve children meals that are substantially the same as those served to staff unless special dietary needs require differences in diet.
- J. A licensee shall allow children to eat at a reasonable rate; unless otherwise prescribed in agency policy, staff shall encourage social interaction and conversation during meals.
- K. A licensee shall have potable water available at all times.
- L. Staff shall directly supervise children involved in food preparation.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2). Amended by final rulemaking at 6 A.A.R. 4032, effective September 29, 2000 (Supp. 00-3).

R6-5-7447. Sleeping Arrangements

A licensee shall comply with the sleeping arrangement provisions in this Section.

- 1. A child age 6 or older shall not share a bedroom with a child of the opposite gender.
- 2. A child shall not share a bedroom with an adult unless one of the conditions listed in this subsection is met.
 - a. The child is younger than age 3.
 - b. The child's service plan contains specific reasons and authorization from the placing agency or person for a shared bedroom.

- c. The child has a temporary need for special adult care during sleeping hours and the need is documented in the child's service plan.
 - d. The child has regularly shared a bedroom with another child in the licensee's care; the other child has reached age 18; and the placing agency and licensee agree that continuing the shared arrangement is in the best interests of both the child and the adult.
 - e. The child is sharing a room with his or her parent.
 - f. The sleeping area at the facility is a barracks that has been approved as described in R6-5-7461(B) and R6-5-7462(B), and a paid staff member sleeps in the same room to supervise the children in care.
3. Only children age 8 or older may sleep on the upper bed of a bunk bed.
4. If a child has a documented record of behavior that poses a risk to other children in care, the licensee, in consultation with the placing agency or person, shall develop special sleeping arrangements for that child, to minimize the risk of harm to other children. The licensee shall document the arrangements in the child's service plan.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2). Amended by emergency rulemaking at 12 A.A.R. 2233, effective June 1, 2006 for 180 days (Supp. 06-2). Emergency renewed at 12 A.A.R. 4732, effective November 28, 2006 for 180 days (Supp. 06-4). Amended by final rulemaking at 13 A.A.R. 2049, effective May 21, 2007 (Supp. 07-2).

R6-5-7448. Visitation, Outings, Mail, and Telephones

- A. The licensee shall have a written policy and procedures regarding visitation, mail, telephone calls, and other forms of communication between children and family, friends, and other persons. The policy and procedures shall conform to the requirements of this Section.
 - 1. The licensee shall allow a child reasonable privacy during a visit unless the child's service plan requires supervised visitation.
 - 2. A licensee shall have facility visiting hours which meet the needs of the children and their parents.
 - 3. A licensee shall not deny, monitor, or restrict a child's communication with the child's social worker, attorney, Court Appointed Special Advocate, guardian ad litem, or clergy. The licensee may establish a schedule and rules for communication to prohibit undue interference with programming.
 - 4. A licensee shall not deny, monitor, or restrict communications between a child and the child's parent, guardian, or friends except as prescribed:
 - a. By court order;
 - b. In the child's service plan, which shall contain specific treatment reasons for the restriction which shall be time limited; or
 - c. In the facility's policy and statement of purpose required by R6-5-7423.
 - 5. The licensee may require a child to open mail in the presence of staff in order to inspect the mail for contraband.
 - 6. When a licensee is monitoring a communication as allowed in subsection (A)(4) above, the licensee shall tell the parties to the communication about the monitoring.
- B. The licensee shall have written policy and procedures to govern situations when a child temporarily leaves the facility on a visit or outing with a person other than a staff member. The procedures shall include:

1. A method for recording the child's location, the duration of the activity, and the anticipated and actual time of the child's return;
 2. The name, address, and telephone number of the person responsible for the child while the child is absent from the facility; and
 3. A procedure for action if a child fails to return.
- C. Subsection (B) does not apply to regularly scheduled trips to school.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7449. Educational and Vocational Services; Work Assignments

- A. The licensee shall have a written policy regarding its educational program or a plan for ensuring that each child attends an educational program in accordance with state and local laws.
- B. Within 10 local school days of a child's admission to a facility, the licensee shall arrange for the educational needs of the child. The arrangements shall:
1. Meet the child's individual needs;
 2. Be consistent with the child's Individual Education Plan (I.E.P.) if applicable; and
 3. Comply with federal and state education laws.
- C. The licensee shall communicate with staff at an educational program in which a child in care is enrolled to discuss the child's progress. At a minimum, the licensee shall attend scheduled parent-teacher conferences.
- D. If a child's service plan provides for the child to receive vocational services, the licensee shall comply with the plan requirements.
- E. The licensee shall provide children in care with:
1. Space for quiet study;
 2. Developmentally appropriate supervision and assistance with homework; and
 3. Access to necessary reference materials.
- F. The licensee may use work assignments to provide an instructional experience for children in care, but shall not use a child as an unpaid substitute for staff.
- G. A work assignment shall be developmentally appropriate for a child, and scheduled at a time that does not interfere with other routine activities such as school, homework, sleep, and meals.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7450. Recreation, Leisure, Cultural Activities, and Community Interaction

- A. A licensee shall have a written plan for making a variety of cultural, religious, indoor and outdoor recreational and leisure opportunities available for children in care. The plan shall:
1. Reflect the interests and needs of the children in care, including an allotment of time for children to pursue individual interests, and time to address the special needs of the children in the living unit;
 2. Provide for use of community resources such as schools, museums, libraries, parks, recreational facilities, and places of worship; and
 3. Specify procedures for children's participation in community activities and use of community resources.
- B. A licensee shall help children in care learn about the community in which the facility is located and use community resources, as developmentally appropriate.

- C. A licensee shall arrange transportation and supervision so that children in care can attend community activities and maximize use of community resources.
- D. The licensee shall make available recreational equipment that is suitable to the size, age, and developmental level of children in care.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7451. Religion, Culture, and Ethnic Heritage

- A. A licensee shall have a written description of:
1. Its religious orientation, if any;
 2. Any religious practices observed at a facility;
 3. Any restrictions on admission based on religion; and
 4. How the licensee provides opportunities for each child to participate in religious activities in accordance with the faith of the child or the child's parent or guardian.
- B. A licensee's program and the service plans of children in care shall reflect consideration of and sensitivity to the racial, cultural, ethnic, and religious backgrounds of children in care.
- C. A licensee may encourage children to participate in religious, cultural, and ethnic activities but shall not require children to participate unless otherwise provided in the licensee's statement of purpose and program description.
- D. If a child asks to change religious affiliation while in care, the licensee shall obtain the written permission of the child's parent or guardian before assisting the child in making the change. A licensee is not required to obtain this permission if a child changes religious affiliation without the licensee's assistance.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7452. Medical and Health Care

- A. General health care.
1. A licensee shall have a written plan for meeting the preventive, routine, and emergency physical and mental health needs of children in care. The plan shall identify where and from whom children at a facility may obtain qualified health care, 24-hours per day, seven days per week.
 2. A licensee shall ensure that children in care receive:
 - a. Preventive health services, including routine medical examinations and dental cleanings and examinations; and
 - b. The following health services, if necessary:
 - i. Evaluation and diagnosis,
 - ii. Treatment, and
 - iii. Consultation.
 3. A licensee shall ensure that a child in care receives a developmentally appropriate explanation of any health treatment the child receives, in a language and manner the child can understand.
 4. A licensee shall not ignore a child's complaints of pain or illness and shall document persistent complaints and any actions taken in response to the complaints.
- B. Medical care.
1. A licensee shall arrange for a physician, physician's assistant, or nurse practitioner to give a child a medical examination within one week of the child's admission unless:
 - a. A licensed medical practitioner examined the child within the 45 days preceding the child's admission; and

- b. The licensee has a report of the examination as prescribed in R6-5-7438(E)(4)(a).
- 2. A licensee shall also arrange for a child in care to receive an annual medical exam from a physician, physician's assistant, or nurse practitioner.
- 3. The initial and annual medical examinations shall include:
 - a. Screening for communicable disease unless restricted by law;
 - b. Vision and hearing screening; and
 - c. For children who wish to participate in sports or physically strenuous activities such as backpacking, an evaluation of the child's capacity to participate.
- 4. A licensee shall obtain a report of the examination, and, if applicable, a statement signed by the medical practitioner conducting the examination, or the practitioner's designee, regarding the child's capacity, fitness, and clearance to participate in sports or physically strenuous activities.
- 5. After attempting to determine a child's immunization history, a licensee shall arrange for the child to receive any routine immunizations and booster shots within 30 days of admission.

C. Dental care.

- 1. A licensee shall arrange for each child to have a dental examination within 60 days of admission unless the licensee is provided the written results of a dental examination conducted within six months prior to admission.
- 2. A licensee shall arrange for each child age 3 and older to receive a dental examination every six months.
- 3. In cooperation with the placing agency or person, a licensee shall arrange for a child to receive any prescribed dental care.

D. First aid. A licensee shall equip the residence of each living unit with at least the following first aid supplies:

- 1. Adhesive strip bandages;
- 2. Sterile, individually wrapped gauze squares;
- 3. Roller gauze;
- 4. Adhesive tape;
- 5. Individually wrapped non-stick sterile pads;
- 6. A triangular bandage to be used for a sling;
- 7. Disposable latex gloves;
- 8. A pair of scissors;
- 9. A pair of tweezers; and
- 10. A cardiopulmonary resuscitation mouth guard or mouth shield.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7453. Medications

- A.** A licensee shall have written policies and procedures governing medications. The policies and procedures shall specify:
- 1. The conditions under which medications can be prescribed and administered which shall be in accordance with any applicable laws;
 - 2. The qualifications of the persons allowed to administer medications;
 - 3. The qualifications of persons allowed to supervise self-administration of medication;
 - 4. How a facility will document the prescription and administration of medication, medication errors, and drug reactions; and
 - 5. How staff will notify a child's attending physician in cases of medication errors and drug reactions.

- B.** The licensee shall have a written medication schedule for each child who receives medication. The schedule shall include the following information:

- 1. Child's name;
- 2. Name of the prescribing physician;
- 3. Telephone number at which the prescribing physician can be reached in case of medical emergency;
- 4. Reason for prescribing the medication;
- 5. Date on which the medication was prescribed;
- 6. Generic or commercial name of the medication;
- 7. Dosage level and time of day when medication is to be administered, including any special administration instructions;
- 8. The date, time, and dosage administered; and
- 9. The signature of the person administering each dosage. If the medication is self-administered, the chart shall include the signature of the child and the person supervising the child's self-administration.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7454. Storage of Medications

A licensee shall store medications as prescribed in this Section.

- 1. Medications shall be kept in securely locked spaces that are not used for any other purpose and to which children do not have access.
- 2. All medications requiring refrigeration shall be stored separately from food items, in a locked container, in a refrigerator and under temperature ranges recommended by the manufacturer.
- 3. All prescription medication shall be kept in its original container which shall have a label with the following information:
 - a. Child's name;
 - b. Name of the medication;
 - c. Prescribing physician;
 - d. Date of purchase and, if known, expiration date; and
 - e. Directions for administering.
- 4. All over-the-counter medication shall be kept in its original container with the manufacturer's label.
- 5. At least once every 90 days, the licensee shall dispose of all:
 - a. Outdated medications;
 - b. Medications for children no longer at the facility; and
 - c. Medications specifically prescribed for an illness from which a child has recovered.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7455. Children's Medical and Dental Records

A licensee shall maintain health records for each child. The records shall include the information listed in this Section if available to the licensee.

- 1. The child's past medical history of:
 - a. Immunizations,
 - b. Serious illness or injuries,
 - c. Surgeries,
 - d. Known allergies, and
 - e. Adverse drug reactions.
- 2. Developmental history.
- 3. Medication history.
- 4. History of any alcohol or substance abuse and treatment.
- 5. Immunizations provided while in care.

6. Medications received while in care and a record of any medication errors.
 7. Copies of consents for treatment or care.
 8. Authorization to participate in sports or physically strenuous activities, if applicable.
 9. Reports of vision and hearing screening and physical and dental examinations.
 10. Record of any treatment provided for specific illness or medical emergencies, including the name and location of medical personnel who provided treatment.
 11. The name of the person or agency bearing financial responsibility for the child's health care.
 12. Documentation showing the licensee's efforts, consistent with the terms of the placing agreement, to obtain glasses, hearing aids, prosthetic devices, corrective physical or dental devices, or any other health equipment recommended by a child's attending physician.
7. Requiring a child to take a painfully uncomfortable position, such as squatting or bending for extended periods of time; and
 8. Administration of prescribed medication or medication dosage without specific physician authorization.
- D.** To determine whether a licensee has violated subsection (C)(7), the Licensing Authority shall consider all the circumstances at the time of the action, including the following:
1. The child's physical condition;
 2. Whether the child was taking any medications that may have affected the child's ability to perform the action, such as psychotropic medications or antibiotics;
 3. The climatic conditions under which the child was performing the action, such as intense heat or cold, rain, or snow;
 4. The level of force, if any, the licensee used to require the child to perform the activity and whether any use of force resulted in injury to the child; and
 5. Whether the activity was consistent with the licensee's program description and procedures.
- E.** The behavior management practices listed in this subsection are restricted. A licensee may use a restricted practice only when the licensee satisfies the conditions listed in subsection (F) and any additional conditions listed in this subsection.
1. Required physical exercises such as running laps or performing push-ups, and assignment of physically strenuous activities, except:
 - a. As expressly prescribed in a child's service plan and as part of a regular physical conditioning program, or as part of a work experience that meets the requirements of R6-5-7449(F) and (G);
 - b. With documented clearance by a physician who is knowledgeable about the physical activities in which the child will participate; and
 - c. Within sight supervision of staff.
 2. Disciplinary measures taken against a group because of the individual behavior of a member of the group.
 3. Denial of visitation or communication with significant persons outside the facility solely as a consequence for inappropriate behavior.
 4. Use of a mechanical restraint unless:
 - a. The licensee's policy lists the qualifications of staff allowed to use the restraint;
 - b. Staff allowed to use the restraint have received training in the proper use of the restraint;
 - c. The licensee has documentation of the restraint training in the personnel file of the staff member;
 - d. Use of the restraint is authorized in a child's individual service plan; and
 - e. Staff have tried less restrictive measures which have failed.
 5. Physical restraint, except:
 - a. When the child needs restraint to prevent danger to the child or danger to another; and
 - b. After staff have tried less restrictive measures which have failed.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7456. Behavior Management

- A.** A licensee shall have written behavior management policies and procedures which shall:
1. Be developmentally appropriate for the children in care;
 2. Be designed to encourage and support the development of self-control;
 3. Describe the following:
 - a. Behavior expectations of children;
 - b. Consequences for violations of the licensee's policies and rules which shall be:
 - i. Reasonably related to the violation; and
 - ii. Administered without prolonged and unreasonable delay;
 - c. Physical restraint and restrictive behavior management techniques used by the licensee;
 - d. The kinds of behaviors warranting use of physical restraints or restrictive behavior management techniques;
 - e. The licensee's methods of documenting use of physical restraints or restrictive behavior management techniques;
 - f. Behavior management techniques which require supervisory authorization or written documentation before being used;
 - g. The licensee's process for supervisory review to evaluate whether staff properly applied the restraints or techniques in a particular case; and
 - h. Behavior management techniques prohibited by the licensee.
- B.** The licensee's staff are responsible for control and discipline of children in care. The licensee shall not allow children to discipline other children.
- C.** The licensee shall not threaten a child or allow any child to be subjected to maltreatment, abuse, neglect, or cruel, unusual, or corporal punishment, including the following practices:
1. Spanking or paddling a child;
 2. All forms of physical violence inflicted in any manner upon the body;
 3. Verbal abuse, ridicule, or humiliation;
 4. Deprivation of shelter, bedding, food, water, clothing, sufficient sleep, or opportunity for toileting;
 5. Force-feeding, except as prescribed by a licensed medical practitioner;
 6. Placing a child in seclusion;
- F.** A licensee may use a restricted practice only when the practice and the circumstances warranting its use are:
1. Consistent with the licensee's program description and purpose;
 2. Described in the licensee's behavior management policy;
 3. Used as prescribed in this Section; and
 4. Not otherwise prohibited by these rules.
- G.** If a licensee cannot use a specific physical restraint or behavior management technique on a particular child, the child's service plan shall describe the restriction.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7457. Body Searches

If a licensee permits a body search of children in care, the licensee shall have a written policy describing the conditions warranting a body search and the procedures for conducting the search.

1. When searching a child, staff shall use the minimum amount of physical contact required to determine if the child has contraband.
2. The licensee shall not conduct an internal body cavity search on a child.
3. The licensee shall not use any instruments to search a child.
4. The licensee shall not conduct a strip search beyond underwear.
5. Unless a licensed medical practitioner is searching a child, a person of the same gender as the child shall do the search.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7458. Buildings; Grounds; and Water Supply

A. Structures and Improvements: A licensee shall maintain a facility's structures and improvements in good repair, free from danger to health or safety, and as prescribed in this subsection. The licensee shall:

1. Repair doors, windows and other building features that protect a building from weather damage or pest infestation, within 48 hours of finding that the building part is in disrepair;
2. Document efforts to make or obtain repairs if repairs cannot be completed in 48 hours;
3. Keep buildings free of vermin infestation;
4. Keep exits free of obstruction or impediments to immediate use; and
5. Have barriers appropriate to the developmental needs of children in care to prevent falls from porches and elevated areas, walkways, and stairs.

B. Exits: The licensee shall equip each building used by children with exits as prescribed in this subsection.

1. Each building shall have at least two exterior means of egress on each floor.
2. Exits above ground level shall have an outside fire escape or a fire-resistant stairwell that has been approved by the state or a local fire inspector.
3. Exit doors shall have only locks that allow the doors to be opened from the inside without use of a key or knowledge of special or restrictive operating procedures.

C. Grounds: A licensee shall maintain a facility's grounds in good condition, free from danger to health or safety, and as prescribed in this subsection. The licensee shall:

1. Store garbage and rubbish in non-combustible, covered containers, separate from play areas;
2. Remove refuse and recyclables from the building at least once a day;
3. Remove refuse and recyclables from the facility grounds at least once a week.
4. Use safeguarding measures to separate children in care from potentially hazardous areas on or near the facility grounds;
5. Maintain fences and other barriers in good repair; and
6. Locate and install playground or recreational equipment at the facility in accordance with the manufacturer's

instructions and recommendations, and maintain the equipment in good repair and in accordance with the manufacturer's instructions and recommendations.

- D.** Water supply: If a facility's water is from any source other than an approved public water supply, the licensee shall obtain a written water analysis report, showing that the water is potable and meets the applicable requirements for safe drinking water in 18 A.A.C. 4. The licensee shall get the analysis and report from a laboratory certified by the Department of Health Services before initial operation and each annual renewal.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7459. Building Interior

A. A licensee shall ensure that a facility's physical plant can structurally accommodate the physical and program needs of all children in care according to the standards prescribed in this Article and the licensee's own program description.

B. The licensee shall keep a facility clean and sanitary.

C. The licensee shall have and maintain furnishings as prescribed in this subsection.

1. All living areas shall have furniture designed to suit the size and capabilities of the children in care.
2. A licensee shall replace or repair broken, dilapidated, or defective furnishings and equipment.
3. A licensee shall have mirrors in the facility to permit children in care to examine their personal appearance.
4. A licensee shall secure the mirrors to walls at heights convenient to the children in care.

D. A licensee shall ensure that all spaces used by children have outside ventilation from a window, louvers, air conditioning, or other mechanical equipment. A window or door used for outside ventilation shall have a screen.

E. A licensee shall maintain a facility's residential environment at temperatures that do not:

1. Exceed 85° F,
2. Fall below 65° F during daylight hours, or
3. Fall below 60° F during sleeping hours.

F. A licensee shall use thermometers scaled at no more than 2 degree increments to determine temperature.

G. A licensee shall not use free-standing stoves that use wood, sawdust, coal, or pellets, or portable heaters as the primary source of heat for a residential area.

H. A licensee shall safeguard hot water radiators or steam radiators and pipes or any other heating device capable of causing a burn.

I. A licensee shall maintain and use all electrical equipment, wiring, cords, switches, sockets, and outlets in good working order, under safe conditions, in accordance with the manufacturer's recommendations, and as prescribed in this subsection.

1. Electrical outlets in areas accessible to children younger than 6 shall have safety plugs or plates.
2. The licensee shall not:
 - a. Use extension cords exceeding 7 feet in length,
 - b. Allow extension cords to be connected together to extend their length, or
 - c. Allow extension cords to run across or through a room or to pass from one room into another.

J. A licensee shall provide illumination for a facility's rooms, corridors, and stairways so that children and personnel can perform activities and tasks safely and without eye strain.

K. A licensee shall illuminate a facility's outdoor walkways and premises so that children and personnel using areas at night can perform activities and tasks safely.

- L.** A licensee housing more than 10 children shall install and maintain emergency lighting systems in children's living quarters.

1. In this subsection, "emergency lighting system" means a battery or generator operated system that:
 - a. Automatically activates if electrical power fails; and
 - b. Provides sufficient light for persons to exit safely in an emergency.
2. If a licensee provides written documentation showing that a facility's emergency lighting system meets applicable city or county building codes for such systems, the system is presumed adequate to satisfy this subsection.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2). Amended by final rulemaking at 6 A.A.R. 4032, effective September 29, 2000 (Supp. 00-3).

R6-5-7460. Kitchens; Food Preparation; and Dining Areas

- A.** A licensee shall maintain a facility's kitchen and dining areas, and shall handle food, as prescribed in this Section.
- B.** The licensee shall:
1. Equip a facility kitchen used for meal preparation with the fixtures, appliances, equipment, tools, and utensils ("kitchen equipment") necessary for the safe and sanitary preparation, storage, service, and cleanup of food;
 2. Keep kitchen equipment clean and in good working order;
 3. Not use defective, damaged, tin, or aluminum dishes or utensils;
 4. Not use disposable dinnerware or flatware on a daily basis unless the licensee provides evidence, at the time of initial licensure and at each renewal, that disposable items are necessary to protect the health or safety of children in care;
 5. Maintain the temperature of potentially hazardous food at or below 45° F or above 140° F, except when the food is being handled or served;
 6. Cover all food that is to be transported outside of the kitchen and dining areas of the facility; and
 7. Not use home canned foods.
- C.** If a facility has more than 20 children, the licensee shall comply with the requirements in A.A.C. R9-8-132 through R9-8-137.
- D.** If a facility has less than 21 children, the licensee shall comply with A.A.C. R9-8-113, R9-8-115, R9-8-116, R9-8-117, and R9-8-121 through R9-8-127, and shall have:
1. One refrigerator for each 10 children at a facility; and
 2. A three-compartment sink; or
 3. A National Sanitation Foundation (NSF)-listed dishwasher; or
 4. A domestic dishwasher with a sanitizer cycle.
- E.** A facility shall have clean dining areas and tables which allow children, staff, and guests to eat together.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7461. Sleeping Areas and Furnishings

- A.** A licensee shall provide each child in care with a designated area for rest and sleep as prescribed in this Section.
1. A licensee shall not use mobile dwellings, trailers, or vehicles as sleeping quarters.
 2. The licensee shall provide children in care with bedroom space that:
 - a. Has a direct source of natural light;

- b. Has a window that:
 - i. Opens to the outside without a grill or other impediment to immediate, emergency exit;
 - ii. Can be easily opened from the inside;
 - iii. Measures at least 22 inches on each side; and
 - iv. Has a bottom sill that is no more than 48 inches from the floor; and
- c. Is at least:
 - i. A 74 square foot floor area for a single occupant;
 - ii. A 50 square foot floor area for each occupant in a multiple sleeping area; or
 - iii. A 40 square foot floor area for each crib.
3. The licensee shall provide each child in care with a bed that:
 - a. Is proportional to the child's height,
 - b. Is at least 30 inches wide,
 - c. Has a solidly constructed bed frame, and
 - d. Has safety railings if developmentally appropriate for the child using the bed.
4. If a licensee uses a bunk bed, the bed shall be limited to a double bunk, and shall have sufficient head room to allow the upper occupant to sit up.
5. A licensee shall use only cribs that have:
 - a. Bars or slats no more than 2 3/8 inches apart;
 - b. A mattress that fits snugly into the crib frame so that there is no space between the mattress and frame; and
 - c. No openings through which a child could place his or her head.
6. A licensee shall provide sheets, pillow cases, and blankets for each child and shall maintain bedding in good repair, without tears or stains.
 - a. The licensee shall ensure that sheets and pillowcases are washed at least weekly and more frequently if necessary.
 - b. The licensee shall use water resistant bedding when necessary.
7. A licensee shall provide each child with a dresser or other storage space adequate to contain the child's belongings and a designated space for hanging clothing in or near the child's bedroom.

- B.** The square footage area prescribed in subsection (A)(2)(c) is presumed adequate. If a licensee operates a barracks type facility that does not meet these square footage requirements, the licensee shall present a written plan showing how the licensee's square footage provides enough space for sleeping, rest, study, recreation, ingress, and egress in an emergency. The Licensing Authority shall review and approve the plan if it is consistent with the licensee's described program and does not pose a risk of harm to children in care.
- C.** A licensee shall not have bedroom doors that can be locked.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2). Amended by final rulemaking at 6 A.A.R. 4032, effective September 29, 2000 (Supp. 00-3).

R6-5-7462. Bathrooms

- A.** A licensee shall maintain bathrooms and bathroom fixtures in good operating and sanitary condition, and as prescribed in this Section.
1. The licensee shall have facility bathrooms equipped with:
 - a. At least one wash basin and one toilet for every six children in care;

- b. At least one bathtub or shower for every eight children in care;
 - c. Cold and hot running water, with enough hot water to allow each child a daily bath or shower;
 - d. Bathtubs and showers that are slip-resistant; and
 - e. Toilets and bathtubs or showers which allow a child to have privacy, as developmentally appropriate, or as otherwise prescribed in written program policy.
 - 2. The licensee shall not permit children age 5 or older who are of different genders to share a bathroom at the same time.
 - 3. The licensee shall equip bathrooms to facilitate maximum self-help by children through one or more of the following methods:
 - a. Providing children with step-stools to reach a sink,
 - b. Providing smaller sized bathroom fixtures,
 - c. Providing training toilets,
 - d. Placing towel racks and dispensers at lower heights, or
 - e. Other similar or comparable methods.
 - 4. A licensee shall have bathrooms large enough to permit staff to help children who require it.
 - 5. A licensee shall provide bathrooms with sufficient toilet paper, towels, soap, and other items required to maintain good personal hygiene, or shall provide children with personal supplies of these items.
- B.** The bathroom fixture requirements prescribed in subsections (A)(1)(a) and (b) are presumed adequate. If a licensee operates a barracks type facility which does not meet these requirements, the licensee shall present a written plan showing how the licensee's bathroom facilities permit children in care to maintain adequate hygiene. The Licensing Authority shall review and approve the plan if it is consistent with the licensee's described program and does not pose a risk of harm to children in care.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7463. Other Facility Space; Staff Quarters

- A.** A licensee shall ensure that a facility has:
- 1. A place other than children's living areas to serve as an administrative office for records, secretarial work, and bookkeeping; and
 - 2. Space for private discussions and counseling sessions between individual children and staff.
- B.** If a licensee has staff who reside at the facility, the licensee shall provide those staff with living and sleeping space that is separate from children's areas, including a separate bathroom. The licensee shall provide the children of these staff, who also reside at the facility, with a residential environment that meets the requirements of this Article for children in care.
- C.** A licensee operating a barracks type facility that has been approved as described in R6-5-7461(B) and R6-5-7462(B) is not required to provide separate space as described in subsection (B).

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7464. Fire, Emergency, and Fire Prevention

- A.** Emergency Procedures: A licensee shall have written procedures for staff and children to follow in case of emergency or disaster (natural, medical, or human-caused). The procedures shall include the following:

- 1. Provisions for the evacuation of buildings, including the evacuation of children with physical disabilities;
 - 2. Assignment of staff to specific tasks and responsibilities;
 - 3. Instructions on the use of alarm systems and signals;
 - 4. Specification of evacuation routes and procedures, with clearly marked diagrams; and
 - 5. Notification as prescribed in R6-5-7434.
- B.** Emergency Practices and Drills: A licensee shall prepare staff and children to respond to emergencies as prescribed in this subsection.
- 1. The licensee shall train all staff to perform assigned tasks during emergencies, including the location and use of fire fighting equipment.
 - 2. The licensee shall train staff and children to report fires and other emergencies in accordance with written emergency procedures.
 - 3. The licensee shall post evacuation procedures in conspicuous locations throughout all buildings.
 - 4. The licensee shall train staff and children in evacuation procedures and conduct emergency drills at least once a month as prescribed in this subsection.
 - a. Practice drills shall include actual evacuation of children to safe areas.
 - b. Drills shall be held at random times and under varying conditions to simulate the possible conditions in case of fire or other disaster.
 - c. All persons in the building at the time of a drill shall participate in the drill.
 - 5. A licensee shall maintain a record of all emergency drills. The record shall include:
 - a. Date and time of drill,
 - b. Total evacuation time,
 - c. Exits used,
 - d. Problems noted, and
 - e. Measures taken to ensure that children understand the purpose of a drill and their responsibilities during a drill.
- C.** Fire Prevention and Control: A licensee shall have and maintain fire prevention and safety equipment as prescribed in this subsection.
- 1. In a facility's residential environment, the licensee shall install and maintain smoke detectors according to the manufacturer's instructions, recommendations, and test specifications and shall maintain smoke detectors in good working order. Each smoke detector shall have a signal to indicate that batteries are low or are not working properly.
 - 2. The licensee shall put a smoke detector in each separate sleeping area.
 - 3. The licensee shall clean and test smoke detectors at least every three months. The licensee shall keep a written record of the cleaning and testing at the facility.
 - 4. A licensee shall install and maintain portable fire extinguishers appropriate in number and size to the area to be protected.
 - 5. A licensee shall have a qualified person inspect and, if necessary, recharge fire extinguishers at least once a year and immediately after use.
 - 6. A licensee shall:
 - a. Document the dates that a fire extinguisher is charged and the person or agency responsible for charging it; and
 - b. Attach the documentation to the extinguisher.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7465. General Safety

- A.** Ground Floor: A licensee shall house non-ambulatory children and children younger than 6 only on the ground floor.
- B.** Licensees that provide services to young adults:
1. A licensee that provides services to young adults shall provide adequate safety information and individualized instruction to promote the safe use of a substance or item that is:
 - a. Required to be safeguarded under this Section; and
 - b. Necessary for the young adult's self-sufficiency, such as laundry and cleaning supplies, tools, and kitchen knives.
 2. A licensee that provides services to young adults placed in care with their own children shall safeguard substances and items in a manner appropriate to protect the youngest child in residence.
- C.** Dangerous objects: A licensee shall safeguard all potentially dangerous objects, including:
1. Firearms and ammunition;
 2. Recreation and hunting equipment;
 3. Household and automotive tools;
 4. Sharp objects such as knives, glass objects, and pieces of metal;
 5. Fireplace tools, matches, and other types of lighters;
 6. Machinery;
 7. Electrical wires, boxes, and outlets;
 8. Gas appliances;
 9. Chemicals, cleaners, and toxic or flammable substances;
 10. Swimming pools, ponds, spas, and other natural or artificial bodies of water; and
 11. Motorized vehicles.
- D.** Water Temperature: A licensee shall maintain water that is accessible to children for personal use at a temperature at or below 120° F.
- E.** Gas appliances:
1. A licensee shall have a licensed and bonded heating and cooling technician annually inspect all gas-fired devices at a facility. The licensee shall get a written report of the inspection for submission to the Licensing Authority at the time of license renewal.
 2. A licensee shall equip all gas-fired devices with an automatic pilot gas shut-off control.
 3. A licensee shall remove the valves from unused gas outlets and cap the disconnected gas line with a standard pipe cap.
 4. A licensee shall not use unvented water heaters.
 5. A licensee shall not use kerosene or gasoline for lighting, cooking, or heating.
 6. If a licensee uses a natural or propane gas burning device inside a facility, the licensee shall:
 - a. Install, test, and check carbon monoxide monitoring equipment in a facility's residential environment according to the manufacturer's instructions;
 - b. Maintain the monitoring equipment in good working condition; and
 - c. At the facility, keep a copy of the manufacturer's instructions, and, for one year, a record of the tests.
- F.** Finishes and surfaces:
1. A licensee shall not surface walls or ceilings with materials that contain lead except as allowed by law for protection from wood, pellet, or peat burning stoves.
 2. A licensee shall not have any walls, equipment, furnishings, toys, or decorations surfaced with lead paint.
 3. A licensee that accepts children who are under age 6, developmentally disabled, or severely emotionally disturbed, shall maintain the facility free of lead paint hazards, including permanent removal of any paint that a child may ingest.
- G.** Toxic and Flammable Substances:
1. A licensee shall ensure that any poisons and toxic or flammable substances used at a facility are used in a manner and under conditions that will not contaminate food or be hazardous to children.
 2. A licensee shall ensure that containers of poisons and toxic or flammable substances are prominently and distinctly marked or labeled for easy identification of contents.
 3. A licensee may burn trash only when:
 - a. Local authorities and ordinances allow burning;
 - b. The fire is at least 50 feet from any building used for children's residences; and
 - c. An adult supervises any child involved in the burning.
 4. A licensee shall not use charcoal or gas grills indoors or on covered porches.
- H.** Firearms, Weapons, and Recreational and Hunting Equipment:
1. A licensee shall ban firearms, explosives, and ammunition from a facility and grounds, except a licensee may allow the following:
 - a. Firearms maintained and used exclusively by trained security guards; and
 - b. Non-functional, permanently disabled firearms used for ceremonial purposes if such use is documented in the licensee's policy and procedures.
 2. A licensee shall keep bows and arrows, knives, and other potentially hazardous hunting and recreational equipment in locked secure storage that is not accessible to children.
- I.** Tools and Equipment: A licensee shall maintain lawn and garden equipment and maintenance tools and equipment safe and in good repair, and shall allow children to use them only under the supervision of staff. Depending on the developmental level of the child, the supervision need not be direct supervision.
- J.** Telephone service:
1. A licensee shall equip each living unit that does not house young adults with 24-hour telephone service or an intercom system linked to an outside telephone service, or
 2. A licensee that provides services to young adults shall provide a device in each living unit that allows a young adult to immediately summon on-duty staff or emergency services. In addition, the licensee shall provide a telephone onsite. The licensee shall provide written and verbal information to each young adult explaining how to summon assistance in the event of an emergency.
 3. A licensee shall conspicuously post, adjacent to the telephone:
 - a. The address and telephone number of the facility; and
 - b. Emergency telephone numbers, including fire, police, physician, poison control, Child Protective Services, and ambulance.
- K.** Smoking:
1. A licensee shall not expose a child in care to tobacco products or smoke.
 2. A licensee shall not allow any person to use tobacco products inside buildings.
 3. A licensee shall not allow a child in care to use or possess tobacco products.
- L.** Animals:
1. The licensee shall not maintain, at a facility, any animal that poses a danger to children in care.
 2. The licensee shall have written evidence that dogs kept at a facility have current vaccinations against rabies.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2). Amended by emergency rulemaking at 12 A.A.R. 2233, effective June 1, 2006 for 180 days (Supp. 06-2). Emergency renewed at 12 A.A.R. 4732, effective November 28, 2006 for 180 days (Supp. 06-4). Amended by final rulemaking at 13 A.A.R. 2049, effective May 21, 2007 (Supp. 07-2).

R6-5-7466. Swimming Areas

- A.** A licensee shall fence an outdoor swimming pool to separate it from all buildings, with a fence that:
 - 1. Is at least 5 feet high, as measured on the exterior side of the fence; and
 - 2. Has a self-closing, self-latching gate that opens away from the swimming pool. The licensee shall maintain the latching equipment in good working order.
- B.** If the licensee accepts children younger than 6, the fence shall:
 - 1. Have no opening through which a spherical object of 4 inches in diameter can pass;
 - 2. Have horizontal components which:
 - a. Are spaced at least 45 inches apart, measured vertically; or
 - b. Do not have any openings greater than 1 3/4 inches, measured horizontally; or
 - 3. Not have any openings for handholds or footholds, or any horizontal components, that can be used to climb the fence from the outside.
- C.** Subsections (A) and (B) do not apply to outdoor swimming pools that are entirely surrounded by permanent walls or buildings with doors that can be locked, so long as the walls or building meet the requirements for fencing set forth in subsections (A) and (B).
- D.** A licensee shall lock all entrances to a swimming pool when the pool is not in use.
- E.** A licensee shall maintain the following life-saving equipment in good repair and readily accessible to the swimming pool:
 - 1. A ring buoy with 1/2-inch width rope that is at least half the distance of the pool measured at its longest point, plus 10 feet; and
 - 2. A shepherd's crook attached to its own pole.
- F.** At least one of the staff members supervising children in a pool, shall remain out of the water.
- G.** When a pool is in use, a licensee shall keep a daily log to record water quality test results of an on-grounds swimming pool and shall maintain the pool free from contamination in accordance with 9 A.A.C. 8, Article 8.
- H.** The licensee shall, when chlorination is used, maintain a free chlorine residual of between 0.1 and 4.0 parts per million, and a pH range of 7.0 to 8.0. A licensee may add dry or liquid chemical sources directly to pool water only when enough time exists for dispersal before use.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7467. Access; Transportation; Outings

- A.** Access.
 - 1. A facility shall be accessible by public or private motor vehicle.
 - 2. If the facility cannot be accessed by a road that is passable by motor vehicle 12 months of the year the licensee shall have alternative transportation arrangements to provide access to the facility.
- B.** Transportation.
 - 1. A licensee shall provide, arrange, or negotiate responsibility for arranging, with the placing agency or person,

transportation required to implement a child's service plan.

- 2. A licensee shall provide staff supervision in any vehicle the licensee uses to transport a child in care.

C. Outings.

- 1. For every facility sponsored outing which is not part of the daily routine, such as a recreational trip of four hours or more, or an outing where emergency medical services cannot respond within 12 minutes, a licensee shall maintain, at the facility, a record of the following information:
 - a. A list of children participating in the outing;
 - b. Departure time and anticipated return time;
 - c. License plate numbers of every vehicle used for the outing; and
 - d. Name, location, and, if known, telephone number of the destination.
- 2. The licensee shall give the driver of a vehicle written emergency information on each child who is participating in the outing and riding with that particular driver.
- 3. The person supervising the child shall keep the information during the outing. The information shall include:
 - a. Each child's medication requirements, if any;
 - b. Common and known potential adverse reactions a child may have to a medication;
 - c. Adverse reactions a child may have as the result of delay in administration of medication; and
 - d. Any other adverse reaction a child is likely to have due to the child's special needs, including allergic reactions to particular substances or insects.
- 4. The licensee shall tell the driver about a child's particular needs or problems which may reasonably cause difficulties during transportation, including seizures, tendency toward motion sickness, disability, anxiety, or other phobias.

D. Extended outings: If a licensee takes children in care on an outing that lasts more than 30 consecutive days, the licensee shall:

- 1. Obtain court permission for any children who are court wards;
- 2. Comply with the requirements in R6-5-7469 through R6-5-7471 governing outdoor experience programs.

E. Vehicles.

- 1. A licensee shall ensure that all vehicles used for the transportation of children in care:
 - a. Are mechanically sound and in good repair,
 - b. Conform to applicable motor vehicle laws, and
 - c. Have equipment appropriate to the terrain and the weather.
- 2. The licensee shall not allow the number of individuals in a vehicle used to transport children in care to exceed the number of available seats and seat belts in a vehicle other than a bus. If the vehicle is a bus, the licensee shall not exceed the maximum stated occupancy on the bus inspection certificate.
- 3. A licensee serving nonambulatory children or children with disabilities shall provide access to transportation that accommodates the children's special needs and disabilities.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7468. Special Provisions for Shelter Care Facilities

- A.** General Requirements: A licensee operating a shelter care facility shall comply with all requirements prescribed in this Article, unless otherwise provided in this Section.

B. Admission Policy and Practice:

1. If a child has already been in shelter care for more than 42 days, a licensee shall not admit the child into shelter care at the licensee's facility, or permit the child to continue residing at the licensee's facility, unless the licensee has:
 - a. Asked the child's placing agency or person to have a multidisciplinary team:
 - i. Assess the child through a review of the child's records or in person; and
 - ii. Develop a service plan for the child; and
 - b. Documented the request in the child's record.
 2. When a child self-refers to a shelter care facility, the licensee shall, within 24 hours of the child's arrival:
 - a. Notify the Department or the child's guardian; and
 - b. Document the placing agency or person's consent for the child's continued placement in a written agreement with the placing agency or person, or by obtaining a court order.
 3. A licensee does not have to obtain medical information and consents before or at the time of a child's admission to a shelter care facility as prescribed in R6-5-7438(E)(4) and (5), but shall document attempts to obtain the medical consents from the placing agency or person within two days of the child's admission.
 4. At the time of a child's admission, the licensee is not required to obtain the comprehensive intake assessment required by R6-5-7438(D), but shall work with the placing agency or person to compile information on and assess the child's current social, behavioral, psychological, developmental, health, legal, family, and educational status, as applicable to the child.
- C. Staff-child ratio:** A shelter care facility shall comply with the staff-child ratios prescribed in R6-5-7437, except that a licensee who accepts six or more children in care at a shelter facility shall have at least one awake staff member on duty during sleeping hours.
- D. Staff development:** In addition to the training requirements prescribed in R6-5-7433, a licensee shall train staff members who work at a shelter care facility to recognize the signs and effects of:
1. Substance use and abuse,
 2. Common childhood illness, and
 3. Communicable disease.
- E. Medical care:** A shelter care facility does not have to provide or arrange a medical examination as required by R6-5-7452(B)(1) unless the general health assessment required by R6-5-7438(E)(9) indicates a need for further medical attention.
- F. Service planning:** Unless a child remains in continuous shelter care for more than 42 consecutive days, a licensee operating a shelter care facility is not required to comply with the R6-5-7441 regarding service planning.
- G. Children's records:** A licensee shall maintain a record for each child in a shelter care facility as prescribed in R6-5-7428 except the licensee need not:
1. Comply with R6-5-7441, except as otherwise provided in subsection (F) above; or
 2. Maintain treatment or clinical records and reports or progress monitoring notes as required by R6-5-7428(9) and (13).

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7469. Special Provisions and Exemptions for Outdoor Experience Programs

- A.** A licensee operating an outdoor experience program shall comply with the requirements in 6 A.A.C. 5, Article 74, except as otherwise provided in this Section.
- B.** An outdoor experience program shall not accept children younger than age 8.
- C.** An outdoor experience program is exempt from the requirements set forth in the following rules:
1. R6-5-7458. Buildings; Grounds; Water Supply;
 2. R6-5-7459. Building Interior;
 3. R6-5-7460. Kitchens; Food Preparation; and Dining Areas;
 4. R6-5-7461. Sleeping Areas and Furnishings;
 5. R6-5-7462. Bathrooms;
 6. R6-5-7463. Other Facility Space; Staff Quarters;
 7. R6-5-7464. Fire, Emergency, and Fire Prevention;
 8. R6-5-7465. General Safety;
 9. R6-5-7466. Swimming Areas;
 10. R6-5-7467. Access; Transportation; Outings; and
 11. R6-5-7468. Special Provisions for Shelter Care Facilities.
- D.** An outdoor experience program shall comply with the requirements in R6-5-7470 and R6-5-7471.
- E.** If there is a conflict between the requirements set forth in R6-5-7401 through R6-5-7468 and the requirements set forth in R6-5-7469 through R6-5-7471, the latter requirements govern.

Historical Note

Adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7470. Planning Requirements for Outdoor Experience Programs

- A.** Definitions. As used in this Section, the term "agency" means a licensee operating an outdoor experience program.
- B.** Trip itinerary. The agency shall develop a tentative day-to-day itinerary and a trip map for each trip prior to departure. One copy each of the itinerary and map shall be distributed as follows: to the agency for its office files; to the mobile program staff; when appropriate, to local authorities at each point on the itinerary before departure; to the child placing agency representative for each child who will be departing on the trip, and to the Department licensing representative. When major amendments to the itinerary are necessary due to unforeseen circumstances on the trip, written notification to the designated individuals shall be made. The itinerary shall reflect the following:
1. The travel schedule shall allow for daily periodic rest stops, relaxation, exercise, and personal time.
 2. The travel schedule shall not exceed five consecutive days without at least two full intervening non-traveling days, unless emergency conditions such as storms force travel to safer sites.
 3. The travel schedule shall specify the number of days of the trip, including departure and return dates and times, and mileage to be covered each day.
 4. The travel schedule shall specify the route, specific tentatively planned locations of overnight stops, and activities in which children will participate.
 5. The travel schedule shall specify the mode of transportation.
- C.** Trip plans. The agency shall develop written plans prior to the departure of each trip. These plans shall include:
1. The name, age, sex, address, and emergency phone number of each staff participant and of each child's parent or guardian and placing agency;

2. The exact location and access route for emergency rescue, search, fire, and medical assistance and law enforcement authorities at each program stop or location including the names, addresses, telephone numbers of other alternative means of communication with such authorities in case of an emergency. This information shall be included and identified on the trip map;
 3. Contingency plans to deal with medical problems, fire, natural disasters, lost children, and other emergencies;
 4. Plans for the care of any person who, for any reason, must be excluded from the program for a period of time;
 5. Provision for and storage within ready access of the program staff, documents which fully identify the group, its leadership, ownership of equipment, purpose, insurance coverage, home base, and which contain completed health history forms and emergency treatment release forms;
 6. Identification of appropriate sources or locations for water, food, doing laundry, bathing, liquid and solid waste, and garbage disposal;
 7. A scheduled progress and condition report system between the mobile program and the agency administrator;
 8. The maintenance by staff of a trip log which details each day's operation including travel time, mileage covered, and occurrences of the day;
 9. The safe storage for all supplies and equipment while in transit as well as at the campsites.
- D. Pre-departure procedures**
1. The appropriate permissions shall be secured, if possible prior to departure, for traveling on roads and properties, using sites, and building fires.
 2. Prior to departure, each child shall receive medical clearance from a physician in order to participate in the mobile portion of the program.
 3. Prior to departure, all children and staff shall receive instruction in the safe and proper use of all equipment to be used on the trip.
 4. Prior to departure, all children and staff shall be oriented as to safety regulations, emergency procedures, and transportation to emergency facilities or personnel, or both.
 5. Prior to departure, the route, activities and logistics shall be approved in writing by the agency administrator.
 6. An emergency liaison coordinator shall be appointed prior to departure. This coordinator or the coordinator's designee shall be available on a 24-hour basis. This person shall be located at the agency administrative office, and shall be at least 21 years of age and shall possess the following information about the program:
 - a. Names of individuals on the trip, including the staff member in charge;
 - b. Exact trip itinerary;
 - c. Number of days, including departure and return dates and times;
 - d. Rescue and evacuation plans and locations;
 - e. Pertinent medical information about program participants.
- B. Campsite location**
1. General. The agency shall conduct activities on sites appropriate for the children in terms of individual needs, program goals, and access to service facilities.
 2. Hazards
 - a. When selecting a campsite, the agency shall consider supervision of children, security, evacuation routes, animal hazards, and weather conditions, including the possibilities of lightning or flood.
 - b. A campsite shall be located on land that provides good drainage. A campsite shall not be located in a river bed or desert wash.
 - c. A campsite shall be free of debris, poisonous vegetation, and uncontrolled weeds or brush.
 - d. Children shall be warned and protected from hazardous areas such as traffic, cliffs, sinkholes, pits, falling rock or debris, abandoned excavations and poisonous vegetation. Hazardous areas shall be guarded or posted to reduce the possibility of accidents.
- C. Physical environment**
1. Sleeping shelters
 - a. All tents, teepees, or other sleeping shelters made of cloth shall be fire retardant or, if purchased after January 1985, shall be of the fiber-impregnated flame-retardant variety. Plastic sleeping enclosures of any type are prohibited.
 - b. Tents or other shelters used for sleeping areas shall be easily cleanable and in good repair, shall be structured and maintained in safe condition and shall afford adequate protection against inclement weather.
 - c. Tents or other types of temporary shelters shall provide sleeping space of not less than 15 square feet per person.
 - d. Campfires and open flames of any type are prohibited within 21 feet of any tent, teepee, or other sleeping shelter.
 - e. Smoking is prohibited within any sleeping shelter.
 - f. All sleeping shelters shall be posted with a permanent warning "No open flame in or near this shelter." This warning shall be on a sign or stenciled directly on the shelter.
 - g. Sleeping areas shall have direct exit access to the outside which is free of all obstruction or impediments to immediate use in the case of fire or other emergency.
 2. Sleeping equipment
 - a. Sleeping equipment shall be provided by the agency and shall be clean, comfortable, non-toxic and fire-retardant.
 - b. Sleeping equipment shall provide reasonable insulation from cold and dampness. In addition to sleeping bag or blankets, insulation from the ground such as with a waterproof ground cloth or air or foam mattress shall be provided. A waterproof sleeping bag is not satisfactory.
 - c. All sleeping equipment shall be laundered, dry cleaned, and otherwise sanitized between assignment to different children or staff. Bedding shall be aired at least once every five days and laundered, dry cleaned, and sanitized once every 30 days.
 - d. Each child shall have a place for personal own sleeping equipment, clothes, and personal belongings. Such items shall be labeled or marked as to which child is using or owns such items.

Historical Note

Renumbered from R6-5-7307 to R6-5-7470 and amended effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

R6-5-7471. Special Physical Environment and Safety Requirements for Outdoor Experience Programs

- A. Definition.** As used in this Section, the term "agency" means a licensee operating an outdoor experience program.

3. Outdoor toilet areas
 - a. The agency with outdoor toilet areas shall provide facilities which allow for individual privacy.
 - b. Toilet areas shall be constructed, located and maintained so as to prevent any nuisance or public health hazard. Facilities provided for excreta and liquid waste disposal shall be maintained and operated in a sanitary manner as prescribed by the Department of Health Services in A.A.C. R9-8-301 through R9-3-308, and the Department of Environmental Quality in 18 A.A.C. 8, Article 6.
 - c. Toilet areas which do not have plumbing shall be located at least 75 feet from but within 300 feet of any living or sleeping area, or both, and shall be located at least 100 feet from any lake, stream, or water supply.
 - d. Toilets, outhouses, or portable shacks shall be adequate in number based on one seat for every 10 children in care.
 - i. There shall be a minimum of two seats if there are more than five children.
 - ii. If the agency serves physically disabled children, toilet facilities shall provide one seat for every eight persons.
 - e. Toilet facilities shall be well ventilated, allow for air circulation, be screened and periodically treated to deter insects, and be in good repair. An adequate supply of toilet paper shall be provided.
 - f. Toilets, outhouses, and portable shacks shall be cleaned and disinfected at least daily. Portable shacks shall be dumped daily in an approved dump station.
 - g. Toilet seats shall be constructed of nonporous materials. Wood is not acceptable.
 - h. Handwashing facilities shall be adjacent to the toilet area and shall be separate and apart from sinks and areas used for food preparation or washing pots, pans, kitchen, and eating utensils. Individual soaps and hand-drying devices shall be available.
 4. Food preparation and serving
 - a. Menus. Menus shall be planned at least one week in advance and shall then be dated, posted, and kept on file for one year.
 - b. Food
 - i. All food and drink shall be stored to prevent spoilage. Only the foods which can be maintained in a wholesome condition with the equipment available shall be used.
 - ii. All milk and milk products utilized by the agency shall be obtained from sources approved by the State Department of Health Services.
 - iii. Only pasteurized milk and U.S. Government-inspected meat shall be served to the children. Powdered milk may only be used for cooking or when no refrigeration is available on a wilderness trip.
 - iv. Spoiled or contaminated foods shall not be used.
 - v. Raw fruits and vegetables shall be washed before use.
 - c. Preparation
 - i. All persons handling food shall wear clean outer garments and keep their hands and fingernails clean at all times while handling food, drink, utensils, or equipment.
 - ii. Smoking in the food preparation area is prohibited.
 - iii. Handwashing areas, including water, soap, and approved sanitary towels or other approved hand-drying devices, shall be provided adjacent to food preparation areas.
 - iv. Areas in which food and drink are stored, prepared or served, or in which utensils are washed, shall be rodent proof, rodent free, and rubbish free. They shall be cleaned after the serving of each meal. Any floors, walls, shelves, tables, utensils, and equipment in these areas shall be of such construction as to be easily cleaned, and shall be well lighted and ventilated.
 - v. All food preparation and service shall comply with applicable Department of Health Services food service rules in 9 A.A.C. 8, Article 1.
 - vi. No dish, receptacle, or utensil used in handling food for human consumption shall be used or kept for use if chipped, cracked, or broken.
 - vii. Prepared food shall be maintained at temperatures below 45° F or above 140° F; leftovers shall be reheated to 165° F.
 - d. Serving
 - i. Meal time shall be structured to make it a pleasant experience with sufficient time allowed for the children to eat at a reasonable, leisurely rate.
 - ii. Normal conversation shall be allowed and encouraged during meals.
 - e. Dish and utensil washing
 - i. Disposable or single-use dishes, utensils, receptacles or towels used in handling or preparing food shall be discarded after one use.
 - ii. Non-disposable food service dishes and utensils shall be cleaned and disinfected after each use in accordance with the following:
 - (1) A three-compartment sink or vat shall be used. Dishes and utensils shall be thoroughly scraped, washed with soap or detergent in hot water, kept clean, then rinsed free of detergents in clear water and then immersed for a period of at least two minutes in a warm or hot chlorine solution containing at no time less than 50 parts per million of available chlorine or such other solution as may be approved by the state or local health authority.
 - (2) Sinks shall be large enough to thoroughly immerse pots and pans.
 - (3) Dish towels shall not be used.
 - (4) Dishes and utensils shall be air dried. Drain boards shall be provided for draining dishes and utensils.
- D. Equipment
 1. Tools. Power tools, garden tools, and repair equipment shall be kept in a locked area and used by children only under adult supervision.
 2. Protective clothing/equipment. Appropriate protective clothing/equipment shall be provided to children by the agency, when children are participating in potentially hazardous activities.
 3. Program equipment
 - a. The agency shall use program equipment that is maintained in good repair, stored in such a manner as to safeguard the effectiveness of the equipment,

and is given a complete safety check periodically and immediately prior to each use. Equipment shall be discarded after a period of time designated by the manufacturer.

- b. The agency shall use program equipment appropriate to the age, size, and ability of each child in the activity.

E. Storage. The agency shall provide sufficient and appropriate storage facilities.

1. Toxic substances

- a. The agency shall have securely locked storage spaces for all harmful materials. The keys to such storage spaces shall be available only to authorized staff members.
- b. House and garden insecticides and other poisonous materials and all corrosive materials shall be kept in locked storage out of reach of children. Such storage shall not be in or near kitchen or food preparation or storage areas.
- c. The agency shall have only those poisonous or toxic materials needed to maintain the program.

2. Drugs

- a. A special cabinet shall be designated for medicine only. The medicine cabinet shall be kept locked and periodically cleaned. All outdated medications and those prescribed for past illnesses or for children discharged from the agency shall be destroyed.
- b. All prescription medicines, drugs, etc., requiring refrigeration shall be marked with the required temperature range and stored in a refrigerator with a thermometer separate from food items and maintained under temperature ranges recommended by the manufacturer.

3. Flammable materials. Flammable liquids and gases shall be stored in metal containers only. The storage area must be separated from the rest of the living/program area.

4. Food

- a. All food and drink shall be stored so as to be protected from dust, flies, vermin, rodents, and other contamination. No live animals shall be allowed in any area in which food or drink is stored.
- b. Food and nontoxic cleaning supplies must be stored separately. Clean dishes and utensils shall be stored on properly covered shelves or in containers which are cleaned once a week with a chlorine solution (1 tablespoon of bleach to one gallon of water or an acceptable equivalent).
- c. All perishable food items shall be kept refrigerated except during the time of preparation and service.
- d. The temperature of refrigerated food must be maintained within a range from 38°F to 45°F.
- e. A thermometer shall be located in each refrigerator, including ice boxes and ice chests, as well as electric or gas refrigerators. Where ice and ice boxes or chests are used, adequate ice shall be provided, meats and other highly perishable foods shall not be stored over 24 hours and ice chests shall be drained to prevent accumulation of water from melted ice.

F. Water

- 1. Approved source. The agency must have a sufficient water supply which is potable and from an approved source or purified for drinking, brushing teeth, and cooking.
- 2. Water purification. Water purification tablets or other means of disinfecting water shall be available at all times. The agency shall have a written policy on effective purifi-

cation methods to be employed according to the water sources utilized and possible types of contamination.

- 3. Bathing. Warm water facilities shall be planned for and available for each child to bathe at least once a week.

- 4. Washing and laundering. Personal washing and laundering is not permitted in any body of water. Water used for these purposes shall be taken in a container from the lake, river or pond, and after use, shall be dumped on land at least 50 yards from the water source.

5. Drinking water

- a. Cool, potable drinking water shall be available for all children at all times.
- b. The use of a common drinking utensil is prohibited.

G. Sanitation

1. Health and Environmental requirements

- a. The disposal of sewage, garbage, and other wastes shall be done in accordance with local health and applicable state requirements, as provided in 18 A.A.C. 8, Article 6 and 18 A.A.C. 9, Article 8.
- b. The agency shall obtain sanitation inspections of mobile kitchens or mobile toilet facilities, or both, prior to each trip by state or county authorities. Written reports of the sanitary inspections shall be kept on file at the agency. The agency shall meet all local, state, and federal health rules and regulations.

2. Garbage and rubbish

- a. Garbage and rubbish shall be stored securely in durable, noncombustible, leakproof, non-absorbent containers covered with tight-fitting lids. Such containers shall be provided with a waterproof liner or thoroughly cleaned after each emptying.
- b. Garbage and rubbish storage shall be separate from living/sleeping areas.
- c. Garbage, rubbish and other solid wastes shall be disposed of twice weekly at an approved sanitary landfill or similar disposal facility. In areas where no facilities are immediately available, solid wastes shall be packed out or disposed of in a manner in accordance with the regulations governing the area.

3. Sewage and wastes

- a. Sewage and other liquid wastes shall be disposed of in a public sewage system or, in the absence thereof, in a manner approved by the local health authority.
- b. Where possible, adequate and safe sewage facilities with flush toilets shall be provided.

- 4. Insects and rodents. Methods utilized in control of insects and rodents shall be used in a safe, cautious manner to avoid poisonous or toxic contamination to human beings.

H. Safety

1. Emergency procedures

- a. The agency shall have and follow written procedures for staff and children in case of emergency. These procedures shall be developed with the assistance of qualified fire, safety, and rescue personnel and shall include provisions for the evacuation of all program areas and assignment of staff.
- b. The agency shall train staff and children to report fires and other emergencies appropriately. Children and staff shall be trained in fire prevention.
- c. The agency shall conduct emergency drills which shall include actual evacuation of children to safe areas at least monthly. The agency shall provide training for personnel on all shifts in performing assigned tasks during emergencies and making personnel familiar with the use of agency fire-fighting equipment.

- i. Emergency drills shall be held at unexpected times and under varying conditions to simulate the possible conditions of fire or other disasters.
 - ii. All persons in the program area shall participate in emergency drills.
 - iii. A record of such emergency drills shall be maintained.
 - iv. The agency shall make special provisions for the evacuation of any physically handicapped children in the program.
 - v. The agency shall help emotionally disturbed or perceptually handicapped children understand the nature of such drills.
2. General program safety
 - a. The agency shall have written operating procedures, safety regulations, and emergency procedures for special program activities in which children participate, including aquatics, diving, lifesaving, instructional swimming, recreational swimming, water skiing, skin diving, scuba diving, boating, canoeing, rowing, sailing, crafts, bicycling, farming, horse-back riding, mountaineering, rock climbing, rappelling, caving, outdoor living skills, physical fitness, snow and ice activities, archery, gymnastics, riflery, contact sports, backpacking, expedition travel, and animal handling.
 - b. The agency shall provide the written operating procedures, safety regulations, and emergency procedures to the Department licensing staff for review and approval.
 - c. All children and staff shall receive instruction in the safe and proper use of all equipment and animals to be used by the program.
 - d. All children and staff shall be oriented as to safety regulations, emergency procedures and transportation to emergency facilities and/or personnel.
 3. Electrical
 - a. Electrical wiring and electrical appliances shall be installed in accordance with the Arizona State Fire Code at A.A.C. R4-36-201.
 - b. Electrical wires extending over activity areas shall be fully insulated and located at least 12 feet above the activity area.
 - c. All exposed wiring shall be fully insulated.
 4. Gas appliances
 - a. The installation of gas appliances for lighting, cooking, space heating, and water heating shall conform to state and local codes. Where no code applies, the provisions of A.R.S. §§ 36-1621 through 36-1626, together with the standards for the installation of gas appliances and gas piping, shall be followed.
 - b. All unused gas outlets shall have the valves removed and shall be capped off with a standard pipe cap.
 - c. Gasoline shall not be used for lighting, cooking, or heating.
 5. Fire safety equipment
 - a. Portable fire extinguishers shall be available and maintained for emergency fire protection. The number and type shall depend on the area to be protected.
 - b. All fire extinguishers shall be inspected at least monthly by staff members for proper location and to determine whether they are accessible, fully charged, and operable.
 - c. All fire extinguishers shall be inspected by an authorized fire extinguisher company at least once a year from the date of last charge and recharged immediately after use, or as otherwise necessary, showing the date of charging and the agency or company performing the work.
 - d. A dependable method of sounding a fire alarm shall be maintained in every agency area where children are located.
 - e. A written fire evacuation plan shall be posted.
- I. Water safety
 1. Water activities supervision
 - a. A water activities program operated by the agency shall at all times be under the immediate supervision of a person holding current certification as a Red Cross Water Safety Instructor, a YMCA Instructor in swimming and life saving, or an Aquatic Instructor Boy Scouts of America. A water-activities program includes recreational and instructional swimming in a pool, on a beach, or other approved water areas, rowing, canoeing, sailing, boating, water skiing, snorkeling and scuba diving.
 - b. The water activities supervisor shall provide pre-service training programs for participating children, supervise qualified lifeguards for water activities and maintain water activities equipment in safe working order.
 - c. There shall be a minimum of one guard currently certified in Red Cross Advanced Lifesaving, YMCA Lifesaving, or a Lifeguard Boy Scouts of America on duty for each 25 persons in or on the water, and in addition one staff member directly watching every 10 or less persons in or on the water.
 2. Swimming procedures
 - a. American Red Cross, YMCA, or Boy Scouts of America tests shall be used to determine each child's swimming ability. Children shall be confined to an area equal to the limits of their swimming skills or an area requiring lesser skills for which they have been classified.
 - b. A method of supervising and checking bathers shall be established and enforced. The system used shall be supervised during swimming periods by a member of the aquatics staff and checks shall be conducted not less than every 10 minutes. A written "lost swimmer" plan shall be established and all staff shall know exactly what their duties are in case of an emergency.
 - c. Children shall swim only in areas designated by the water activities supervisor as safe.
 - d. Swimming is prohibited during the hours of darkness except in lighted pools.
 3. Swimming areas
 - a. A swimming area shall be maintained in a clean and safe condition, free from holes, sharp edges, and hidden dangers. The agency shall post notice of any known hazard in the vicinity and shall properly safeguard children.
 - b. The swimming area shall have a delineation of areas for non-swimmers, intermediates, and swimmers in accordance with the standards of the American Red Cross, YMCA, Boy Scouts of America.
 - c. Lifesaving equipment shall be provided at a swimming area and placed so it is immediately available in case of an emergency. The equipment shall be

- kept in good working order and include a bell or whistle, two assist poles, and a ring buoy.
- d. The water of a natural swimming area shall be free from contamination by garbage, refuse, sewage pollution, or foreign material.
4. Watercraft and water-skiing
 - a. Any watercraft activities shall be conducted during daylight hours and supervised by the aquatics program instructor. A U.S. Coast Guard-approved life preserver shall be provided for each occupant of a watercraft. A non-swimmer shall wear a vest-type Coast Guard-approved life preserver and not be permitted in a watercraft unless accompanied by a staff member. A child shall wear a vest-type Coast Guard-approved life preserver before entering and while in white water or on a lake when the water is rough or while water-skiing.
 - b. During a watercraft activity period, a lifeguard shall patrol the watercraft area in a lifeboat. A watercraft docking area shall not be in the swimming area.
 - c. The swimming area shall not be used for the launching or stopping of water-skiers.
 - d. The agency which requires or permits children to use watercraft shall have special coverage for such activities included in the agency's liability insurance.
- J. Communications.** The agency shall have a plan for emergency communication and communication equipment available with each mobile program unit, which may include:
1. Telephone in camp units and outposts;
 2. Two-way radio or walkie-talkie;
 3. Knowledge of phone or radio locations on backpack, horseback, canoe or car trips, such as Ranger stations in remote areas;
 4. Simple code by flag, smoke, or mirror or other means if planned in advance.
- K. Transportation**
1. Vehicles
 - a. The agency shall provide or arrange transportation necessary for implementing the child's service plan.
 - b. Vehicles used in transporting children in care of the agency shall be licensed and inspected in accordance with Arizona state law.
 - c. Vehicles used for the transportation of children shall be maintained in a safe condition and be equipped in a fashion appropriate for the season.
 - d. The agency shall maintain written evidence that all vehicles owned, leased, borrowed, or rented by the agency to transport children are serviced regularly and maintained safely.
 - e. Vehicles used for the transportation of children shall be equipped with a first-aid kit and emergency accessories including tools, a fire extinguisher and flares or reflectors.
 - f. The agency shall not allow the number of persons in any vehicle used to transport children to exceed the number of available seats in the vehicle.
 - g. The agency shall not transport children in open truck beds or in trailers.
 - h. The agency shall ensure that any vehicle used to transport children has the following minimum amounts of liability insurance:
Injury per person: \$300,000
Injury per accident: \$1,000,000
2. Drivers
 - a. Any person transporting children in care of the agency shall be licensed to operate that class of vehicle according to Arizona state law.
 - b. The agency shall provide adequate supervision in any vehicle used by the agency to transport children in care.
 - c. The agency shall ascertain the nature of any need or problem of a child which might cause difficulties during transportation, such as seizures, a tendency towards motion sickness, or a disability. The agency shall communicate such information to the operator of any vehicle transporting children in care.
 3. Transportation of nonambulatory children. The following additional arrangements are required for agencies serving handicapped, nonambulatory children.
 - a. A ramp device to permit entry and exit of a child from the vehicle must be provided for all vehicles except automobiles used to transport physically handicapped children. A hydraulic lift may be utilized provided that a ramp is also available in case of emergency.
 - b. In all land vehicles except automobiles, wheelchairs shall be securely fastened to the floor.
 - c. In all land vehicles except automobiles, the arrangement of the wheelchairs shall provide an adequate aisle space and shall not impede access to the exit door of the vehicle.
 4. Emergency transportation
 - a. The agency shall have means of transporting children in cases of emergency.
 - b. The agency shall have a written plan for transportation of injured persons to emergency medical services.
- L. Animals**
1. Safety. The agency shall be responsible for the care and behavior of pets or any animals allowed or used in the program. Animals shall have had necessary rabies shots.
 2. Insurance. The agency which requires or permits children to ride horses or other domesticated animals shall have specific coverage for such activities included in the agency's liability insurance.
 3. Sanitation. A temporary, shelter, corral, tie-rail, or hitching post shall be located beyond 50 feet of an area where food is prepared, cooked, or served. Fly repellents and daily removal of manure shall be used to prevent such a location from becoming an attraction for or breeding place for flies.

Historical Note

Renumbered from R6-5-7308 and amended effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

APPENDIX 1**FACTOR****INDICIA OF A
BEHAVIORAL HEALTH
AGENCY****INDICIA OF A
CHILD WELFARE
AGENCY**

1. Primary purpose

To provide mental health

To provide a safe &

Department of Economic Security – Social Services

	treatment	healthy living environment
2. Accreditation	JCAHO; COA; CARF	COA; Never JCAHO for this specific facility seeking licensure
3. Nursing Services	Integrated into services	Occasional use
4. On-campus educational services	Primarily seriously emotionally disturbed (SED); occasional regular education	Primarily regular education & learning disabilities; occasional SED
5. Population served	Described as psychiatrically disordered; seriously emotionally disturbed; psychologically disturbed	Described as behavior disordered, delinquent, dependent, neglected, undersocialized
6. Self-description	Behavioral Health Program Psychiatric Facility Psychosocial orientation	Child Welfare Agency; Social Services Agency;
Educational		orientation; Re-education
7. Primary source of referrals	Psychologists; psychiatrists; Insurance companies; CHAMPUS; RBHA's	DES; Juvenile courts; Juvenile Corrections; RBHA's as transition or with wrap-around
8. Counseling, psychological, psychiatric services	Routinely provided to all clients	Provided only on an "as-needed" basis
9. Location of behavioral health services	Within the program	Usually in office of contracted practitioner
10. Behavioral health practitioners	Employees or contractors	Usually contracted services; may be contractor from another program or agency
11. Case work services	Social workers, if any, are only part of professional staff	Social workers are primary part of professional staff
12. Staff titles; direct care workers	Behavioral health technicians; psychiatric technicians; psychiatric nurses	House parents; child care workers; teaching parents

Historical Note

Appendix 1 adopted effective July 1, 1997; filed with the Secretary of State's Office May 15, 1997 (Supp. 97-2).

ARTICLE 75. APPEAL AND HEARING PROCEDURES FOR ADVERSE ACTION AGAINST FAMILY FOSTER HOMES, ADOPTION AGENCIES, FAMILY CHILD CARE HOME PROVIDERS, AND PERSONS LISTED ON THE CHILD CARE RESOURCE AND REFERRAL SYSTEM

R6-5-7501. Definitions

The following definitions apply in this Article.

1. "Adverse action" means:
 - a. Denial, suspension, or revocation of a child care provider's certification, an adoption agency license, or a foster home license; and
 - b. Exclusion from the child care resource and referral system described in A.R.S. § 41-1967.
2. "Administration" means the Department organizational unit responsible for taking adverse action which is the subject of an appeal. "Administration" includes the Division of Children, Youth, and Families and the Child Care Administration.
3. "Adoption agency" has the meaning ascribed to "agency" in A.R.S. § 8-101(2).
4. "Appeals Board" means the Department's independent, quasi-judicial, administrative appellate body, established under A.R.S. § 23-672, and authorized to review adminis-

trative decisions issued by hearing officers as prescribed in A.R.S. § 41-1992(D).

5. “Appellant” means a person who seeks a hearing with the Office of Appeals to challenge adverse action taken by the Department.
6. “Child Care Administration” means the administrative unit within the Department which is responsible for certification and supervision of family child care home providers and administration of the Child Care Resource and Referral System.
7. “Child Care Resource and Referral System,” which is sometimes referred to as “CCR&R,” means the child care provider information system which the Department administers under A.R.S. § 41-1967.
8. “Department” means the Arizona Department of Economic Security.
9. “Division of Children, Youth, and Families” means the administrative unit in the Department responsible for licensing foster homes and adoption agencies.
10. “Family child care home provider” has the meaning prescribed in R6-5-5201(29).
11. “Foster parent” has the meaning prescribed in A.R.S. § 8-501(A)(5).
12. “Hearing officer” means an individual appointed by the Department Director under A.R.S. § 41-1992(A) to conduct hearings when an appellant challenges adverse action.
13. “Licensee” means a person:
 - a. Applying for a license as, or currently licensed as, a foster parent or an adoption agency;
 - b. Applying for certification as, or certified as, a family child care home provider; or
 - c. Listed on the Child Care Resource and Referral System.
14. “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).
15. “Person” means a natural person, partnership, joint venture, company, corporation, firm, association, society, or institution.

Historical Note

Adopted effective June 4, 1998 (Supp. 98-2).

R6-5-7502. Entitlement to a Hearing; Appealable Action

- A. A licensee who disputes adverse action may obtain an administrative hearing to challenge the action as provided in this Article.
- B. The following actions are not appealable:
 1. An adverse action resulting from a uniform change in federal or state law, unless the Department has misapplied the law to the person seeking the hearing;
 2. Failure to clear a fingerprint check or criminal history check;
 3. Imposition of noncompliance status as prescribed in R6-5-7035;
 4. Imposition of a corrective action plan as prescribed in R6-5-5818;
 5. Removal of a child from a placement;
 6. Failure to enter into a contract with a particular licensee or to place a child with a particular licensee; and
 7. Imposition of a provisional license as prescribed in A.R.S. § 8-509(D).
- C. Findings made in a Child Protective Services (“CPS”) investigation are not appealable under this Article. A person may

appeal findings made in a CPS investigation of a licensee as prescribed in A.R.S. § 8-546.12.

Historical Note

Adopted effective June 4, 1998 (Supp. 98-2).

R6-5-7503. 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.

Historical Note

Adopted effective June 4, 1998 (Supp. 98-2).

R6-5-7504. Request for Hearing: Form; Time Limits; Presumptions

- A. Except as otherwise provided in R6-5-5010(A) and R6-5-5227, a person who wishes to appeal an adverse action shall file a written request for hearing with the Administration within 20 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.
- B. An appellant shall include the following information in the request for hearing:
 1. Name, address, and telephone number, and, if applicable, telefacsimile number of the person subject to the adverse action;
 2. Identification of the Administration initiating the adverse action;
 3. A description of the adverse action which is the subject of the appeal;
 4. The date of the notice of adverse action; and
 5. A statement explaining why the adverse action is unauthorized, unlawful, or an abuse of discretion.
- 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 and the issue on appeal.
- D. A request for hearing is deemed filed:
 1. On the mailing date, as shown by the postmark, if sent first-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 R6-5-7518.

Historical Note

Adopted effective June 4, 1998 (Supp. 98-2).

R6-5-7505. Administration: Transmittal of Appeal

An Administration that receives a request for appeal shall send the Office of Appeals a copy of the request and the adverse action notice within two work days of receipt of the request.

Historical Note

Adopted effective June 4, 1998 (Supp. 98-2).

R6-5-7506. Stay of Adverse Action Pending Appeal

- A.** The Department shall not carry out the adverse action until the time for appeal has run, except as otherwise provided in subsection (C), and in the following circumstances:

1. The appellant expressly waives the delay of action; or
2. The appellant
 - a. Is subject to the same adverse action for reasons other than those that are the subject of the current adverse action notice, and
 - b. Received notice of and failed to timely appeal the adverse action being imposed for reasons other than those that are the subject of the current notice.

- B.** If an appellant timely appeals an adverse action as provided in R6-5-7504, the Department shall not carry out the adverse action until a hearing officer issues a decision affirming the adverse action, except as otherwise provided in subsection (C), and in the following circumstances:

1. The appellant expressly waives the delay of action;
2. The appellant
 - a. Is subject to the same adverse action for reasons other than those that are the subject of the current adverse action notice; and
 - b. Received notice of and failed to timely appeal the adverse action being imposed for reasons other than those that are the subject of the current notice;
3. The appeal challenges an action that is not appealable according to R6-5-7502(B);
4. The appellant withdraws the request for hearing; or
5. The appellant fails to appear for the hearing.

- C.** The Department may summarily suspend a license, a certificate, or registration on the CCR & R, as provided in A.R.S. § 41-1064(C).

Historical Note

Adopted effective June 4, 1998 (Supp. 98-2).

R6-5-7507. 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 to appear telephonically.

- B.** Unless the parties stipulate to another hearing date, the Office of Appeals shall schedule the hearing as follows:

1. For appeals of adverse action against a foster parent, within 10 days of the date the Department receives the appellant's request for hearing, as required by A.R.S. § 8-506; and
2. For all other appeals, 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, except where the hearing is scheduled within the 10-day period specified in subsection (B)(1). For hearings scheduled

within the 10-day period, the Office of Appeals shall notify the parties telephonically and send written notice at the earliest date practicable.

- 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 R6-5-7511; and
5. A general statement of the hearing procedures.

Historical Note

Adopted effective June 4, 1998 (Supp. 98-2).

R6-5-7508. Rescheduling the Hearing

- A.** An appellant 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. Which did not arise until after the five-day period; and
3. Which could not reasonably have been anticipated.

- C.** When the Office of Appeals reschedules a hearing under this Section or R6-5-7514, the Office of Appeals shall notify all interested parties, in writing, prior to the hearing. The 20-day notice requirement in R6-5-7507(C) does not apply to rescheduled hearings.

Historical Note

Adopted effective June 4, 1998 (Supp. 98-2).

R6-5-7509. 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 irrelevant evidence from the record;
5. Request, receive, and incorporate into the record, relevant evidence;
6. Upon compliance with the requirements of R6-5-7511, 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; and

- e. Exclude non-party witnesses from the hearing room; and
- 11. Issue a written decision resolving the appeal.

Historical Note

Adopted effective June 4, 1998 (Supp. 98-2).

R6-5-7510. 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 as provided in subsection (D), a party may request only one change of hearing officer.
- D. 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.
- E. A party who brings a challenge for cause shall file a request as provided in subsection (A) and send a copy of the request to all other parties. The request shall explain the reason why the assigned hearing officer is not impartial or disinterested.
- F. 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.
- G. 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 (C), or
 - 2. A hearing officer is removed for cause as provided in subsections (D) through (F).
- H. The Office of Appeals shall send the parties written notice of the new hearing officer assignment.

Historical Note

Adopted effective June 4, 1998 (Supp. 98-2).

R6-5-7511. 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 R6-5-7512(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.
- 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, and the name and address of the person in possession of the item; and

- 5. 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 certified mail, return receipt requested, except that the Office of Appeals may serve subpoenas to state employees who are appearing in the course of their state employment, by regular mail, hand-delivery, or state courier service.

Historical Note

Adopted effective June 4, 1998 (Supp. 98-2).

R6-5-7512. 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 R6-5-7510;
- 4. The right to request subpoenas for witnesses and evidence as provided in R6-5-7511;
- 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(a);
- 6. The right to present evidence and to cross-examine witnesses; and
- 7. The right to further appeal, as provided in R6-5-7518 and R6-5-7520, if dissatisfied with an Office of Appeals' decision.

Historical Note

Adopted effective June 4, 1998 (Supp. 98-2).

R6-5-7513. Withdrawal of an Appeal

- A. An appellant may withdraw an appeal at any time prior to the scheduled hearing by signing a written statement expressing the intent to withdraw. The Department shall make a withdrawal form available for this purpose. An appellant may also orally withdraw an appeal on the open record.
- B. Upon receipt of a withdrawal request signed by the appellant or the appellant's representative, or a statement of withdrawal made on the record, the Office of Appeals shall dismiss the appeal.

Historical Note

Adopted effective June 4, 1998 (Supp. 98-2).

R6-5-7514. 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.
- D. The hearing officer may decide the issue of good cause on the available record or may set the matter for briefing or for hearing.
- 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 R6-5-7508(C).
- F. Good cause exists where 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).

Historical Note

Adopted effective June 4, 1998 (Supp. 98-2).

R6-5-7515. 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 tape record all hearings or record the hearing by other stenographic means. 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.
- 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. Unless the hearing officer allows a longer period of time, a statement shall not exceed three minutes.
- 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 and shall exclude any irrelevant evidence.
- 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.

Historical Note

Adopted effective June 4, 1998 (Supp. 98-2).

R6-5-7516. 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 ren-

der 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.

Historical Note

Adopted effective June 4, 1998 (Supp. 98-2).

R6-5-7517. Effect of the Decision

- A. If the hearing officer affirms the adverse action against the appellant, the adverse action is effective on the mailing date of the hearing officer's decision. 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 unless and until the Appeals Board or Arizona Court of Appeals issues a decision affirming the adverse action.

Historical Note

Adopted effective June 4, 1998 (Supp. 98-2).

R6-5-7518. 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.
- 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 Office of Appeals shall have the proceedings of the hearing below transcribed for the Appeals Board.

Historical Note

Adopted effective June 4, 1998 (Supp. 98-2).

R6-5-7519. 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.

Historical Note

Adopted effective June 4, 1998 (Supp. 98-2).

R6-5-7520. Judicial Review

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

Historical Note

Adopted effective June 4, 1998 (Supp. 98-2).

ARTICLE 76. REPEALED

R6-5-7601. Repealed

Historical Note

Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7602. Repealed

Historical Note

Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7603. Repealed

Historical Note

Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7604. Repealed

Historical Note

Adopted effective September 16, 1976 (Supp. 76-4).

R6-5-7605. Repealed

Historical Note

Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7606. Repealed

Historical Note

Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7607. Repealed

Historical Note

Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7608. Repealed

Historical Note

Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7609. Repealed

Historical Note

Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7610. Repealed

Historical Note

Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7611. Repealed

Historical Note

Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7612. Repealed

Historical Note

Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7613. Repealed

Historical Note

Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7614. Repealed

Historical Note

Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7615. Repealed

Historical Note

Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7616. Repealed

Historical Note

Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7617. Repealed

Historical Note

Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7618. Repealed

Historical Note

Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7619. Repealed

Historical Note

Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7620. Repealed

Historical Note

Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7621. Repealed

Historical Note

Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7622. Repealed

Historical Note

Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7623. Repealed

Historical Note

Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7624. Repealed

Historical Note

Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7625. Repealed**Historical Note**

Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7626. Repealed**Historical Note**

Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7627. Repealed**Historical Note**

Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7628. Repealed**Historical Note**

Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7629. Repealed**Historical Note**

Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7630. Repealed**Historical Note**

Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7631. Repealed**Historical Note**

Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7632. Repealed**Historical Note**

Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7633. Repealed**Historical Note**

Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7634. Repealed**Historical Note**

Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7635. Repealed**Historical Note**

Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7636. Repealed**Historical Note**

Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7637. Repealed**Historical Note**

Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7638. Repealed**Historical Note**

Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-7639. Repealed**Historical Note**

Adopted effective September 16, 1976 (Supp. 76-4).
Repealed effective December 17, 1993 (Supp. 93-4).

ARTICLE 77. REPEALED

Former Article 77 consisting of Sections R6-5-7701 through R6-5-7704 repealed effective November 8, 1982.

ARTICLE 78. REPEALED

Former Article 78 consisting of Sections R6-5-7801 through R6-5-7804 repealed effective November 8, 1982.

ARTICLE 79. REPEALED

Former Article 79 consisting of Sections R6-5-7901 through R6-5-7913 repealed effective November 8, 1982.

ARTICLE 80. INTERSTATE COMPACT ON THE PLACEMENT OF CHILDREN**R6-5-8001. Goals**

Interstate services to children are provided to:

1. Achieve or maintain self-sufficiency including reduction or prevention of dependency.
2. Prevent or remedy abuse, neglect or exploitation of children, or preserve, rehabilitate or reunite families.
3. Prevent or reduce inappropriate institutional care.
4. Secure appropriate institutional care.

Historical Note

Adopted effective September 16, 1976 (Supp. 76-4).

R6-5-8002. Objectives

Purpose of the Interstate Compact on the Placement of Children is to:

1. Promote cooperation of the member states in the interstate placement of children.
2. Establish procedures for the placement of children between member states.
3. Assure that the jurisdictional arrangements are made for the care of children who are placed across state lines.
4. Allocate legal and administrative responsibility during the period of an interstate placement.

Historical Note

Adopted effective September 16, 1976 (Supp. 76-4).

R6-5-8003. Authority

A.R.S. §§ 8-503(6) and 8-548 through 8-548.06.

Historical Note

Adopted effective September 16, 1976 (Supp. 76-4).

R6-5-8004. Definitions

- A. "Child." Any person under the age of 18.
- B. "Compact." The Interstate Compact on the Placement of Children.
- C. "Compact administrator." The Department employee who shall be general coordinator of activities under the compact in the state's jurisdiction and who, acting jointly with like officers of other party jurisdictions, shall have power to promulgate rules and regulations to carry out more effectively the terms and provisions of the compact.
- D. "Compact state." A state which is a member of the Interstate Compact on the Placement of Children.

- E. "Department." The Arizona State Department of Economic Security.
- F. "Interstate placement." Any movement of a child from one state to another state for the purpose of establishing a suitable living environment and providing necessary care.
- G. "Intra-state placement." The placement of a child within the state by an agency of that state.
- H. "Placement." The arrangement for the care of a child in a foster home, relative home or adoptive home or in a child-caring agency or institution but does not include any institution caring for the mentally ill, mentally defective or epileptic, or any institution primarily educational in character or any hospital or other medical facility.
- I. "Receiving state." The state to which a child is sent, brought or caused to be sent or brought, whether by public authorities or private person or agencies and whether for placement with state or local public authorities or for placement with private agencies or persons.
- J. "Sending agency"
 - 1. A compact member state, officer or employee thereof,
 - 2. A subdivision of a member state, officer or employee thereof,
 - 3. A court of a member state, or,
 - 4. A person, corporation, association, charitable agency or other entity which sends, brings or causes to be sent or brought any child to another member state.

Historical Note

Adopted effective September 16, 1976 (Supp. 76-4).

R6-5-8005. Placement Agreement

- A. Prior to sending, bringing or causing any child to be sent or brought into a receiving state for placement in foster care or as a preliminary to a possible adoption, the sending agency shall furnish the appropriate public authorities in the receiving state written notice of the intention to send, bring, or place the child in the receiving state.
- B. No person, court or public or private agency in a compact shall place a child in another compact state until the Compact Administrator in the receiving state has notified the Compact Administrator in the sending state on a prescribed form that such placement does not appear to be contrary to the interests of the child and does not violate any applicable laws of the receiving state.

Historical Note

Adopted effective September 16, 1976 (Supp. 76-4).

R6-5-8006. Financial Responsibility

The sending person, court or public or private agency shall be held financially responsible for:

- 1. Sending the child to the receiving state.
- 2. Returning the child if such should be required by the receiving state.
- 3. Support, care, maintenance and treatment of the child during the period of placement.

Historical Note

Adopted effective September 16, 1976 (Supp. 76-4).

R6-5-8007. Eligibility

- A. Interstate Compact statute applies:
 - 1. To the placement of children in another compact state by an agency, court or person which has care or custody of the children.
 - 2. To the placement of foreign-born children who are brought under the jurisdiction of a compact state by an international child placing agency.

- B. Interstate Compact statute does not apply:
 - 1. When a child is sent or brought into a receiving state by his parent, stepparent, grandparent, adult brother or sister, adult uncle or aunt, or his guardian and is left with any such relative or non-agency guardian in the receiving state.
 - 2. When a child is placed in an institution caring for the mentally ill, mentally defective or epileptic or in any institution primarily educational in character or in any hospital or other medical facility.
 - 3. When a child is placed in a receiving state under the provisions of any other interstate compact to which both the sending and the receiving states are parties or any other agreement between the states which has the force of law.
 - 4. To the placement of children into and out of the United States when the other jurisdiction involved is a foreign country.

Historical Note

Adopted effective September 16, 1976 (Supp. 76-4).

R6-5-8008. Placement Approval

Approval must be obtained from the Compact Administrators in both the sending and receiving states prior to the placement of a child in another compact member state.

Historical Note

Adopted effective September 16, 1976 (Supp. 76-4).

R6-5-8009. Case Management

- A. Records and reports. Records shall be established and maintained and reports shall be submitted as prescribed by the Department.
- B. Confidentiality. The rules and regulations of the Department for securing and using confidential information concerning the client will be followed. Refer to Title 6, Chapter 5, Article 23 (Safeguarding of Records and Information).
- C. Civil rights. Refer to Title 6, Chapter 5, Article 26 (Civil Rights).

Historical Note

Adopted effective September 16, 1976 (Supp. 76-4).

R6-5-8010. Terminating the Service

The sending agency shall retain jurisdiction over a child placed in another state until responsibility for the child is discharged with the concurrence of the authority in the receiving state.

Historical Note

Adopted effective September 16, 1976 (Supp. 76-4).

ARTICLE 81. REPEALED

Former Article 81 consisting of Sections R6-5-8101 through R6-5-8104 repealed effective November 8, 1982.

ARTICLE 82. REPEALED

Former Article 82 consisting of Sections R6-5-8201 through R6-5-8204 repealed effective November 8, 1982.

ARTICLE 83. REPEALED**R6-5-8301. Repealed****Historical Note**

Adopted effective January 18, 1977 (Supp. 77-1).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-8302. Repealed**Historical Note**

Adopted effective January 18, 1977 (Supp. 77-1).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-8303. Repealed**Historical Note**

Adopted effective January 18, 1977 (Supp. 77-1).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-8304. Repealed**Historical Note**

Adopted effective January 18, 1977 (Supp. 77-1).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-8305. Repealed**Historical Note**

Adopted effective January 18, 1977 (Supp. 77-1).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-8306. Repealed**Historical Note**

Adopted effective January 18, 1977 (Supp. 77-1).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-35-8307. Repealed**Historical Note**

Adopted effective January 18, 1977 (Supp. 77-1).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-8308. Repealed**Historical Note**

Adopted effective January 18, 1977 (Supp. 77-1).
Repealed effective December 17, 1993 (Supp. 93-4).

ARTICLE 84. REPEALED

Former Article 84 consisting of Sections R6-5-8401 through R6-5-8404 repealed effective November 8, 1982.

ARTICLE 85. REPEALED

Former Article 85 consisting of Sections R6-5-8501 through R6-5-8508 repealed effective November 8, 1982.

ARTICLE 86. REPEALED**R6-5-8601. Repealed****Historical Note**

Adopted effective February 24, 1977 (Supp. 77-1). Former Section R6-5-8601 repealed, new Section R6-5-8601 adopted effective March 8, 1979 (Supp. 79-2). Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-8602. Repealed**Historical Note**

Adopted effective February 24, 1977 (Supp. 77-1). Former Section R6-5-8602 repealed, new Section R6-5-8602 adopted effective March 8, 1979 (Supp. 79-2). Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-8603. Repealed**Historical Note**

Adopted effective February 24, 1977 (Supp. 77-1). Former Section R6-5-8603 repealed, new Section R6-5-8603 adopted effective March 8, 1979 (Supp. 79-2). Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-8604. Repealed**Historical Note**

Adopted effective February 24, 1977 (Supp. 77-1). Former Section R6-5-8604 repealed, new Section R6-5-8604

adopted effective March 8, 1979 (Supp. 79-2). Repealed effective December 17, 1993 (Supp. 93-4).

ARTICLE 87. REPEALED**R6-5-8701. Repealed****Historical Note**

Adopted effective March 9, 1979 (Supp. 79-2). Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-8702. Repealed**Historical Note**

Adopted effective March 9, 1979 (Supp. 79-2). Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-8703. Repealed**Historical Note**

Adopted effective March 9, 1979 (Supp. 79-2). Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-8704. Repealed**Historical Note**

Adopted effective March 9, 1979 (Supp. 79-2). Repealed effective December 17, 1993 (Supp. 93-4).

ARTICLE 88. REPEALED

Former Article 88 consisting of Sections R6-5-8801 through R6-5-8804 repealed effective November 8, 1982.

ARTICLE 89. RESERVED**ARTICLE 90. RESERVED****ARTICLE 91. REPEALED****R6-5-9101. Repealed****Historical Note**

Adopted effective March 12, 1979 (Supp. 79-2).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-9102. Repealed**Historical Note**

Adopted effective March 12, 1979 (Supp. 79-2).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-9103. Repealed**Historical Note**

Adopted effective March 12, 1979 (Supp. 79-2).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-9104. Repealed**Historical Note**

Adopted effective March 12, 1979 (Supp. 79-2).
Repealed effective December 17, 1993 (Supp. 93-4).

ARTICLE 92. REPEALED**R6-5-9201. Repealed****Historical Note**

Adopted effective March 12, 1979 (Supp. 79-2).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-9202. Repealed**Historical Note**

Adopted effective March 12, 1979 (Supp. 79-2).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-9203. Repealed**Historical Note**

Adopted effective March 12, 1979 (Supp. 79-2).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-9204. Repealed**Historical Note**

Adopted effective March 12, 1979 (Supp. 79-2).
Repealed effective December 17, 1993 (Supp. 93-4).

ARTICLE 93. REPEALED

Former Article 93 consisting of Sections R6-5-9301 through R6-5-9304 repealed effective November 8, 1982.

ARTICLE 94. REPEALED

Former Article 94 consisting of Sections R6-5-9401 through R6-5-9404 repealed effective November 8, 1982.

ARTICLE 95. REPEALED

Former Article 95 consisting of Sections R6-5-9501 through R6-5-9504 repealed effective November 8, 1982.

ARTICLE 96. REPEALED

Former Article 96 consisting of Sections R6-5-9601 through R6-5-9604 repealed effective November 8, 1982.

ARTICLE 97. REPEALED

Former Article 97 consisting of Sections R6-5-9701 through R6-5-9704 repealed effective November 8, 1982.

ARTICLE 98. REPEALED

Former Article 98 consisting of Sections R6-5-9801 through R6-5-9804 repealed effective November 8, 1982.

ARTICLE 99. REPEALED

Former Article 99 consisting of Sections R6-5-9901 through R6-5-9904 repealed effective November 8, 1982.

ARTICLE 100. REPEALED

Former Article 100 consisting of Sections R6-5-10001 through R6-5-10004 repealed effective November 8, 1982.

ARTICLE 101. REPEALED

Former Article 101 consisting of Sections R6-5-10101 through R6-5-10104 repealed effective November 8, 1982.

ARTICLE 102. REPEALED

Former Article 102 consisting of Sections R6-5-10201 through R6-5-10204 repealed effective November 8, 1982.

ARTICLE 103. REPEALED

Former Article 103 consisting of Sections R6-5-10301 through R6-5-10304 repealed effective November 8, 1982.

ARTICLE 104. REPEALED**R6-5-10401. Repealed****Historical Note**

Adopted effective March 19, 1979 (Supp. 79-2).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-10402. Repealed**Historical Note**

Adopted effective March 19, 1979 (Supp. 79-2).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-10403. Repealed**Historical Note**

Adopted effective March 19, 1979 (Supp. 79-2).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-10404. Repealed**Historical Note**

Adopted effective March 19, 1979 (Supp. 79-2).
Repealed effective December 17, 1993 (Supp. 93-4).

ARTICLE 105. REPEALED**R6-5-10501. Repealed****Historical Note**

Adopted effective March 12, 1979 (Supp. 79-2).
Repealed effective December 17, 1993 (Supp. 93-4).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-10502. Repealed**Historical Note**

Adopted effective March 12, 1979 (Supp. 79-2).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-10503. Repealed**Historical Note**

Adopted effective March 12, 1979 (Supp. 79-2).
Repealed effective December 17, 1993 (Supp. 93-4).

R6-5-10504. Repealed**Historical Note**

Adopted effective March 12, 1979 (Supp. 79-2).
Repealed effective December 17, 1993 (Supp. 93-4).

ARTICLE 106. REPEALED

Former Article 106 consisting of Sections R6-5-10601 through R6-5-10604 repealed effective November 8, 1982.

ARTICLE 107. REPEALED

Former Article 107 consisting of Sections R6-5-10701 through R6-5-10704 repealed effective November 8, 1982.

ARTICLE 108. REPEALED

Former Article 108 consisting of Sections R6-5-10801 through R6-5-10804 repealed effective November 8, 1982.

ARTICLE 109. REPEALED

Former Article 109 consisting of Sections R6-5-10901 through R6-5-10904 repealed effective November 8, 1982.

ARTICLE 110. REPEALED

Former Article 110 consisting of Sections R6-5-11001 through R6-5-11004 repealed effective November 8, 1982.

TITLE 6. ECONOMIC SECURITY
CHAPTER 8. DEPARTMENT OF ECONOMIC SECURITY
AGING AND ADULT ADMINISTRATION

(Authority: A.R.S. § 41-1954 et seq.)

ARTICLE 1. GRIEVANCES AND HEARINGS

Article 1, consisting of Sections R6-8-101 through R6-8-117, adopted effective August 9, 1993 (Supp. 93-3).

Article 1, consisting of Sections R6-8-101 through R6-8-111, repealed effective August 9, 1993 (Supp. 93-3).

Article 1, consisting of Sections R6-8-101 through R6-8-111, adopted effective May 12, 1981 (Supp. 81-3).

Section

R6-8-101.	Definitions
R6-8-102.	Client Complaint Resolution Procedures
R6-8-103.	Right to Review
R6-8-104.	Administrative Review Procedures
R6-8-105.	Right to Appeal
R6-8-106.	Filing an Appeal
R6-8-107.	Service on Parties
R6-8-108.	Time
R6-8-109.	Scheduling and Notice of Hearing
R6-8-110.	Change of Hearing Officer
R6-8-111.	Failure of a Party to Appear
R6-8-112.	Subpoena of Witnesses and Documents
R6-8-113.	Conduct of Hearing
R6-8-114.	Hearing Decision
R6-8-115.	Termination of Appeal
R6-8-116.	Appeal to the Commissioner on Aging
R 6-8-117.	Review by the Appeals Board

ARTICLE 2. ADULT PROTECTIVE SERVICES

Article 2, consisting of Sections R6-8-201 through R6-8-210, adopted effective August 21, 1996 (Supp. 96-3).

Article 2, consisting of Sections R6-8-201 through R6-8-224, repealed effective August 21, 1996 (Supp. 96-3).

Article 2, consisting of Sections R6-8-201 through R6-8-224, recodified from A.A.C. R6-5-5601 through R6-5-5624 effective February 13, 1996 (Supp. 96-1).

Section

R6-8-201.	Definitions
R6-8-202.	Reporting Requirements for Adult Protective Services Cases
R6-8-203.	Eligibility for Services
R6-8-204.	Jurisdiction
R6-8-205.	Classification
R6-8-206.	Investigation
R6-8-207.	Case Planning
R6-8-208.	Refusal of Services by the Adult or Guardian
R6-8-209.	Case Closure
R6-8-210.	Confidentiality
R6-8-211.	Repealed
R6-8-212.	Repealed
R6-8-213.	Repealed
R6-8-214.	Repealed
R6-8-215.	Repealed
R6-8-216.	Repealed
R6-8-217.	Repealed
R6-8-218.	Repealed
R6-8-219.	Repealed
R6-8-220.	Repealed
R6-8-221.	Repealed
R6-8-222.	Repealed

R6-8-223. Repealed

R6-8-224. Repealed

ARTICLE 1. GRIEVANCES AND HEARINGS

R6-8-101. Definitions

- A. "Aging and Adult Administration" means the Aging and Adult Administration of the Division of Aging and Community Services, Department of Economic Security.
- B. "Area agency" means an organization designated by the Department to develop and administer the area plan for a system of services to older persons.
- C. "Area plan" means a plan for a comprehensive and coordinated system of services for older persons governing activities in a planning and service area.
- D. "Client" means any person who applies for or receives services from the Department or from a service provider under the Older Americans Act, 42 U.S.C. 3001 et seq. or the Arizona Older Americans Act - nonmedical Home and Community-Based Care Services, A.R.S. § 46-191 et seq.
- E. "Department" means the Department of Economic Security.
- F. "Grievant" means an organization listed in R6-8-103 which has filed a request for review with the Department.
- G. "Nutrition project" means the recipient of a subgrant or contract to provide nutrition services, other than the Area Agency.
- H. "Party" means any client or grievant appealing an action under R6-8-105 or the Department.
- I. "Program Administrator" means the Administrator of the Aging and Adult Administration.
- J. "Service provider" means a person or organization that is awarded a subgrant or contract from an area agency to provide services under the area plan.

Historical Note

Adopted effective May 12, 1981 (Supp. 81-3). Section repealed, new Section adopted effective August 9, 1993 (Supp. 93-3).

R6-8-102. Client Complaint Resolution Procedures

- A. Each area agency shall have a written complaint resolution procedure which shall be made available to all clients.
- B. The complaint resolution procedure shall provide for an informal meeting to adjust the dispute and shall inform the client of the right to appeal if not satisfied with the area agency's decision.
- C. The area agency shall issue its decision within 30 days of the date the complaint is filed.

Historical Note

Adopted effective May 12, 1981 (Supp. 81-3). Section repealed, new Section adopted effective August 9, 1993 (Supp. 93-3).

R6-8-103. Right to Review

An administrative review shall be available to:

1. Any area agency when the Department proposes to disapprove an area plan or plan amendment submitted by the area agency, or withdraw the area agency's designation;
2. Any applicant for designation as a planning and service area whose application is denied;
3. Any nutrition project for which the area agency proposes to cancel funding;

4. Any service provider whose application to provide services under an area plan is denied or whose subgrant or contract is terminated or not renewed.

Historical Note

Adopted effective May 12, 1981 (Supp. 81-3). Section repealed, new Section adopted effective August 9, 1993 (Supp. 93-3).

R6-8-104. Administrative Review Procedures

- A. A request for administrative review must be filed in writing within 30 days of receipt of the notice of an adverse action. The request shall be signed by the grievant or an authorized representative of the grievant and directed to:
 - The Program Administrator
 - Aging and Adult Administration
 - Department of Economic Security
 - P.O. Box 6123
 - Phoenix, Arizona 85005
- B. The Program Administrator or the Administrator's designee shall schedule an administrative review conference to meet with the grievant or a representative of the grievant. At the administrative review conference, the grievant or the grievant's representative may review pertinent evidence on which the action was based.
- C. The Program Administrator shall issue a final decision within 60 days of the filing of the request for administrative review.

Historical Note

Adopted effective May 12, 1981 (Supp. 81-3). Section repealed, new Section adopted effective August 9, 1993 (Supp. 93-3).

R6-8-105. Right to Appeal

- A. A client who is dissatisfied with the final decision issued by the area agency pursuant to R6-8-102 of this Article has the right to appeal that decision.
- B. A grievant who is dissatisfied with the final decision issued by the Program Administrator pursuant to R6-8-103 of this Article has the right to appeal that decision.

Historical Note

Adopted effective May 12, 1981 (Supp. 81-3). Section repealed, new Section adopted effective August 9, 1993 (Supp. 93-3).

R6-8-106. Filing an Appeal

- A. Any client or grievant filing an appeal under these rules shall file a written request for hearing with the Program Administrator within 15 days after the mailing date of the area agency or Program Administrator's decision.
- B. A document shall be considered received by and filed with the Department:
 1. If transmitted via the United States Postal Service, on the date it is mailed. The mailing date shall be:
 - a. As shown by the postmark; or
 - b. As shown by the postage meter mark of the envelope in which it is received if there is no postmark; or
 - c. The date entered on the document as the date of its completion, if there is no postmark, or no postage meter mark, or if the mark is illegible.
 2. On the date it is received by the Department, if transmitted by any means other than the United States Postal Service.
 3. The submission of document not within the specified statutory or regulatory period shall be considered timely if it is established to the satisfaction of the Department that the delay in submission was due to Department error or

misinformation, or to delay by the United States Postal Service.

Historical Note

Adopted effective May 12, 1981 (Supp. 81-3). Section repealed, new Section adopted effective August 9, 1993 (Supp. 93-3).

R6-8-107. Service on Parties

Any document mailed by the Department shall be considered as having been served on the addressee on the date it is mailed to the addressee's last known address. The date mailed shall be presumed to be the date of the document, unless otherwise indicated by the facts.

Historical Note

Adopted effective May 12, 1981 (Supp. 81-3). Section repealed, new Section adopted effective August 9, 1993 (Supp. 93-3).

R6-8-108. Time

Any reference within this Article to "days" shall mean calendar days unless otherwise specified. In computing any period of time, the date of the act, event, or default from which the designated period of time begins to run shall not be included. The last day of the period so computed shall be counted, unless it is a Saturday, a Sunday, or a legal holiday, in which event the period runs until the end of the next day which is not a Saturday, a Sunday, or a legal holiday.

Historical Note

Adopted effective May 12, 1981 (Supp. 81-3). Section repealed, new Section adopted effective August 9, 1993 (Supp. 93-3).

R6-8-109. Scheduling and Notice of Hearing

- A. Hearings shall be held at those regularly established hearing locations most convenient to the parties or, at the discretion of the hearing officer, by telephone. The parties shall be given no less than 20 days' notice of hearing, except that the parties may waive the notice period or request a delay.
- B. The notice of hearing shall inform the parties of the date, time, and place of hearing, the name of the hearing officer, the issues involved, and the right to:
 1. Present the case in person or by telephone.
 2. Copy any documents to be used by the Department at the hearing at a reasonable time before the hearing.
 3. Request a change of hearing officer.
- C. If a party contacts the Office of Appeals promptly after receiving the notice of hearing and requests a postponement for good cause, the hearing officer shall grant a postponement for a reasonable period. Good cause exists when the circumstances causing the request are beyond the reasonable control of the requesting party and failure to grant the postponement would result in undue hardship to the requesting party.
- D. All scheduling is the responsibility of the Office of Appeals.

Historical Note

Adopted effective May 12, 1981 (Supp. 81-3). Section repealed, new Section adopted effective August 9, 1993 (Supp. 93-3).

R6-8-110. Change of Hearing Officer

Not less than five days before the date set for the hearing, any party may file a written request for change of hearing officer and the matter shall immediately be transferred to another hearing officer. A hearing officer may be challenged for cause at any time before a decision becomes final. Except for good cause, not more than one change of hearing officer shall be granted to any one party.

Historical Note

Adopted effective May 12, 1981 (Supp. 81-3). Section repealed, new Section adopted effective August 9, 1993 (Supp. 93-3).

R6-8-111. Failure of a Party to Appear

- A. If there is no appearance on behalf of a party at a scheduled hearing, the hearing officer may adjourn the hearing to a later date or may make the decision on the record and on such evidence as may be presented at the scheduled hearing.
- B. If, within 15 days of the scheduled hearing, a party files a written request to reopen the proceedings and establishes good cause for failure to appear at the scheduled hearing, the hearing shall be rescheduled. Notice shall be given of the time, place, and the purpose of any continued, reopened, or rescheduled hearing to all parties. Good cause shall be established upon proof that both the failure to appear and failure to timely notify the hearing officer were beyond the reasonable control of the nonappearing party.

Historical Note

Adopted effective May 12, 1981 (Supp. 81-3). Section repealed, new Section adopted effective August 9, 1993 (Supp. 93-3).

R6-8-112. Subpoena of Witnesses and Documents

The hearing officer may subpoena any witnesses or documents requested by any party or upon the hearing officer's own motion.

- 1. The request shall be in writing and shall state the name and address of the witness and the nature of the expected testimony. The nature of the witness' testimony must be relevant to the issues of the hearing; otherwise the hearing officer may deny the request.
- 2. A request for subpoena of documents shall describe them in detail and provide the name and address of the custodian.
- 3. The request for the issuance of a subpoena shall be filed a minimum of five working days before the hearing.
- 4. The Department shall prepare and serve all subpoenas. Service of the subpoena shall be accomplished by certified mail, return receipt requested.

Historical Note

Adopted effective August 9, 1993 (Supp. 93-3).

R6-8-113. Conduct of Hearing

- A. Hearings shall be conducted in an orderly and dignified manner. All hearings shall be open to the public, but the hearing officer conducting a hearing may close the hearing to other than parties to the extent necessary to protect the interests and rights of the parties.
- B. Hearings shall be opened, conducted, and closed by the hearing officer who shall rule on the admissibility of evidence and shall direct the order of proof. The hearing officer shall have the power to administer oaths and affirmations, take depositions, certify official acts, and issue subpoenas to compel the attendance of witnesses and the production of any documents deemed necessary as evidence in connection with a hearing.
- C. Evidence not related to the issue shall not be allowed to become a part of the record.
- D. The hearing officer may, on the hearing officer's own motion or at the request of a party, exclude witnesses from the hearing room.
- E. The parties may present evidence, cross-examine witnesses, and present arguments.
- F. The parties to an appeal, with the consent of the hearing officer, may stipulate to facts involved in writing or on the record.
- G. At the conclusion of the hearing, the parties shall be granted a reasonable opportunity to present argument on all issues of

fact and law to be decided. The hearing officer shall afford the parties an opportunity to present oral argument, or to file briefs, or both.

- H. A full and complete record shall be kept of all proceedings in connection with an appeal. The record shall be open for inspection by the parties. A transcript of the proceedings need not be made unless it is required for further proceedings,

Historical Note

Adopted effective August 9, 1993 (Supp. 93-3).

R6-8-114. Hearing Decision

- A. A hearing decision shall be rendered exclusively on the evidence and testimony produced at the hearing, appropriate state and federal law, and Department rules governing the issue in dispute.
- B. The decision shall set forth the pertinent facts involved, the conclusions drawn from such facts, the sections of applicable law or rule, the decision, and the reasons therefor. A copy of the decision, together with an explanation of the appeal rights, shall be delivered or mailed to each party or designated representative not more than 60 days from the date of filing the request for hearing unless the delay was caused by the appellant, in which case the time limit for delivery is extended by the number of days attributable to the appellant.
- C. All decisions in favor of the appellant apply retroactively to the date of the action being appealed or to the date the hearing officer specifically finds appropriate.
- D. The decision of the hearing officer shall become the final decision of the Department 15 days after it is issued unless a written petition for review has been filed.

Historical Note

Adopted effective August 9, 1993 (Supp. 93-3).

R6-8-115. Termination of Appeal

An appeal may be terminated as follows:

- 1. By voluntary withdrawal if the appellant submits a signed letter or on the record at any time before the decision is issued.
- 2. By default when a party fails to appear at a scheduled hearing and fails to request a rescheduled hearing within 15 days. An appeal will not be considered abandoned if the party provides notification up to the time of the hearing that he is unable, due to good cause, to appear and that he still wishes a hearing, or that the matter be considered on the record.

Historical Note

Adopted effective August 9, 1993 (Supp. 93-3).

R6-8-116. Appeal to the Commissioner on Aging

- A. An appellant which has been denied designation as a planning and service area may appeal to the Commissioner on Aging, Department of Health and Human Services, within 30 days after the hearing officer's decision is mailed or otherwise delivered.
- B. The appeal shall be in writing, signed, and dated. It shall set forth the grounds for the request and may be filed personally or by mail to the Administrator, Aging and Adult Administration.

Historical Note

Adopted effective August 9, 1993 (Supp. 93-3).

R6-8-117. Review by the Appeals Board

- A. In all cases not covered by R6-8-116 of this Article, a party may petition for review of an adverse hearing decision within 15 days after the decision is mailed or otherwise delivered to the appellant. The petition for review shall be in writing,

signed, and dated. It shall state the grounds for the request and may be filed personally or by mail to the Aging and Adult Administration or the Office of Appeals.

- B. The Appeals Board may remove to itself any matter before a hearing officer before the issuance of a decision or, if a decision has been issued, before the decision has become final. Upon removal, the Appeals Board shall notify the parties of the removal.
- C. In any case of removal or review, the Appeals Board shall notify the Office of Appeals that it has accepted jurisdiction, and the Office of Appeals shall prepare a complete record of the case, including a transcript, which shall be provided to the parties upon request.
- D. A copy of the Appeals Board decision, together with a statement specifying the rights to further review, shall be distributed to each party.

Historical Note

Adopted effective August 9, 1993 (Supp. 93-3).

ARTICLE 2. ADULT PROTECTIVE SERVICES

R6-8-201. Definitions

In addition to the definitions in A.R.S. § 46-451, the following definitions apply in this Article unless the context requires otherwise.

1. "Adult" means a person 18 years of age or older.
2. "Adult Protective Services" or "APS" means a program within the Department of Economic Security which provides protective services.
3. "Conservator" means a person who has been appointed by a court to manage the affairs of another, as prescribed in A.R.S. § 14-5401 et seq.
4. "Danger to self" means:
 - a. Behavior which, as a result of a mental disorder, constitutes a danger of inflicting serious physical harm upon oneself, including attempted suicide or the serious threat thereof, if the threat is such that, when considered in the light of its context and in light of the individual's previous acts, it is substantially supportive of an expectation that the threat will be carried out; {or}
 - b. Behavior which, as a result of a mental disorder, will, without hospitalization, result in serious physical harm or serious illness to the person, except that this definition shall not include behavior which establishes only the condition of gravely disabled. A.R.S. § 36-501(5).
5. "Department" means the Department of Economic Security.
6. "Gravely disabled" means "a condition, evidenced by behavior in which a person, as a result of a mental disorder, is likely to come to serious physical harm, or serious illness because he is unable to provide for his basic physical needs." A.R.S. § 36-501.
7. "Guardian" means a person who has been appointed by a court to manage the affairs of another, as prescribed in A.R.S. § 14-5301 et seq.
8. "Information and referral" means the provision of information or referral to help a person who contacts or is reported to the Department, but is not alleged to be abused, neglected, or exploited, to locate and obtain help with a problem.
9. "Intake" means a duty performed by APS staff in receiving reports or providing information and referral.
10. "Jurisdiction" means the state of Arizona, exclusive of Native American Reservation land.
11. "Life-threatening situation" means a situation or circumstance that is likely to result in death if not corrected by medical or law enforcement intervention.
12. "Mental disorder" means "a substantial disorder of a person's emotional processes, thought, cognition, or memory. Mental disorder is distinguished from:
 - a. Conditions which are primarily those of drug abuse, alcoholism, or mental retardation, unless, in addition to 1 or more of these conditions, the person has a mental disorder;
 - b. The declining mental abilities that directly accompany impending death; and
 - c. Character and personality disorders characterized by lifelong and deeply ingrained anti-social behavior patterns, including sexual behaviors which are abnormal and prohibited by statute unless the behavior results from a mental disorder". A.R.S. § 36-501.
13. "Personally identifiable information" means any information that can indicate a person's identity including:
 - a. Name;
 - b. Address;
 - c. Telephone number;
 - d. Fax number;
 - e. Photograph;
 - f. Fingerprints;
 - g. Physical description;
 - h. Place, address, or telephone number of employment;
 - i. Social security number;
 - j. Tribal affiliation;
 - k. Tribal identification number;
 - l. Driver's license number;
 - m. Birthdate;
 - n. Medical information, history, and diagnosis; or
 - o. Any other information that would reasonably lead to the identification of a person.
14. "Prepetition screening" means the "review of each application requesting court-ordered evaluation, including an investigation of facts alleged in such application, an interview with each applicant and an interview, if possible, with the proposed patient. The purpose of the interview with the proposed patient is to assess the problem, explain the application, and, when indicated, attempt to persuade the proposed patient to receive, on a voluntary basis, evaluation or other services". A.R.S. § 36-501(30).
15. "Protected person" means "a minor or any other person for whom a conservator has been appointed or any other protective order has been made". A.R.S. § 14-5101(4).
16. "Protective services" means "a program of identifiable and specialized social services that may offer social services appropriate to resolve problems of abuse, exploitation or neglect of an incapacitated or vulnerable adult". A.R.S. § 46-451(A)(8).
17. "Record" means a collection of documents, including electronic documents, related to casework about a person reported to APS, or receiving APS services.
18. "Report" means a communication which alleges abuse, neglect, or exploitation of an incapacitated or vulnerable adult, or information regarding an adult who may be in need of protective services.
19. "Special visitation warrant" means an order of the Superior court that is issued as prescribed in A.R.S. § 14-5310.01 and which permits an APS worker, accompanied by a peace officer, to visit the residence of an adult

believed to be incapacitated and abused, neglected, or exploited.

20. "Business day" means 8:00 a.m. to 5:00 p.m., Monday through Friday, excluding Arizona state holidays.

Historical Note

R6-8-201 recodified from A.A.C. R6-5-5601 effective February 13, 1996 (Supp. 96-1). Former Section R6-8-201 repealed, new Section R6-8-201 adopted effective August 21, 1996 (Supp. 96-3). Amended by final rulemaking at 18 A.A.R. 2716, effective December 2, 2012 (Supp. 12-4).

R6-8-202. Reporting Requirements for Adult Protective Service Cases

Upon receipt of a report, as prescribed in A.R.S. § 46-454, APS shall ask the reporting source to provide:

1. All information as prescribed in A.R.S. § 46-454(C); and,
2. As much information regarding the allegedly incapacitated, or vulnerable adult as is available to the source including:
 - a. The names and addresses of those involved and their roles;
 - b. The length of time the situation has been ongoing;
 - c. The client's functional level;
 - d. Whether other agencies are providing assistance and, if so, what type of assistance; and,
 - e. Any other information that may assist the APS worker in the investigation.

Historical Note

R6-8-202 recodified from A.A.C. R6-5-5602 effective February 13, 1996 (Supp. 96-1). Former Section R6-8-202 repealed, new Section R6-8-202 adopted effective August 21, 1996 (Supp. 96-3).

R6-8-203. Eligibility for Services

To be eligible for APS services, a person shall be:

1. Age 18 years or older;
2. Incapacitated or vulnerable;
3. The victim or alleged victim of abuse, neglect, or exploitation; and,
4. Within the jurisdiction.

Historical Note

R6-8-203 recodified from A.A.C. R6-5-5603 effective February 13, 1996 (Supp. 96-1). Former Section R6-8-203 repealed, new Section R6-8-203 adopted effective August 21, 1996 (Supp. 96-3).

R6-8-204. Jurisdiction

- A. An APS worker shall not investigate reports of events that occurred in another state or foreign country.
- B. An APS worker shall investigate reports that occurred on an Indian reservation, upon written invitation by the tribal council.

Historical Note

R6-8-204 recodified from A.A.C. R6-5-5604 effective February 13, 1996 (Supp. 96-1). Former Section R6-8-204 repealed, new Section R6-8-204 adopted effective August 21, 1996 (Supp. 96-3). Amended by final rulemaking at 18 A.A.R. 2716, effective December 2, 2012 (Supp. 12-4).

R6-8-205. Classification

At intake, an APS worker shall classify the incoming communication into one of the following two categories:

1. Information and referral, or
2. Report accepted for evaluation and investigation.

Historical Note

R6-8-205 recodified from A.A.C. R6-5-5605 effective February 13, 1996 (Supp. 96-1). Former Section R6-8-205 repealed, new Section R6-8-205 adopted effective August 21, 1996 (Supp. 96-3). Amended by final rulemaking at 18 A.A.R. 2716, effective December 2, 2012 (Supp. 12-4).

R6-8-206. Investigation

Reports Accepted for Evaluation and Investigation:

1. In alleged life-threatening situations, the APS worker shall refer the reporting source or initiate contact with:
 - a. Local law enforcement authorities,
 - b. Paramedics, or
 - c. An emergency medical team.
2. When an APS worker investigates a situation that may present a danger to the APS worker or client, the APS worker may ask law enforcement authorities to participate in the investigation either at the time of the report or upon arrival at the scene.
3. An APS worker shall visit a person who may be in need of adult protective services within the following established time-frames:
 - a. Priority 1. The APS worker shall initiate an assessment within one business day following a report of a qualifying problem with an imminent and substantial risk of life-threatening harm.
 - b. Priority 2. The APS worker shall initiate an assessment within two business days following a report of a qualifying problem with aggravating circumstances.
 - c. Priority 3. The APS worker shall initiate assessment within five business days following a report of a qualifying problem with mitigating or no aggravating circumstances.
4. The APS worker shall investigate, determine, and document in the record whether:
 - a. The allegations are proposed for substantiation,
 - b. The client needs services,
 - c. The client will accept services,
 - d. The client appears able to provide informed consent for the provision of services,
 - e. The Department needs to request an outside mental health assessment, or
 - f. The Department needs to file for a special visitation warrant.
5. To make the assessment described in subsection (A)(4), the APS worker shall consider all relevant circumstances regarding the client, which may include the following:
 - a. The client's appearance,
 - b. Identifying information,
 - c. Financial information,
 - d. Existing protective arrangements,
 - e. Physical status including any disabilities,
 - f. Medications,
 - g. Medical history,
 - h. Mental status,
 - i. Functional status,
 - j. Behavioral status,
 - k. Social environment,
 - l. Physical environment,
 - m. Nutrition,
 - n. Services provided by other resources,
 - o. The client's perception of the situation, and
 - p. The perception of the client's situation by:
 - i. Family,
 - ii. Neighbors,

- iii. Caregivers,
- iv. Friends, or
- v. Other concerned parties.

Historical Note

R6-8-206 recodified from A.A.C. R6-5-5606 effective February 13, 1996 (Supp. 96-1). Former Section R6-8-206 repealed, new Section R6-8-206 adopted effective August 21, 1996 (Supp. 96-3). Amended by final rulemaking at 18 A.A.R. 2716, effective December 2, 2012 (Supp. 12-4).

R6-8-207. Case Planning

- A. The APS worker shall maintain a case plan for clients in need of protective services.
 - 1. The case plan shall contain:
 - a. Specific goals and objectives,
 - b. Outline of casework activities for achieving objectives, and
 - c. Time frames for achieving objectives.
- B. An APS worker shall:
 - 1. Involve the client in identifying and understanding the client's needs and planning of services to address those needs, unless the client's mental or physical condition prevents the client from participating in planning;
 - 2. Locate persons who can help the client achieve planned goals;
 - 3. Regularly assess the client's progress towards the goals;
 - 4. Revise goals to meet the changing needs of the client; and,
 - 5. Coordinate with other agencies to address the client's needs.

Historical Note

R6-8-207 recodified from A.A.C. R6-5-5607 effective February 13, 1996 (Supp. 96-1). Former Section R6-8-207 repealed, new Section R6-8-207 adopted effective August 21, 1996 (Supp. 96-3).

R6-8-208. Refusal of Services by the Adult or Guardian

- A. An adult may refuse adult protective services.
- B. If an APS worker believes that a client in need of services is a danger to self or gravely disabled due to a mental disorder, as prescribed in A.R.S. § 36-501 or in need of a guardianship or conservatorship, the APS worker may obtain further assessment of the client's physical or mental health in order to take action to protect the client.
 - 1. The action may include:
 - a. Seeking a special visitation warrant if the APS worker is denied access to a client,
 - b. Petitioning for appointment of a conservator or guardian, or
 - c. Applying for prepetition screening.
- C. A guardian may refuse services on behalf of a protected person.
- D. If an APS worker finds that a guardian is not acting in the best interest of a protected person, the APS worker may petition the court to review the guardianship. The petition shall include the specific reasons that the APS worker believes that the guardian is not acting in the best interest of the ward.

Historical Note

R6-8-208 recodified from A.A.C. R6-5-5608 effective February 13, 1996 (Supp. 96-1). Former Section R6-8-208 repealed, new Section R6-8-208 adopted effective August 21, 1996 (Supp. 96-3).

R6-8-209. Case Closure

APS may close a case when:

- 1. Allegations of abuse, neglect, or exploitation are not substantiated;
- 2. The abuse, neglect, or exploitation is resolved by the provision of services or other methods;
- 3. The client's capacity is not in question, and the client is refusing APS involvement or is not accepting viable remedies for prevention of risk;
- 4. The client is admitted to care in a state institution or other care facility;
- 5. The client has moved outside the jurisdiction;
- 6. The client dies;
- 7. Contact with the client is lost and 3 attempts to reestablish contact have failed; or,
- 8. Guardianship or conservatorship is obtained.

Historical Note

R6-8-209 recodified from A.A.C. R6-5-5609 effective February 13, 1996 (Supp. 96-1). Former Section R6-8-209 repealed, new Section R6-8-209 adopted effective August 21, 1996 (Supp. 96-3).

R6-8-210. Confidentiality

- A. All personally identifiable information is confidential as prescribed in A.R.S. § 41-1959. A person who is entitled to obtain information pursuant to A.R.S. § 41-1959(C) and who wishes to obtain information shall comply with the requirements of this Section.
- B. The person shall send a written request to the Custodian of Records at the Department of Economic Security, Division of Aging and Adult Services, Adult Protective Services, Central Office, 1789 W. Jefferson, Site code 950A, Phoenix, Arizona 85007. The request shall include the following information:
 - 1. The name, address, and telephone number of the person, organization, or entity requesting information;
 - 2. If the request is on behalf of an organization or entity, the name and title of the person signing the request;
 - 3. The purpose for which the information is sought;
 - 4. The Section of A.R.S. § 41-1959(C) authorizing the person to obtain the information;
 - 5. The name of the client who is the subject of the APS report, with as much of the following information as the requester can provide:
 - a. Other possible spellings, names, or aliases of the client;
 - b. The approximate date of the APS report; and,
 - c. Any other data that the requester believes will be likely to assist the Department in identifying the information requested.
- C. Upon receipt of a request for information, the Department shall determine if the request is complete. If the request is not complete, the Department shall contact the requester for the missing information.
- D. The receipt date is the day that the receiving office designated on the request actually receives the complete request, as prescribed in subsection (B).
- E. The Department shall respond to the requester within 15 business days.
- F. The person releasing the information shall document in the case record:
 - 1. The name of the person to whom the information was released,
 - 2. The date and method of release, and
 - 3. A description of the information released.

Historical Note

R6-8-210 recodified from A.A.C. R6-5-5610 effective February 13, 1996 (Supp. 96-1). Former Section R6-8-210 repealed, new Section R6-8-210 adopted effective

August 21, 1996 (Supp. 96-3). Amended by final rulemaking at 18 A.A.R. 2716, effective December 2, 2012 (Supp. 12-4).

R6-8-211. Repealed**Historical Note**

R6-8-211 recodified from A.A.C. R6-5-5611 effective February 13, 1996 (Supp. 96-1). Repealed effective August 21, 1996 (Supp. 96-3).

R6-8-212. Repealed**Historical Note**

R6-8-212 recodified from A.A.C. R6-5-5612 effective February 13, 1996 (Supp. 96-1). Repealed effective August 21, 1996 (Supp. 96-3).

R6-8-213. Repealed**Historical Note**

R6-8-213 recodified from A.A.C. R6-5-5613 effective February 13, 1996 (Supp. 96-1). Repealed effective August 21, 1996 (Supp. 96-3).

R6-8-214. Repealed**Historical Note**

R6-8-214 recodified from A.A.C. R6-5-5614 effective February 13, 1996 (Supp. 96-1). Repealed effective August 21, 1996 (Supp. 96-3).

R6-8-215. Repealed**Historical Note**

R6-8-215 recodified from A.A.C. R6-5-5615 effective February 13, 1996 (Supp. 96-1). Repealed effective August 21, 1996 (Supp. 96-3).

R6-8-216. Repealed**Historical Note**

R6-8-216 recodified from A.A.C. R6-5-5616 effective February 13, 1996 (Supp. 96-1). Repealed effective August 21, 1996 (Supp. 96-3).

R6-8-217. Repealed**Historical Note**

R6-8-217 recodified from A.A.C. R6-5-5617 effective February 13, 1996 (Supp. 96-1). Repealed effective August 21, 1996 (Supp. 96-3).

R6-8-218. Repealed**Historical Note**

Adopted effective July 6, 1976 (Supp. 76-4). Former Section R6-5-5617 renumbered as Section R6-5-5618 effective January 13, 1977 (Supp. 77-1). R6-8-218 recodified from A.A.C. R6-5-5618 effective February 13, 1996 (Supp. 96-1). Repealed effective August 21, 1996 (Supp. 96-3).

R6-8-219. Repealed**Historical Note**

R6-8-219 recodified from A.A.C. R6-5-5619 effective February 13, 1996 (Supp. 96-1). Repealed effective August 21, 1996 (Supp. 96-3).

R6-8-220. Repealed**Historical Note**

R6-8-220 recodified from A.A.C. R6-5-5620 effective February 13, 1996 (Supp. 96-1). Repealed effective August 21, 1996 (Supp. 96-3).

R6-8-221. Repealed**Historical Note**

R6-8-221 recodified from A.A.C. R6-5-5621 effective February 13, 1996 (Supp. 96-1). Repealed effective August 21, 1996 (Supp. 96-3).

R6-8-222. Repealed**Historical Note**

R6-8-222 recodified from A.A.C. R6-5-5622 effective February 13, 1996 (Supp. 96-1). Repealed effective August 21, 1996 (Supp. 96-3).

R6-8-223. Repealed**Historical Note**

R6-8-223 recodified from A.A.C. R6-5-5623 effective February 13, 1996 (Supp. 96-1). Repealed effective August 21, 1996 (Supp. 96-3).

R6-8-224. Repealed**Historical Note**

R6-8-224 recodified from A.A.C. R6-5-5624 effective February 13, 1996 (Supp. 96-1). Repealed effective August 21, 1996 (Supp. 96-3).

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Supplement to the

Arizona Administrative Code

The official compilation of Arizona Rules

Arizona Secretary of State's Office

Public Services Division

1700 W. Washington Street, Fl 7.

Phoenix, AZ 85007

Replacement Check List

For rules filed within the

4th Calendar Quarter

October 1 - December 31, 2012

Code Release Number: Supp. 12-4

Within the stated calendar quarter, this Title contains all rules made, amended, repealed, renumbered, and recodified, or rules that have expired or were terminated due to an agency being eliminated under sunset law. These rules were either certified by the Governor's Regulatory Review Council or the Attorney General's Office, or exempt from the rulemaking process, and filed with the Office of the Secretary of State. Refer to the historical notes for more information. Please note that some rules you are about to remove may still be in effect after the publication date of this Supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

Follow the instructions to replace the updated Chapters.

TITLE 9. HEALTH SERVICES

Chapter 17. Department of Public Safety - Medical Marijuana Program

Sections, Parts, Exhibits, Tables or Appendices modified

R9-17-101 through R9-17-103, R9-17-107, Table 1.1, R9-17-109, R9-17-202, R9-17-203, R9-17-302 through R9-17-304,
R9-17-308 through R9-17-312, R9-17-322

REMOVE Supp. 12-2
Pages: 1 - 39

REPLACE with Supp. 12-4
Pages: 1 - 30

Chapter 22. Arizona Health Care Cost Containment System - Administration

Sections, Parts, Exhibits, Tables or Appendices modified

R9-22-710

REMOVE Supp. 12-3
Pages: 1 - 110

REPLACE with Supp. 12-4
Pages: 1 - 110

Chapter 28. Arizona Health Care Cost Containment System - Arizona Long-term Care System

Sections, Parts, Exhibits, Tables or Appendices modified

R9-28-101, R9-28-509, R9-28-510

REMOVE Supp. 12-3
Pages: 1 - 42

REPLACE with Supp. 12-4
Pages: 1 - 42

Chapter 29. Arizona Health Care Cost Containment System - Medicare Cost Sharing Program

Sections, Parts, Exhibits, Tables or Appendices modified

R9-29-101, R9-29-102, R9-29-201 through R9-29-224, R9-29-301 through R9-29-304, R9-29-401, R9-29-501,
R9-29-503, R9-29-601

REMOVE Supp. 06-1
Pages: 1 - 4

REPLACE with Supp. 12-4
Pages: 1 - 6

Chapter 33. Department of Health Services - Group Homes for Individuals with a Developmental Disability

Sections, Parts, Exhibits, Tables or Appendices modified

R9-33-101 through R9-33-109, Table 1.1, R9-33-201 through R9-33-207

REMOVE Supp. 02-1
Pages: 1 - 5

REPLACE with Supp. 12-4
Pages: 1 - 8

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Department of Health Services — Medical Marijuana Program

TITLE 9. HEALTH SERVICES

CHAPTER 17. DEPARTMENT OF HEALTH SERVICES
MEDICAL MARIJUANA PROGRAM

Authority: A.R.S. § 36-2803

Editor's Note: This Chapter was adopted under a one-year exemption from the Arizona Administrative Procedure Act (A.R.S. Title 41, Chapter 6) pursuant to Proposition 203 passed by the voters in November 2010. Although exempt from certain provisions of the rulemaking process, Section 6 of the Proposition required the Department to provide the public with an opportunity to comment on these rules before publishing the exempted rules. The Department posted proposed rules for comment on its web site, conducted statewide public meetings and also posted public comments received on its web site. (Supp. 11-2).

Editor's Note: 9 A.A.C. 17, formerly contained the rules of the Department of Health Services - Pure Food Control. This Chapter expired under A.R.S. § 41-1056(E) at 13 A.A.R. 3531, effective August 31, 2007 (Supp. 07-3).

ARTICLE 1. GENERAL

Article 1, consisting of Sections R9-17-101 through R9-17-109, made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2).

Section

- R9-17-101. Definitions
- R9-17-102. Fees
- R9-17-103. Application Submission
- R9-17-104. Changing Information on a Registry Identification Card
- R9-17-105. Requesting a Replacement Registry Identification Card
- R9-17-106. Adding a Debilitating Medical Condition
- R9-17-107. Time-frames
 - Table 1.1. Time-frames
- R9-17-108. Expiration of a Registry Identification Card or a Dispensary Registration Certificate
- R9-17-109. Notifications and Void Registry Identification Cards

ARTICLE 2. QUALIFYING PATIENTS AND DESIGNATED CAREGIVERS

Article 2, consisting of Sections R9-17-201 through R9-17-205, made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2).

Section

- R9-17-201. Debilitating Medical Conditions
- R9-17-202. Applying for a Registry Identification Card for a Qualifying Patient or a Designated Caregiver
- R9-17-203. Amending a Qualifying Patient's or Designated Caregiver's Registry Identification Card
- R9-17-204. Renewing a Qualifying Patient's or Designated Caregiver's Registry Identification Card
- R9-17-205. Denial or Revocation of a Qualifying Patient's or Designated Caregiver's Registry Identification Card

ARTICLE 3. DISPENSARIES AND DISPENSARY AGENTS

Article 3, consisting of Sections R9-17-301 through R9-17-323, made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2).

Section

- R9-17-301. Principal Officers and Board Members
- R9-17-302. Repealed
- R9-17-303. Dispensary Registration Certificate Allocation Process
- R9-17-304. Applying for a Dispensary Registration Certificate
- R9-17-305. Applying for Approval to Operate a Dispensary
- R9-17-306. Changes to a Dispensary Registration Certificate
- R9-17-307. Applying to Change a Dispensary's Location or Change or Add a Dispensary's Cultivation Site

- R9-17-308. Renewing a Dispensary Registration Certificate
- R9-17-309. Inspections
- R9-17-310. Administration
- R9-17-311. Submitting an Application for a Dispensary Agent Registry Identification Card
- R9-17-312. Submitting an Application to Renew a Dispensary Agent's Registry Identification Card
- R9-17-313. Medical Director
- R9-17-314. Dispensing Medical Marijuana
- R9-17-315. Qualifying Patient Records
- R9-17-316. Inventory Control System
- R9-17-317. Product Labeling and Analysis
- R9-17-318. Security
- R9-17-319. Edible Food Products
- R9-17-320. Cleaning and Sanitation
- R9-17-321. Physical Plant
- R9-17-322. Denial or Revocation of a Dispensary Registration Certificate
- R9-17-323. Denial or Revocation of a Dispensary Agent's Registry Identification Card

ARTICLE 1. GENERAL

R9-17-101. Definitions

In addition to the definitions in A.R.S. § 36-2801, the following definitions apply in this Chapter unless otherwise stated:

1. "Acquire" means to obtain through any type of transaction and from any source.
2. "Activities of daily living" means ambulating, bathing, dressing, grooming, eating, toileting, and getting in and out of bed.
3. "Amend" means adding or deleting information on an individual's registry identification card that affects the individual's ability to perform or delegate a specific act or function.
4. "Batch" means a specific lot of medical marijuana grown from one or more seeds or cuttings that are planted and harvested at the same time.
5. "Batch number" means a unique numeric or alphanumeric identifier assigned to a batch by a dispensary when the batch is planted.
6. "Calendar day" means each day, not including the day of the act, event, or default from which a designated period of time begins to run, but including the last day of the period unless it is a Saturday, Sunday, statewide furlough day, or legal holiday, in which case the period runs until the end of the next day that is not a Saturday, Sunday, statewide furlough day, or legal holiday.
7. "CHAA" means a Community Health Analysis Area, a geographic area based on population, established by the Department for use by public health programs.

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8. “Change” means adding or deleting information on an individual’s registry identification card that does not substantively affect the individual’s ability to perform or delegate a specific act or function.
9. “Commercial device” means the same as in A.R.S. § 41-2051.
10. “Cultivation site” means the one additional location where marijuana may be cultivated, infused, or prepared for sale by and for a dispensary.
11. “Current photograph” means an image of an individual, taken no more than 60 calendar days before the submission of the individual’s application, in a Department-approved electronic format capable of producing an image that:
 - a. Has a resolution of at least 600 x 600 pixels but not more than 1200 x 1200 pixels;
 - b. Is 2 inches by 2 inches in size;
 - c. Is in natural color;
 - d. Is a front view of the individual’s full face, without a hat or headgear that obscures the hair or hairline;
 - e. Has a plain white or off-white background; and
 - f. Has between 1 and 1 3/8 inches from the bottom of the chin to the top of the head.
12. “Denial” means the Department’s final decision not to issue a registry identification card, a dispensary registration certificate, or an approval of a change of dispensary or a dispensary’s cultivation site location, to an applicant because the applicant or the application does not comply with the applicable requirements in A.R.S. Title 36, Chapter 28.1 or this Chapter.
13. “Dispensary” means the same as “nonprofit medical marijuana dispensary” as defined in A.R.S. § 36-2801.
14. “Dispensary agent” means the same as “nonprofit medical marijuana dispensary agent” as defined in A.R.S. § 36-2801.
15. “Edible food product” means a substance, beverage, or ingredient used or intended for use or for sale in whole or in part for human consumption.
16. “Enclosed area” when used in conjunction with “enclosed, locked facility” means outdoor space surrounded by solid, 10-foot walls, constructed of metal, concrete, or stone that prevent any viewing of the marijuana plants, and a 1-inch thick metal gate.
17. “Entity” means a “person” as defined in A.R.S. § 1-215.
18. “Generally accepted accounting principles” means the set of financial reporting standards established by the Financial Accounting Standards Board, the Governmental Accounting Standards Board, or another specialized body dealing with accounting and auditing matters.
19. “In-state financial institution” means the same as in A.R.S. § 6-101.
20. “Legal guardian” means an adult who is responsible for a minor:
 - a. Through acceptance of guardianship of the minor through a testamentary appointment or an appointment by a court pursuant to A.R.S. Title 14, Chapter 5, Article 2; or
 - b. As a “custodian” as defined in A.R.S. § 8-201.
21. “Medical record” means the same as:
 - a. “Adequate records” as defined in A.R.S. § 32-1401,
 - b. “Adequate medical records” as defined in A.R.S. § 32-1501,
 - c. “Adequate records” as defined in A.R.S. § 32-1800, or
 - d. “Adequate records” as defined in A.R.S. § 32-2901.
22. “Out-of-state financial institution” means the same as in A.R.S. § 6-101.
23. “Private school” means the same as in A.R.S. § 15-101.
24. “Public place”:
 - a. Means any location, facility, or venue that is not intended for the regular exclusive use of an individual or a specific group of individuals;
 - b. Includes, but not is limited to:
 - i. Airports;
 - ii. Banks;
 - iii. Bars;
 - iv. Child care facilities;
 - v. Child care group homes during hours of operation;
 - vi. Common areas of apartment buildings, condominiums, or other multifamily housing facilities;
 - vii. Educational facilities;
 - viii. Entertainment facilities or venues;
 - ix. Health care institutions, except as provided in subsection (24)(c);
 - x. Hotel and motel common areas;
 - xi. Laundromats;
 - xii. Libraries;
 - xiii. Office buildings;
 - xiv. Parking lots;
 - xv. Parks;
 - xvi. Public transportation facilities;
 - xvii. Reception areas;
 - xviii. Restaurants;
 - xix. Retail food production or marketing establishments;
 - xx. Retail service establishments;
 - xxi. Retail stores;
 - xxii. Shopping malls;
 - xxiii. Sidewalks;
 - xxiv. Sports facilities;
 - xxv. Theaters; and
 - xxvi. Waiting rooms; and
 - c. Does not include:
 - i. Nursing care institutions as defined in A.R.S. § 36-401,
 - ii. Hospices as defined in A.R.S. § 36-401,
 - iii. Assisted living centers as defined in A.R.S. § 36-401,
 - iv. Assisted living homes as defined in A.R.S. § 36-401,
 - v. Adult day health care facilities as defined in A.R.S. § 36-401,
 - vi. Adult foster care homes as defined in A.R.S. § 36-401, or
 - vii. Private residences.
25. “Public school” means the same as “school” as defined in A.R.S. § 15-101.
26. “Registry identification number” means the random 20-digit alphanumeric identifier generated by the Department, containing at least four numbers and four letters, issued by the Department to a qualifying patient, designated caregiver, dispensary, or dispensary agent.
27. “Revocation” means the Department’s final decision that an individual’s registry identification card or a dispensary registration certificate is rescinded because the individual or the dispensary does not comply with the applicable requirements in A.R.S. Title 36, Chapter 28.1 or this Chapter.

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28. “Working day” means a Monday, Tuesday, Wednesday, Thursday, or Friday that is not a state holiday or a state-wide furlough day.

Historical Note

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by final rulemaking at 18 A.A.R. 3354, with an immediate effective date of December 5, 2012 (Supp. 12-4).

R9-17-102. Fees

- A.** An applicant submitting an application to the Department shall submit the following nonrefundable fees:
1. Except as provided in R9-17-303(D), for registration of a dispensary, \$5,000;
 2. To renew the registration of a dispensary, \$1,000;
 3. To change the location of a dispensary, \$2,500;
 4. To change the location of a dispensary’s cultivation site or add a cultivation site, \$2,500;
 5. For a registry identification card for a:
 - a. Qualifying patient, except as provided in subsection (B), \$150;
 - b. Designated caregiver, \$200; and
 - c. Dispensary agent, \$500;
 6. For renewing a registry identification card for a:
 - a. Qualifying patient, except as provided in subsection (B), \$150;
 - b. Designated caregiver, \$200; and
 - c. Dispensary agent, \$500;
 7. For amending or changing a registry identification card, \$10; and
 8. For requesting a replacement registry identification card, \$10.
- B.** A qualifying patient may pay a reduced fee of \$75 if the qualifying patient submits, with the qualifying patient’s application for a registry identification card or the qualifying patient’s application to renew the qualifying patient’s registry identification card, a copy of an eligibility notice or electronic benefits transfer card demonstrating current participation in the U.S. Department of Agriculture, Food and Nutrition Services, Supplemental Nutrition Assistance Program.

Historical Note

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by final rulemaking at 18 A.A.R. 3354, with an immediate effective date of December 5, 2012 (Supp. 12-4).

R9-17-103. Application Submission

- A.** An applicant submitting an application for a registry identification card or to amend, change, or replace a registry identification card for a qualifying patient, designated caregiver, or dispensary agent shall submit the application electronically in a Department-provided format.
- B.** A residence address or mailing address submitted for a qualifying patient or designated caregiver as part of an application for a registry identification card is located in Arizona.
- C.** A mailing address submitted for a principal officer or board member as part of a dispensary certificate registration application or as part of an application for a dispensary agent registration identification card is located in Arizona.

Historical Note

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by final rulemaking at 18 A.A.R. 3354, with an immediate effective date of December 5, 2012 (Supp. 12-4).

R9-17-104. Changing Information on a Registry Identification Card

Except as provided in R9-17-203(B) and (C), to make a change to a cardholder’s name or address on the cardholder’s registry identification card, the cardholder shall submit to the Department, within 10 working days after the change, a request for the change that includes:

1. The cardholder’s name and the registry identification number on the cardholder’s current registry identification card;
2. The cardholder’s new name or address, as applicable;
3. For a change in the cardholder’s name, one of the following with the cardholder’s new name:
 - a. An Arizona driver’s license,
 - b. An Arizona identification card, or
 - c. The photograph page in the cardholder’s U.S. passport;
4. For a change in address, the county where the new address is located;
5. The effective date of the cardholder’s new name or address; and
6. The applicable fee in R9-17-102 for changing a registry identification card.

Historical Note

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2).

R9-17-105. Requesting a Replacement Registry Identification Card

To request a replacement card for a cardholder’s registry identification card that has been lost, stolen, or destroyed, the cardholder shall submit to the Department, within 10 working days after the cardholder’s registry identification card was lost, stolen, or destroyed, a request for a replacement card that includes:

1. The cardholder’s name and date of birth;
2. If known, the registry identification number on the cardholder’s lost, stolen, or destroyed registry identification card;
3. If the cardholder cannot provide the registry identification number on the cardholder’s lost, stolen, or destroyed registry identification card, a copy of one of the following documents that the cardholder submitted when the cardholder obtained the registry identification card:
 - a. Arizona driver’s license,
 - b. Arizona identification card,
 - c. Arizona registry identification card, or
 - d. Photograph page in the cardholder’s U.S. passport; and
4. The applicable fee in R9-17-102 for requesting a replacement registry identification card.

Historical Note

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2).

R9-17-106. Adding a Debilitating Medical Condition

- A.** An entity may request the addition of a medical condition to the list of debilitating medical conditions in R9-17-201 by submitting to the Department, at the times specified in subsection (C), the following in writing:
1. The entity’s name;
 2. The entity’s mailing address, name of contact individual, telephone number, and, if applicable, e-mail address;
 3. The name of the medical condition the entity is requesting be added;
 4. A description of the symptoms and other physiological effects experienced by an individual suffering from the

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medical condition or a treatment of the medical condition that may impair the ability of the individual to accomplish activities of daily living;

5. The availability of conventional medical treatments to provide therapeutic or palliative benefit for the medical condition or a treatment of the medical condition;
 6. A summary of the evidence that the use of marijuana will provide therapeutic or palliative benefit for the medical condition or a treatment of the medical condition; and
 7. Articles, published in peer-reviewed scientific journals, reporting the results of research on the effects of marijuana on the medical condition or a treatment of the medical condition supporting why the medical condition should be added.
- B.** The Department shall:
1. Acknowledge in writing the Department's receipt of a request for the addition of a medical condition to the list of debilitating medical conditions listed in R9-17-201 within 30 calendar days after receiving the request;
 2. Review the request to determine if the requester has provided evidence that:
 - a. The specified medical condition or treatment of the medical condition impairs the ability of the individual to accomplish activities of daily living, and
 - b. Marijuana usage provides a therapeutic or palliative benefit to an individual suffering from the medical condition or treatment of the medical condition;
 3. Within 90 calendar days after receiving the request, notify the requester that the Department has determined that the information provided by the requester:
 - a. Meets the requirements in subsection (B)(2) and the date the Department will conduct a public hearing to discuss the request; or
 - b. Does not meet the requirements in subsection (B)(2), the specific reason for the determination, and the process for requesting judicial review of the Department's determination pursuant to A.R.S. Title 12, Chapter 7, Article 6;
 4. If applicable:
 - a. Schedule a public hearing to discuss the request;
 - b. Provide public notice of the public hearing by submitting a Notice of Public Information to the Office of the Secretary of State, for publication in the *Arizona Administrative Register* at least 30 calendar days before the date of the public hearing;
 - c. Post a copy of the request on the Department's web site for public comment at least 30 calendar days before the date of the public hearing; and
 - d. Hold the public hearing no more than 150 calendar days after receiving the request; and
 5. Within 180 calendar days after receiving the request:
 - a. Add the medical condition to the list of debilitating medical conditions, or
 - b. Provide written notice to the requester of the Department's decision to deny the request that includes:
 - i. The specific reasons for the Department's decision; and
 - ii. The process for requesting judicial review of the Department's decision pursuant to A.R.S. Title 12, Chapter 7, Article 6.
- C.** The Department shall accept requests for the addition of a medical condition to the list of debilitating medical conditions in R9-17-201 in January and July of each calendar year starting in January 2012.

734, effective April 14, 2011 (Supp. 11-2).

R9-17-107. Time-frames

- A.** Within the administrative completeness review time-frame for each type of approval in Table 1.1, the Department shall:
1. Issue a registry identification card or dispensary registration certificate;
 2. Provide a notice of administrative completeness to an applicant; or
 3. Provide a notice of deficiencies to an applicant, including a list of the information or documents needed to complete the application.
- B.** An application for approval to operate a dispensary is not complete until the date the applicant states on a written notice provided to the Department that the dispensary is ready for an inspection by the Department.
- C.** If the Department provides a notice of deficiencies to an applicant:
1. The administrative completeness review time-frame and the overall time-frame are suspended from the date of the notice of deficiencies until the date the Department receives the missing information or documents from the applicant;
 2. If the applicant does not submit the missing information or documents to the Department within the time-frame in Table 1.1, the Department shall consider the application withdrawn; and
 3. If the applicant submits the missing information or documents to the Department within the time-frame in Table 1.1, the substantive review time-frame begins on the date the Department receives the missing information or documents.
- D.** Within the substantive review time-frame for each type of approval in Table 1.1, the Department:
1. Shall issue or deny a registry identification card or dispensary registration certificate;
 2. May complete an inspection that may require more than one visit to a dispensary and, if applicable, the dispensary's cultivation site; and
 3. May make one written comprehensive request for more information, unless the Department and the applicant agree in writing to allow the Department to submit supplemental requests for information.
- E.** If the Department issues a written comprehensive request or a supplemental request for information:
1. The substantive review time-frame and the overall time-frame are suspended from the date of the written comprehensive request or the supplemental request for information until the date the Department receives all of the information requested, and
 2. The applicant shall submit to the Department all of the information and documents listed in the written comprehensive request or supplemental request for information within 10 working days after the date of the comprehensive written request or supplemental request for information.
- F.** If an applicant for an initial dispensary registration certificate is allocated a dispensary registration certificate as provided in R9-17-303, the Department shall provide a written notice to the applicant of the allocation of the dispensary registration certificate that contains the dispensary's registry identification number.
1. After the applicant receives the written notice of the allocation, the applicant shall submit to the Department for each principal officer or board member for whom fingerprints were submitted:

Historical Note

New Section made by exempt rulemaking at 17 A.A.R.

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- a. An application for a dispensary agent registry identification card that includes:
 - i. The principal officer's or board member's first name; middle initial, if applicable; last name; and suffix, if applicable;
 - ii. The principal officer's or board member's residence address and mailing address;
 - iii. The county where the principal officer or board member resides;
 - iv. The principal officer's or board member's date of birth;
 - v. The identifying number on the applicable card or document in subsection (F)(1)(b)(i) through (v);
 - vi. The name and registry identification number of the dispensary;
 - vii. One of the following:
 - (1) A statement that the principal officer or board member does not currently hold a valid registry identification card, or
 - (2) The assigned registry identification number for each valid registry identification card currently held by the principal officer or board member;
 - viii. A statement signed by the principal officer or board member pledging not to divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1;
 - ix. An attestation that the information provided in and with the application is true and correct; and
 - x. The signature of the principal officer or board member and the date the principal officer or board member signed;
 - b. A copy the principal officer's or board member's:
 - i. Arizona driver's license issued on or after October 1, 1996;
 - ii. Arizona identification card issued on or after October 1, 1996;
 - iii. Arizona registry identification card;
 - iv. Photograph page in the principal officer's or board member's U.S. passport; or
 - v. Arizona driver's license or identification card issued before October 1, 1996 and one of the following for the principal officer or board member:
 - (1) Birth certificate verifying U.S. citizenship,
 - (2) U. S. Certificate of Naturalization, or
 - (3) U. S. Certificate of Citizenship;
 - c. A current photograph of the principal officer or board member; and
 - d. The applicable fee in R9-17-102 for applying for a dispensary agent registry identification card.
2. After receipt of the information and documents in subsection (F)(1), the Department shall review the information and documents.
 - a. If the information and documents for at least one of the principal officers or board members complies with the A.R.S. Title 36, Chapter 28.1 and this Chapter, the Department shall issue:
 - i. A dispensary agent registry identification card to any principal officer or board member whose dispensary agent registry identification card application complies with A.R.S. Title 36, Chapter 28.1 and this Chapter; and
 - ii. The dispensary registration certificate.
 - b. If the information and documents for a dispensary agent registry identification card application for any principal officer or board member does not comply with A.R.S. Title 36, Chapter 28.1 and this Chapter, the Department shall deny the dispensary agent registry identification card application and provide notice to the principal officer or board member and to the dispensary that includes:
 - i. The specific reasons for the denial; and
 - ii. The process for requesting a judicial review of the Department's decision pursuant to A.R.S. Title 12, Chapter 7, Article 6.
- G.** The Department shall issue:
1. A registry identification card or an approval to operate a dispensary, as applicable, if the Department determines that the applicant complies with A.R.S. Title 36, Chapter 28.1 and this Chapter;
 2. For an applicant for a registry identification card, a denial that includes the reason for the denial and the process for requesting judicial review if:
 - a. The Department determines that the applicant does not comply with A.R.S. Title 36, Chapter 28.1 and this Chapter; or
 - b. The applicant does not submit all of the information and documents listed in the written comprehensive request or supplemental request for information within 10 working days after the date of the comprehensive written request or supplemental request for information;
 3. For an applicant for a dispensary registration certificate, if the Department determines that the dispensary registration certificate application complies with A.R.S. Title 36, Chapter 28.1 and this Chapter but the Department is not issuing a dispensary registration certificate to the applicant because all available dispensary registration certificates have been allocated according to the criteria and processes in R9-17-303, written notice that:
 - a. The dispensary registration certificate application complies with A.R.S. Title 36, Chapter 28.1 and this Chapter;
 - b. The applicant was not allocated a dispensary registration certificate according to the criteria and processes in R9-17-303; and
 - c. The written notice is not a denial and is not considered a final decision of the Department subject to administrative review; or
 4. For an applicant for a dispensary registration certificate, a denial that includes the reason for the denial and the process for administrative review if:
 - a. The Department determines that a dispensary registration certificate application does not comply with A.R.S. Title 36, Chapter 28.1 or this Chapter; or
 - b. The applicant does not submit all of the information and documents listed in the written comprehensive request or supplemental request for information within 10 working days after the date of the comprehensive written request or supplemental request for information.

Historical Note

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by final rulemaking at 18 A.A.R. 3354, with an immediate effective date of December 5, 2012 (Supp. 12-4).

Table 1.1 Time-frames

Type of approval	Authority (A.R.S. § or A.A.C.)	Overall Time-frame (in working days)	Time-frame for applicant to complete application (in working days)	Administrative Completeness Time-frame (in working days)	Substantive Review Time-frame (in working days)
Changing a registry identification card	36-2808	10	10	5	5
Requesting a replacement registry identification card	36-2804.06	5	5	2	3
Applying for a registry identification card for a qualifying patient or a designated caregiver	36-2804.02(A)	15	30	5	10
Amending a registry identification card for a qualifying patient or a designated caregiver	36-2808	10	10	5	5
Renewing a qualifying patient's or designated caregiver's registry identification card	36-2804.02(A) and 36-2804.06	15	15	5	10
Applying for a dispensary registration certificate	36-2804	30	10	5	25
Applying for approval to operate a dispensary	R9-17-305	45		15	30
Changing a dispensary location or adding or changing a dispensary's cultivation site location	36-2804 and R9-17-307	90	90	30	60
Renewing a dispensary registration certificate	36-2804.06	15	15	5	10
Applying for a dispensary agent registry identification card	36-2804.01 and 36-2804.03	15	30	5	10
Renewing a dispensary agent's registry identification card	36-2804.06	15	15	5	10

Historical Note

New Table 1.1 made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Table 1.1 amended by emergency rulemaking at 18 A.A.R. 1010, effective April 11, 2012 for 180 days (Supp. 12-2). Emergency expired; Table 1.1 amended by final rulemaking at 18 A.A.R. 3354, with an immediate effective date of December 5, 2012 (Supp. 12-4).

R9-17-108. Expiration of a Registry Identification Card or a Dispensary Registration Certificate

- A. Except as provided in subsection (B), a registry identification card issued to a qualifying patient, designated caregiver, or dispensary agent is valid for one year after the date of issuance.
- B. If the Department issues a registry identification card to a qualifying patient, designated caregiver, or dispensary agent based on a request for a replacement registry identification card or an application to change or amend a registry identification card; the replacement, changed, or amended registry identification card shall have the same expiration date as the registry identification card being replaced, changed, or amended.
- C. Except as provided in subsection (D), a dispensary registration certificate is valid for one year after the date of issuance.
- D. If the Department issues an amended dispensary registration certificate based on a change of location or an addition of a cultivation site, the dispensary registration certificate shall

have the same expiration date as the dispensary registration certificate previously held by the dispensary.

- E. An approval to operate a dispensary shall have the same expiration date as the dispensary registration certificate associated with the approval to operate the dispensary.

Historical Note

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2).

R9-17-109. Notifications and Void Registry Identification Cards

- A. The Department shall provide written notice that a cardholder's registry identification card is void and no longer valid under A.R.S. Title 36, Chapter 28.1 and this Chapter to a:
 - 1. Qualifying patient when the Department receives notification from:
 - a. The qualifying patient that the qualifying patient no longer has a debilitating medical condition, or
 - b. The physician who provided the qualifying patient's written certification that the:

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- i. Qualifying patient no longer has a debilitating medical condition,
 - ii. Physician no longer believes that the qualifying patient would receive therapeutic or palliative benefit from the medical use of marijuana, or
 - iii. Physician believes that the qualifying patient is not using the medical marijuana as recommended,
- 2. Designated caregiver when:
 - a. The Department receives notification from the designated caregiver's qualifying patient that the designated caregiver no longer assists the qualifying patient with the medical use of marijuana, or
 - b. The registry identification card for the qualifying patient that is listed on the designated caregiver's registry identification card is no longer valid, or
- 3. Dispensary agent when:
 - a. The Department receives the written notification, required in R9-17-310(A)(9), that the dispensary agent:
 - i. No longer serves as a principal officer, board member, or medical director for the dispensary;
 - ii. Is no longer employed by the dispensary; or
 - iii. No longer provides volunteer service at or on behalf of the dispensary; or
 - b. The registration certificate for the dispensary that is listed on the dispensary agent's registry identification card is no longer valid.
- B. The Department shall void a qualifying patient's registry identification card:
 - 1. When the Department receives notification that the qualifying patient is deceased; or
 - 2. For a qualifying patient under 18 years of age, when the qualifying patient's designated caregiver's registry identification card is revoked.
- C. The written notice required in subsection (A) that a registry identification card is void is not a revocation and is not considered a final decision of the Department subject to judicial review.

Historical Note

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by final rulemaking at 18 A.A.R. 3354, with an immediate effective date of December 5, 2012 (Supp. 12-4).

ARTICLE 2. QUALIFYING PATIENTS AND DESIGNATED CAREGIVERS

R9-17-201. Debilitating Medical Conditions

An individual applying for a qualifying patient registry identification card shall have a diagnosis from a physician of at least one of the following debilitating medical conditions:

- 1. Cancer;
- 2. Glaucoma;
- 3. Human immunodeficiency virus;
- 4. Acquired immune deficiency syndrome;
- 5. Hepatitis C;
- 6. Amyotrophic lateral sclerosis;
- 7. Crohn's disease;
- 8. Agitation of Alzheimer's disease;
- 9. A chronic or debilitating disease or medical condition or the treatment for a chronic or debilitating disease or medical condition that produces cachexia or wasting syndrome;
- 10. A chronic or debilitating disease or medical condition or the treatment for a chronic or debilitating disease or medical condition that produces severe and chronic pain;
- 11. A chronic or debilitating disease or medical condition or the treatment for a chronic or debilitating disease or medical condition that produces severe nausea;
- 12. A chronic or debilitating disease or medical condition or the treatment for a chronic or debilitating disease or medical condition that produces seizures, including those characteristic of epilepsy;
- 13. A chronic or debilitating disease or medical condition or the treatment for a chronic or debilitating disease or medical condition that produces severe or persistent muscle spasms, including those characteristic of multiple sclerosis; or
- 14. A debilitating medical condition approved by the Department under A.R.S. § 36-2801.01 and R9-17-106.

Historical Note

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2).

R9-17-202. Applying for a Registry Identification Card for a Qualifying Patient or a Designated Caregiver

- A. Except for a qualifying patient who is under 18 years of age, a qualifying patient is not required to have a designated caregiver.
- B. A qualifying patient may have only one designated caregiver at any given time.
- C. Except for a qualifying patient who is under 18 years of age, if the information submitted for a qualifying patient complies with A.R.S. Title 36, Chapter 28.1 and this Chapter but the information for the qualifying patient's designated caregiver does not comply with A.R.S. Title 36, Chapter 28.1 and this Chapter, the Department shall issue the registry identification card for the qualifying patient separate from issuing a registry identification card for the qualifying patient's designated caregiver.
- D. If the Department issues a registry identification card to a qualifying patient under subsection (C), the Department shall continue the process for issuing or denying the qualifying patient's designated caregiver's registry identification card.
- E. The Department shall not issue a designated caregiver's registry identification card before the Department issues the designated caregiver's qualifying patient's registry identification card.
- F. Except as provided in subsection (G), to apply for a registry identification card, a qualifying patient shall submit to the Department the following:
 - 1. An application in a Department-provided format that includes:
 - a. The qualifying patient's:
 - i. First name; middle initial, if applicable; last name; and suffix, if applicable;
 - ii. Date of birth; and
 - iii. Gender;
 - b. Except as provided in subsection (F)(1)(i), the qualifying patient's residence address and mailing address;
 - c. The county where the qualifying patient resides;
 - d. The qualifying patient's e-mail address;
 - e. The identifying number on the applicable card or document in subsection (F)(2)(a) through (e);
 - f. The name, address, and telephone number of the physician providing the written certification for medical marijuana for the qualifying patient;

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- g. Whether the qualifying patient is requesting authorization for cultivating marijuana plants for the qualifying patient's medical use because the qualifying patient believes that the qualifying patient resides at least 25 miles from the nearest operating dispensary;
 - h. If the qualifying patient is requesting authorization for cultivating marijuana plants, whether the qualifying patient is designating the qualifying patient's designated caregiver to cultivate marijuana plants for the qualifying patient's medical use;
 - i. If the qualifying patient is homeless, an address where the qualifying patient can receive mail;
 - j. Whether the qualifying patient would like notification of any clinical studies needing human subjects for research on the medical use of marijuana;
 - k. An attestation that the information provided in the application is true and correct; and
 - l. The signature of the qualifying patient and date the qualifying patient signed;
2. A copy of the qualifying patient's:
 - a. Arizona driver's license issued on or after October 1, 1996;
 - b. Arizona identification card issued on or after October 1, 1996;
 - c. Arizona registry identification card;
 - d. Photograph page in the qualifying patient's U.S. passport; or
 - e. Arizona driver's license or identification card issued before October 1, 1996 and one of the following for the qualifying patient:
 - i. Birth certificate verifying U.S. citizenship,
 - ii. U.S. Certificate of Naturalization, or
 - iii. U.S. Certificate of Citizenship;
 3. A current photograph of the qualifying patient;
 4. A statement in a Department-provided format signed by the qualifying patient pledging not to divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1;
 5. A physician's written certification in a Department-provided format dated within 90 calendar days before the submission of the qualifying patient's application that includes:
 - a. The physician's:
 - i. Name,
 - ii. License number including an identification of the physician license type,
 - iii. Office address on file with the physician's licensing board,
 - iv. Telephone number on file with the physician's licensing board, and
 - v. E-mail address;
 - b. The qualifying patient's name and date of birth;
 - c. A statement that the physician has made or confirmed a diagnosis of a debilitating medical condition as defined in A.R.S. § 36-2801 for the qualifying patient;
 - d. An identification, initialed by the physician, of one or more of the debilitating medical conditions in R9-17-201 as the qualifying patient's specific debilitating medical condition;
 - e. If the debilitating medical condition identified in subsection (F)(5)(d) is a condition in:
 - i. R9-17-201(9) through (13), the underlying chronic or debilitating disease or medical condition; or
 - ii. R9-17-201(14), the debilitating medical condition;
 - f. A statement, initialed by the physician, that the physician:
 - i. Has established a medical record for the qualifying patient, and
 - ii. Is maintaining the qualifying patient's medical record as required in A.R.S. § 12-2297;
 - g. A statement, initialed by the physician, that the physician has conducted an in-person physical examination of the qualifying patient within the previous 90 calendar days appropriate to the qualifying patient's presenting symptoms and the qualifying patient's debilitating medical condition diagnosed or confirmed by the physician;
 - h. The date the physician conducted the in-person physical examination of the qualifying patient;
 - i. A statement, initialed by the physician, that the physician reviewed the qualifying patient's:
 - i. Medical records including medical records from other treating physicians from the previous 12 months,
 - ii. Response to conventional medications and medical therapies, and
 - iii. Profile on the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program database;
 - j. A statement, initialed by the physician, that the physician has explained the potential risks and benefits of the medical use of marijuana to the qualifying patient;
 - k. A statement, initialed by the physician, that in the physician's professional opinion, the qualifying patient is likely to receive therapeutic or palliative benefit from the qualifying patient's medical use of marijuana to treat or alleviate the qualifying patient's debilitating medical condition;
 - l. A statement, initialed by the physician, that if the physician has referred the qualifying patient to a dispensary, the physician has disclosed to the qualifying patient any personal or professional relationship the physician has with the dispensary;
 - m. An attestation that the information provided in the written certification is true and correct; and
 - n. The physician's signature and the date the physician signed;
6. If the qualifying patient is designating a caregiver, the following in a Department-provided format:
 - a. The designated caregiver's first name; middle initial, if applicable; last name; and suffix, if applicable;
 - b. The designated caregiver's date of birth;
 - c. The designated caregiver's residence address and mailing address;
 - d. The county where the designated caregiver resides;
 - e. The identifying number on the applicable card or document in subsection (F)(6)(i)(i) through (v);
 - f. One of the following:
 - i. A statement that the designated caregiver does not currently hold a valid registry identification card, or
 - ii. The assigned registry identification number for the designated caregiver for each valid registry identification card currently held by the designated caregiver;
 - g. An attestation signed and dated by the designated caregiver that the designated caregiver has not been

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- convicted of an excluded felony offense as defined in A.R.S. § 36-2801;
- h. A statement signed by the designated caregiver:
 - i. Agreeing to assist the qualifying patient with the medical use of marijuana; and
 - ii. Pledging not to divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1;
 - i. A copy of the designated caregiver's:
 - i. Arizona driver's license issued on or after October 1, 1996;
 - ii. Arizona identification card issued on or after October 1, 1996;
 - iii. Arizona registry identification card;
 - iv. Photograph page in the designated caregiver's U.S. passport; or
 - v. Arizona driver's license or identification card issued before October 1, 1996 and one of the following for the designated caregiver:
 - (1) Birth certificate verifying U.S. citizenship,
 - (2) U.S. Certificate of Naturalization, or
 - (3) U.S. Certificate of Citizenship;
 - j. A current photograph of the designated caregiver; and
 - k. For the Department's criminal records check authorized in A.R.S. § 36-2804.05:
 - i. The designated caregiver's fingerprints on a fingerprint card that includes:
 - (1) The designated caregiver's first name; middle initial, if applicable; and last name;
 - (2) The designated caregiver's signature;
 - (3) If different from the designated caregiver, the signature of the individual physically rolling the designated caregiver's fingerprints;
 - (4) The designated caregiver's address;
 - (5) If applicable, the designated caregiver's surname before marriage and any names previously used by the designated caregiver;
 - (6) The designated caregiver's date of birth;
 - (7) The designated caregiver's Social Security number;
 - (8) The designated caregiver's citizenship status;
 - (9) The designated caregiver's gender;
 - (10) The designated caregiver's race;
 - (11) The designated caregiver's height;
 - (12) The designated caregiver's weight;
 - (13) The designated caregiver's hair color;
 - (14) The designated caregiver's eye color; and
 - (15) The designated caregiver's place of birth; or
 - ii. If the designated caregiver's fingerprints and information required in subsection (F)(6)(k)(i) were submitted to the Department as part of an application for a designated caregiver or a dispensary agent registry identification card within the previous six months, the registry identification number on the registry identification card issued to the designated caregiver as a result of the application; and
7. The applicable fees in R9-17-102 for applying for:
- a. A qualifying patient registry identification card; and
 - b. If applicable, a designated caregiver registry identification card.
- G.** To apply for a registry identification card for a qualifying patient who is under 18 years of age, the qualifying patient's custodial parent or legal guardian responsible for health care decisions for the qualifying patient shall submit to the Department the following:
1. An application in a Department-provided format that includes:
 - a. The qualifying patient's:
 - i. First name; middle initial, if applicable; last name; and suffix, if applicable;
 - ii. Date of birth; and
 - iii. Gender;
 - b. The qualifying patient's residence address and mailing address;
 - c. The county where the qualifying patient resides;
 - d. The qualifying patient's custodial parent's or legal guardian's first name; middle initial, if applicable; last name; and suffix, if applicable;
 - e. The identifying number on the applicable card or document in subsection (G)(5)(a) through (e);
 - f. The qualifying patient's custodial parent's or legal guardian's residence address and mailing address;
 - g. The county where the qualifying patient's custodial parent or legal guardian resides;
 - h. The qualifying patient's custodial parent's or legal guardian's e-mail address;
 - i. The name, address, and telephone number of a physician who has a physician-patient relationship with the qualifying patient and is providing the written certification for medical marijuana for the qualifying patient;
 - j. The name, address, and telephone number of a second physician who has conducted a comprehensive review of the patient's medical record maintained by other treating physicians, and is providing a written certification for medical marijuana for the qualifying patient;
 - k. The qualifying patient's custodial parent's or legal guardian's date of birth;
 1. Whether the qualifying patient's custodial parent or legal guardian is requesting authorization for cultivating medical marijuana plants for the qualifying patient's medical use because the qualifying patient's custodial parent or legal guardian believes that the qualifying patient resides at least 25 miles from the nearest operating dispensary;
 - m. Whether the qualifying patient's custodial parent or legal guardian would like notification of any clinical studies needing human subjects for research on the medical use of marijuana;
 - n. Whether the individual submitting the application on behalf of the qualifying patient under 18 years of age is the qualifying patient's custodial parent or legal guardian;
 - o. One of the following:
 - i. A statement that the qualifying patient's custodial parent or legal guardian does not currently hold a valid registry identification card, or
 - ii. The assigned registry identification number for the qualifying patient's custodial parent or legal guardian for each valid registry identification card currently held by the qualifying patient's custodial parent or legal guardian;

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- p. An attestation that the information provided in the application is true and correct; and
- q. The signature of the qualifying patient's custodial parent or legal guardian and the date the qualifying patient's custodial parent or legal guardian signed;
- 2. A current photograph of the:
 - a. Qualifying patient, and
 - b. Qualifying patient's custodial parent or legal guardian serving as the qualifying patient's designated caregiver;
- 3. An attestation in a Department-provided format signed and dated by the qualifying patient's custodial parent or legal guardian that the qualifying patient's custodial parent or legal guardian has not been convicted of an excluded felony offense as defined in A.R.S. § 36-2801;
- 4. A statement in a Department-provided format signed by the qualifying patient's custodial parent or legal guardian who is serving as the qualifying patient's designated caregiver:
 - a. Allowing the qualifying patient's medical use of marijuana;
 - b. Agreeing to assist the qualifying patient with the medical use of marijuana; and
 - c. Pledging not to divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1;
- 5. A copy of one of the following for the qualifying patient's custodial parent or legal guardian:
 - a. Arizona driver's license issued on or after October 1, 1996;
 - b. Arizona identification card issued on or after October 1, 1996;
 - c. Arizona registry identification card;
 - d. Photograph page in the qualifying patient's custodial parent or legal guardian U.S. passport; or
 - e. Arizona driver's license or identification card issued before October 1, 1996 and one of the following for the qualifying patient's custodial parent or legal guardian:
 - i. Birth certificate verifying U.S. citizenship,
 - ii. U. S. Certificate of Naturalization, or
 - iii. U. S. Certificate of Citizenship;
- 6. If the individual submitting the application on behalf of a qualifying patient is the qualifying patient's legal guardian, a copy of documentation establishing the individual as the qualifying patient's legal guardian;
- 7. For the Department's criminal records check authorized in A.R.S. § 36-2804.05:
 - a. The qualifying patient's custodial parent or legal guardian's fingerprints on a fingerprint card that includes:
 - i. The qualifying patient's custodial parent or legal guardian's first name; middle initial, if applicable; and last name;
 - ii. The qualifying patient's custodial parent or legal guardian's signature;
 - iii. If different from the qualifying patient's custodial parent or legal guardian, the signature of the individual physically rolling the qualifying patient's custodial parent's or legal guardian's fingerprints;
 - iv. The qualifying patient's custodial parent's or legal guardian's address;
 - v. If applicable, the qualifying patient's custodial parent's or legal guardian's surname before marriage and any names previously used by the qualifying patient's custodial parent or legal guardian;
- vi. The qualifying patient's custodial parent's or legal guardian's date of birth;
- vii. The qualifying patient's custodial parent's or legal guardian's Social Security number;
- viii. The qualifying patient's custodial parent's or legal guardian's citizenship status;
- ix. The qualifying patient's custodial parent's or legal guardian's gender;
- x. The qualifying patient's custodial parent's or legal guardian's race;
- xi. The qualifying patient's custodial parent's or legal guardian's height;
- xii. The qualifying patient's custodial parent's or legal guardian's weight;
- xiii. The qualifying patient's custodial parent's or legal guardian's hair color;
- xiv. The qualifying patient's custodial parent's or legal guardian's eye color; and
- xv. The qualifying patient's custodial parent's or legal guardian's place of birth; or
- b. If the qualifying patient's custodial parent's or legal guardian's fingerprints and information required in subsection (G)(7)(a) were submitted to the Department as part of an application for a designated caregiver or a dispensary agent registry identification card within the previous six months, the registry identification number on the registry identification card issued to the qualifying patient's custodial parent or legal guardian as a result of the application;
- 8. A written certification from the physician in subsection (G)(1)(i) and a separate written certification from the physician in (G)(1)(j) in a Department-provided format dated within 90 calendar days before the submission of the qualifying patient's application that includes:
 - a. The physician's:
 - i. Name,
 - ii. License number including an identification of the physician license type,
 - iii. Office address on file with the physician's licensing board,
 - iv. Telephone number on file with the physician's licensing board, and
 - v. E-mail address;
 - b. The qualifying patient's name and date of birth;
 - c. An identification of one or more of the debilitating medical conditions in R9-17-201 as the qualifying patient's specific debilitating medical condition;
 - d. If the debilitating medical condition identified in subsection (G)(9)(c) is a condition in:
 - i. R9-17-201(9) through (13), the underlying chronic or debilitating disease or medical condition; or
 - ii. R9-17-201(14), the debilitating medical condition;
 - e. For the physician listed in subsection (G)(1)(i):
 - i. A statement that the physician has made or confirmed a diagnosis of a debilitating medical condition as defined in A.R.S. § 36-2801 for the qualifying patient;
 - ii. A statement, initialed by the physician, that the physician:
 - (1) Has established a medical record for the qualifying patient, and
 - (2) Is maintaining the qualifying patient's

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medical record as required in A.R.S. § 12-2297;

- iii. A statement, initialed by the physician, that the physician has conducted an in-person physical examination of the qualifying patient within the previous 90 calendar days appropriate to the qualifying patient's presenting symptoms and the qualifying patient's debilitating medical condition diagnosed or confirmed by the physician;
 - iv. The date the physician conducted the in-person physical examination of the qualifying patient;
 - v. A statement, initialed by the physician, that the physician reviewed the qualifying patient's:
 - (1) Medical records including medical records from other treating physicians from the previous 12 months,
 - (2) Response to conventional medications and medical therapies, and
 - (3) Profile on the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program database; and
 - vi. A statement, initialed by the physician, that the physician has explained the potential risks and benefits of the use of medical marijuana to the qualifying patient's custodial parent or legal guardian responsible for health care decisions for the qualifying patient;
 - f. For the physician listed in subsection (G)(1)(j), a statement, initialed by the physician, that the physician conducted a comprehensive review of the qualifying patient's medical records from other treating physicians;
 - g. A statement, initialed by the physician, that, in the physician's professional opinion, the qualifying patient is likely to receive therapeutic or palliative benefit from the qualifying patient's medical use of marijuana to treat or alleviate the qualifying patient's debilitating medical condition;
 - h. A statement, initialed by the physician, that if the physician has referred the qualifying patient's custodial parent or legal guardian to a dispensary, the physician has disclosed to the qualifying patient any personal or professional relationship the physician has with the dispensary;
 - i. An attestation that the information provided in the written certification is true and correct; and
 - j. The physician's signature and the date the physician signed; and
 - 9. The applicable fees in R9-17-102 for applying for a:
 - a. Qualifying patient registry identification card, and
 - b. Designated caregiver registry identification card.
- H.** For purposes of this Article, "25 miles" includes the area contained within a circle that extends for 25 miles in all directions from a specific location.
- I.** For purposes of this Article, "residence address" when used in conjunction with a qualifying patient means:
- 1. The street address including town or city and zip code assigned by a local jurisdiction; or
 - 2. For property that does not have a street address assigned by a local jurisdiction, the legal description of the property on the title documents recorded by the assessor of the county in which the property is located.

Historical Note

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by

final rulemaking at 18 A.A.R. 3354, with an immediate effective date of December 5, 2012 (Supp. 12-4).

R9-17-203. Amending a Qualifying Patient's or Designated Caregiver's Registry Identification Card

- A.** To add a designated caregiver or to request a change of a qualifying patient's designated caregiver, the qualifying patient shall submit to the Department, within 10 working days after the addition or the change, the following:
- 1. An application in a Department-provided format that includes:
 - a. The qualifying patient's name and the registry identification number on the qualifying patient's current registry identification card;
 - b. If applicable, the name of the qualifying patient's current designated caregiver and the date the designated caregiver last provided or will last provide assistance to the qualifying patient;
 - c. The name of that the individual the qualifying patient is designating as caregiver; and
 - d. The signature of the qualifying patient and date the qualifying patient signed;
 - 2. For the caregiver the qualifying patient is designating:
 - a. The designated caregiver's first name; middle initial, if applicable; last name; and suffix, if applicable;
 - b. The designated caregiver's date of birth;
 - c. The designated caregiver's residence address and mailing address;
 - d. The county where the designated caregiver resides;
 - e. The identifying number on the applicable card or document in subsection (A)(2)(i)(i) through (v);
 - f. One of the following:
 - i. A statement that the designated caregiver does not currently hold a valid registry identification card, or
 - ii. The assigned registry identification number for the designated caregiver for each valid registry identification card currently held by the designated caregiver;
 - g. An attestation in a Department-provided format signed and dated by the designated caregiver that the designated caregiver has not been convicted of an excluded felony offense as defined in A.R.S. § 36-2801;
 - h. A statement in a Department-provided format signed by the designated caregiver:
 - i. Agreeing to assist the qualifying patient with the medical use of marijuana; and
 - ii. Pledging not to divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1;
 - i. A copy the designated caregiver's:
 - i. Arizona driver's license issued on or after October 1, 1996;
 - ii. Arizona identification card issued on or after October 1, 1996;
 - iii. Arizona registry identification card;
 - iv. Photograph page in the designated caregiver's U.S. passport; or
 - v. Arizona driver's license or identification card issued before October 1, 1996 and one of the following for the designated caregiver:
 - (1) Birth certificate verifying U.S. citizenship,
 - (2) U. S. Certificate of Naturalization, or
 - (3) U. S. Certificate of Citizenship;

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- j. A current photograph of the designated caregiver; and
 - k. For the Department's criminal records check authorized in A.R.S. § 36-2804.05:
 - i. The designated caregiver's fingerprints on a fingerprint card that includes:
 - (1) The designated caregiver's first name; middle initial, if applicable; and last name;
 - (2) The designated caregiver's signature;
 - (3) If different from the designated caregiver, the signature of the individual physically rolling the designated caregiver's fingerprints;
 - (4) The designated caregiver's address;
 - (5) If applicable, the designated caregiver's surname before marriage and any names previously used by the designated caregiver;
 - (6) The designated caregiver's date of birth;
 - (7) The designated caregiver's Social Security number;
 - (8) The designated caregiver's citizenship status;
 - (9) The designated caregiver's gender;
 - (10) The designated caregiver's race;
 - (11) The designated caregiver's height;
 - (12) The designated caregiver's weight;
 - (13) The designated caregiver's hair color;
 - (14) The designated caregiver's eye color; and
 - (15) The designated caregiver's place of birth; or
 - ii. If the designated caregiver's fingerprints and information required in subsection (A)(2)(k)(i) were submitted to the Department as part of an application for a designated caregiver or a dispensary agent within the previous six months, the registry identification number on the registry identification card issued to the designated caregiver as a result of the application; and
 - 3. The applicable fee in R9-17-102 for applying for a designated caregiver registry identification card.
- B.** To amend a qualifying patient's address on the qualifying patient's registry identification card when the qualifying patient or the qualifying patient's designated caregiver is authorized to cultivate marijuana, the qualifying patient shall submit to the Department, within 10 working days after the change in address, the following:
- 1. The qualifying patient's name and the registry identification number on the qualifying patient's current registry identification card;
 - 2. The qualifying patient's new address;
 - 3. The county where the new address is located;
 - 4. The name of the qualifying patient's designated caregiver, if applicable;
 - 5. Whether the qualifying patient is requesting authorization for cultivating marijuana plants for the qualifying patient's medical use because the qualifying patient believes that the qualifying patient resides at least 25 miles from the nearest operating dispensary;
 - 6. If the qualifying patient is requesting authorization for cultivating marijuana plants, whether the qualifying patient is designating the qualifying patient's designated caregiver to cultivate marijuana plants for the qualifying patient's medical use;
 - 7. The effective date of the qualifying patient's new address; and
 - 8. The applicable fee in R9-17-102 for applying to:
 - a. Amend a qualifying patient's registry identification card; and
 - b. If the qualifying patient is designating a designated caregiver for cultivation authorization, amend a designated caregiver's registry identification card.
- C.** To request authorization to cultivate marijuana based on a qualifying patient's current address or a new address, the qualifying patient shall submit to the Department, if applicable within 10 working days after the change in address, the following:
- 1. The qualifying patient's name and the registry identification number on the qualifying patient's current registry identification card;
 - 2. If the qualifying patient's address is a new address, the qualifying patient's:
 - a. Current address,
 - b. New address,
 - c. The county where the new address is located, and
 - d. The effective date of the qualifying patient's new address;
 - 3. The name of the qualifying patient's designated caregiver, if applicable;
 - 4. Whether the qualifying patient is requesting authorization for cultivating marijuana plants for the qualifying patient's medical use because the qualifying patient believes that the qualifying patient resides at least 25 miles from the nearest operating dispensary;
 - 5. If the qualifying patient is requesting authorization for cultivating marijuana plants, whether the qualifying patient is designating the qualifying patient's designated caregiver to cultivate marijuana plants for the qualifying patient's medical use; and
 - 6. The applicable fee in R9-17-102 for applying to:
 - a. Amend a qualifying patient's registry identification card; and
 - b. If the qualifying patient is designating a designated caregiver for cultivation authorization, amend a designated caregiver's registry identification card.

Historical Note

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by final rulemaking at 18 A.A.R. 3354, with an immediate effective date of December 5, 2012 (Supp. 12-4).

R9-17-204. Renewing a Qualifying Patient's or Designated Caregiver's Registry Identification Card

- A.** Except for a qualifying patient who is under 18 years of age, to renew a qualifying patient's registry identification card, the qualifying patient shall submit the following to the Department at least 30 calendar days before the expiration date of the qualifying patient's registry identification card:
- 1. An application in a Department-provided format that includes:
 - a. The qualifying patient's first name; middle initial, if applicable; last name; and suffix, if applicable;
 - b. The qualifying patient's date of birth;
 - c. Except as provided in subsection (A)(1)(j), the qualifying patient's residence address and mailing address;
 - d. The county where the qualifying patient resides;
 - e. The qualifying patient's e-mail address;
 - f. The registry identification number on the qualifying patient's current registry identification card;

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- g. The name, address, and telephone number of the physician providing the written certification for medical marijuana for the qualifying patient;
 - h. Whether the qualifying patient is requesting authorization for cultivating marijuana plants for the qualifying patient's medical use because the qualifying patient believes that the qualifying patient resides at least 25 miles from the nearest operating dispensary;
 - i. If the qualifying patient is requesting authorization for cultivating marijuana plants, whether the qualifying patient is designating the qualifying patient's designated caregiver to cultivate marijuana plants for the qualifying patient's medical use;
 - j. If the qualifying patient is homeless, an address where the qualifying patient can receive mail;
 - k. Whether the qualifying patient would like notification of any clinical studies needing human subjects for research on the medical use of marijuana;
 - l. An attestation that the information provided in the application is true and correct; and
 - m. The signature of the qualifying patient and the date the qualifying patient signed;
2. If the qualifying patient's name in subsection (A)(1)(a) is not the same name as on the qualifying patient's current registry identification card, one of the following with the qualifying patient's new name:
 - a. An Arizona driver's license,
 - b. An Arizona identification card, or
 - c. The photograph page in the qualifying patient's U.S. passport;
 3. A current photograph of the qualifying patient;
 4. A statement in a Department-provided format signed by the qualifying patient pledging not to divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1;
 5. A physician's written certification in a Department-provided format dated within 90 calendar days before the submission of the qualifying patient's renewal application that includes:
 - a. The physician's:
 - i. Name,
 - ii. License number including an identification of the physician license type,
 - iii. Office address on file with the physician's licensing board,
 - iv. Telephone number on file with the physician's licensing board, and
 - v. E-mail address;
 - b. The qualifying patient's name and date of birth;
 - c. A statement that the physician has made or confirmed a diagnosis of a debilitating medical condition as defined in A.R.S. § 36-2801 for the qualifying patient;
 - d. An identification of one or more of the debilitating medical conditions in R9-17-201 as the qualifying patient's specific debilitating medical condition;
 - e. If the debilitating medical condition identified in subsection (A)(5)(d) is a condition in:
 - i. R9-17-201(9) through (13), the underlying chronic or debilitating disease or medical condition; or
 - ii. R9-17-201(14), the debilitating medical condition;
 - f. A statement, initialed by the physician, that the physician:
 - i. Has established a medical record for the qualifying patient, and
 - ii. Is maintaining the qualifying patient's medical record as required in A.R.S. § 12-2297;
 - g. A statement, initialed by the physician, that the physician has conducted an in-person physical examination of the qualifying patient within the previous 90 calendar days appropriate to the qualifying patient's presenting symptoms and the qualifying patient's debilitating medical condition diagnosed or confirmed by the physician;
 - h. The date the physician conducted the in-person physical examination of the qualifying patient;
 - i. A statement, initialed by the physician, that the physician reviewed the qualifying patient's:
 - i. Medical records including medical records from other treating physicians from the previous 12 months,
 - ii. Response to conventional medications and medical therapies, and
 - iii. Profile on the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program database;
 - j. A statement, initialed by the physician, that the physician has explained the potential risks and benefits of the medical use of marijuana to the qualifying patient;
 - k. A statement, initialed by the physician, that in the physician's professional opinion, the qualifying patient is likely to receive therapeutic or palliative benefit from the qualifying patient's medical use of marijuana to treat or alleviate the qualifying patient's debilitating medical condition;
 - l. A statement, initialed by the physician, that if the physician has referred the qualifying patient to a dispensary, the physician has disclosed to the qualifying patient any personal or professional relationship the physician has with the dispensary;
 - m. An attestation that the information provided in the written certification is true and correct; and
 - n. The physician's signature and the date the physician signed;
 6. If the qualifying patient is designating a caregiver or if the qualifying patient's designated caregiver's registry identification card has the same expiration date as the qualifying patient's registry identification card, the following in a Department-provided format:
 - a. The designated caregiver's first name; middle initial, if applicable; last name; and suffix, if applicable;
 - b. The designated caregiver's date of birth;
 - c. The designated caregiver's residence address and mailing address;
 - d. The county where the designated caregiver resides;
 - e. If the qualifying patient is renewing the designated caregiver's registry identification card, the registry identification number on the designated caregiver's registry identification card associated with the qualifying patient;
 - f. If the qualifying patient is designating an individual not previously designated as the qualifying patient's designated caregiver, the identification number on and a copy of the designated caregiver's:
 - i. Arizona driver's license issued on or after October 1, 1996;
 - ii. Arizona identification card issued on or after October 1, 1996;

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- iii. Arizona registry identification card;
 - iv. Photograph page in the designated caregiver's U. S. passport; or
 - v. Arizona driver's license or identification card issued before October 1, 1996 and one of the following for the designated caregiver:
 - (1) Birth certificate verifying U.S. citizenship,
 - (2) U. S. Certificate of Naturalization, or
 - (3) U. S. Certificate of Citizenship;
 - g. If the qualifying patient is designating an individual not previously designated as the qualifying patient's designated caregiver, one of the following:
 - i. A statement that the designated caregiver does not currently hold a valid registry identification card, or
 - ii. The assigned registry identification number for the designated caregiver for each valid registry identification card currently held by the designated caregiver;
 - h. A current photograph of the designated caregiver;
 - i. An attestation signed and dated by the designated caregiver that the designated caregiver has not been convicted of an excluded felony offense as defined in A.R.S. § 36-2801;
 - j. A statement in a Department-provided format signed by the designated caregiver:
 - i. Agreeing to assist the qualifying patient with the medical use of marijuana; and
 - ii. Pledging not to divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1; and
 - k. For the Department's criminal records check authorized in A.R.S. § 36-2804.05:
 - i. The designated caregiver's fingerprints on a fingerprint card that includes:
 - (1) The designated caregiver's first name; middle initial, if applicable; and last name;
 - (2) The designated caregiver's signature;
 - (3) If different from the designated caregiver, the signature of the individual physically rolling the designated caregiver's fingerprints;
 - (4) The designated caregiver's address;
 - (5) If applicable, the designated caregiver's surname before marriage and any names previously used by the designated caregiver;
 - (6) The designated caregiver's date of birth;
 - (7) The designated caregiver's Social Security number;
 - (8) The designated caregiver's citizenship status;
 - (9) The designated caregiver's gender;
 - (10) The designated caregiver's race;
 - (11) The designated caregiver's height;
 - (12) The designated caregiver's weight;
 - (13) The designated caregiver's hair color;
 - (14) The designated caregiver's eye color; and
 - (15) The designated caregiver's place of birth; or
 - ii. If the designated caregiver's fingerprints and information required in subsection (A)(6)(k)(i) were submitted to the Department as part of an application for a designated caregiver or a dispensary agent registry identification card within the previous six months, the registry identification number on the registry identification card issued to the designated caregiver as a result of the application;
7. If the qualifying patient's designated caregiver's registry identification card has the same expiration date as the qualifying patient's registry identification card and the designated caregiver's name in subsection (A)(6)(a) is not the same name as on the designated caregiver's current registry identification card, one of the following with the designated caregiver's new name:
- a. An Arizona driver's license,
 - b. An Arizona identification card, or
 - c. The photograph page in the designated caregiver's U.S. passport; and
8. The applicable fees in R9-17-102 for applying to:
- a. Renew a qualifying patient's registry identification card; and
 - b. If applicable, issue or renew a designated caregiver's registry identification card.
- B.** To renew a registry identification card for a qualifying patient who is under 18 years of age, the qualifying patient's custodial parent or legal guardian responsible for health care decisions for the qualifying patient shall submit to the Department the following:
- 1. An application in a Department-provided format that includes:
 - a. The qualifying patient's:
 - i. First name; middle initial, if applicable; last name; and suffix, if applicable; and
 - ii. Date of birth;
 - b. The qualifying patient's residence address and mailing address;
 - c. The county where the qualifying patient resides;
 - d. The registry identification number on the qualifying patient's current registry identification card;
 - e. The qualifying patient's custodial parent's or legal guardian's first name; middle initial, if applicable; last name; and suffix, if applicable;
 - f. The qualifying patient's custodial parent's or legal guardian's residence address and mailing address;
 - g. The county where the qualifying patient's custodial parent or legal guardian resides;
 - h. The qualifying patient's custodial parent's or legal guardian's e-mail address;
 - i. The registry identification number on the qualifying patient's custodial parent's or legal guardian's current registry identification card;
 - j. The name, address, and telephone number of a physician who has a physician-patient relationship with the qualifying patient and is providing the written certification for medical marijuana for the qualifying patient;
 - k. The name, address, and telephone number of a second physician who has conducted a comprehensive review of the qualifying patient's medical record maintained by other treating physicians, and is providing a written certification for medical marijuana for the qualifying patient;
 - l. Whether the qualifying patient's custodial parent or legal guardian is requesting approval for cultivating marijuana plants for the qualifying patient's medical use because the qualifying patient's custodial parent or legal guardian believes that the qualifying patient resides at least 25 miles from the nearest operating dispensary;

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- m. Whether the qualifying patient's custodial parent or legal guardian would like notification of any clinical studies needing human subjects for research on the medical use of marijuana;
- n. A statement in a Department-provided format signed by the qualifying patient's custodial parent or legal guardian who is serving as the qualifying patient's designated caregiver:
 - i. Allowing the qualifying patient's medical use of marijuana;
 - ii. Agreeing to assist the qualifying patient with the medical use of marijuana; and
 - iii. Pledging not to divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1;
- o. An attestation that the information provided in the application is true and correct; and
- p. The signature of the qualifying patient's custodial parent or legal guardian and the date the qualifying patient's custodial parent or legal guardian signed;
- 2. If the qualifying patient's custodial parent's or legal guardian's name in subsection (B)(1)(e) is not the same name as on the qualifying patient's custodial parent's or legal guardian's current registry identification card, one of the following with the custodial parent's or legal guardian's new name:
 - a. An Arizona driver's license,
 - b. An Arizona identification card, or
 - c. The photograph page in the qualifying patient's custodial parent's or legal guardian's U.S. passport;
- 3. A current photograph of the qualifying patient;
- 4. A written certification from the physician in subsection (B)(1)(j) and a separate written certification from the physician in subsection (B)(1)(k) in a Department-provided format dated within 90 calendar days before the submission of the qualifying patient's renewal application that includes:
 - a. The physician's:
 - i. Name,
 - ii. License number including an identification of the physician license type,
 - iii. Office address on file with the physician's licensing board,
 - iv. Telephone number on file with the physician's licensing board, and
 - v. E-mail address;
 - b. The qualifying patient's name and date of birth;
 - c. An identification of one or more of the debilitating medical conditions in R9-17-201 as the qualifying patient's specific debilitating medical condition;
 - d. If the debilitating medical condition identified in subsection (B)(4)(c) is a condition in:
 - i. R9-17-201(9) through (13), the underlying chronic or debilitating disease or medical condition; or
 - ii. R9-17-201(14), the debilitating medical condition;
 - e. For the physician listed in subsection (B)(1)(j):
 - i. A statement that the physician has made or confirmed a diagnosis of a debilitating medical condition as defined in A.R.S. § 36-2801 for the qualifying patient;
 - ii. A statement, initialed by the physician, that the physician:
 - (1) Has established a medical record for the qualifying patient, and
 - (2) Is maintaining the qualifying patient's medical record as required in A.R.S. § 12-2297;
- iii. A statement, initialed by the physician, that the physician has conducted an in-person physical examination of the qualifying patient within the previous 90 calendar days appropriate to the qualifying patient's presenting symptoms and the qualifying patient's debilitating medical condition diagnosed or confirmed by the physician;
- iv. The date the physician conducted the in-person physical examination of the qualifying patient;
- v. A statement, initialed by the physician, that the physician reviewed the qualifying patient's:
 - (1) Medical records including medical records from other treating physicians from the previous 12 months,
 - (2) Response to conventional medications and medical therapies, and
 - (3) Profile on the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program database; and
- vi. A statement, initialed by the physician, that the physician has explained the potential risks and benefits of the use of medical marijuana to the qualifying patient's custodial parent or legal guardian responsible for health care decisions for the qualifying patient;
- f. For the physician listed in subsection (B)(1)(k), a statement, initialed by the physician, that the physician conducted a comprehensive review of the qualifying patient's medical records from other treating physicians;
- g. A statement, initialed by the physician, that in the physician's professional opinion the qualifying patient is likely to receive therapeutic or palliative benefit from the qualifying patient's medical use of marijuana to treat or alleviate the qualifying patient's debilitating medical condition;
- h. A statement, initialed by the physician, that if the physician has referred the qualifying patient's custodial parent or legal guardian to a dispensary, the physician has disclosed to the qualifying patient's custodial parent or legal guardian any personal or professional relationship the physician has with the dispensary;
- i. An attestation that the information provided in the written certification is true and correct; and
- j. The physician's signature and the date the physician signed; and
- 5. A current photograph of the qualifying patient's custodial parent or legal guardian;
- 6. For the Department's criminal records check authorized in A.R.S. § 36-2804.05:
 - a. The qualifying patient's custodial parent's or legal guardian's fingerprints on a fingerprint card that includes:
 - i. The qualifying patient's custodial parent's or legal guardian's first name; middle initial, if applicable; and last name;
 - ii. The qualifying patient's custodial parent's or legal guardian's signature;
 - iii. If different from the qualifying patient's custodial parent or legal guardian, the signature of

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- the individual physically rolling the qualifying patient's custodial parent's or legal guardian's fingerprints;
 - iv. The qualifying patient's custodial parent's or legal guardian's address;
 - v. If applicable, the qualifying patient's custodial parent's or legal guardian's surname before marriage and any names previously used by the qualifying patient's custodial parent or legal guardian;
 - vi. The qualifying patient's custodial parent's or legal guardian's date of birth;
 - vii. The qualifying patient's custodial parent's or legal guardian's Social Security number;
 - viii. The qualifying patient's custodial parent's or legal guardian's citizenship status;
 - ix. The qualifying patient's custodial parent's or legal guardian's gender;
 - x. The qualifying patient's custodial parent's or legal guardian's race;
 - xi. The qualifying patient's custodial parent's or legal guardian's height;
 - xii. The qualifying patient's custodial parent's or legal guardian's weight;
 - xiii. The qualifying patient's custodial parent's or legal guardian's hair color;
 - xiv. The qualifying patient's custodial parent's or legal guardian's eye color; and
 - xv. The qualifying patient's custodial parent's or legal guardian's place of birth; or
 - b. If the qualifying patient's custodial parent's or legal guardian's fingerprints and information required in subsection (B)(6)(a) were submitted as part of an application for a designated caregiver or a dispensary agent registry identification card to the Department within the previous six months, the registry identification number on the registry identification card issued to the patient's custodial parent or legal guardian serving as the qualifying patient's designated caregiver as a result of the application; and
7. The applicable fees in R9-17-102 for applying to renew a:
- a. Qualifying patient's registry identification card, and
 - b. Designated caregiver's registry identification card.
- C.** Except as provided in subsection (A)(6), to renew a qualifying patient's designated caregiver's registry identification card, the qualifying patient shall submit to the Department, at least 30 calendar days before the expiration date of the designated caregiver's registry identification card, the following:
1. An application in a Department-provided format that includes:
 - a. The qualifying patient's first name; middle initial, if applicable; last name; and suffix, if applicable;
 - b. The registry identification number on the qualifying patient's current registry identification card;
 - c. The designated caregiver's first name; middle initial, if applicable; last name; and suffix, if applicable;
 - d. The designated caregiver's date of birth;
 - e. The designated caregiver's residence address and mailing address;
 - f. The county where the designated caregiver resides;
 - g. The registry identification number on the designated caregiver's current registry identification card;
 2. If the designated caregiver's name in subsection (C)(1)(a) is not the same name as on the designated caregiver's current registry identification card, one of the following with the designated caregiver's new name:
 - a. An Arizona driver's license,
 - b. An Arizona identification card, or
 - c. The photograph page in the designated caregiver's U.S. passport;
 3. A current photograph of the designated caregiver;
 4. A statement in a Department-provided format signed by the designated caregiver:
 - a. Agreeing to assist the qualifying patient with the medical use of marijuana; and
 - b. Pledging not to divert marijuana to any individual or person who is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1; and
 5. For the Department's criminal records check authorized in A.R.S. § 36-2804.05:
 - a. The designated caregiver's fingerprints on a fingerprint card that includes:
 - i. The designated caregiver's first name; middle initial, if applicable; and last name;
 - ii. The designated caregiver's signature;
 - iii. If different from the designated caregiver, the signature of the individual physically rolling the designated caregiver's fingerprints;
 - iv. The designated caregiver's address;
 - v. If applicable, the designated caregiver's surname before marriage and any names previously used by the designated caregiver;
 - vi. The designated caregiver's date of birth;
 - vii. The designated caregiver's Social Security number;
 - viii. The designated caregiver's citizenship status;
 - ix. The designated caregiver's gender;
 - x. The designated caregiver's race;
 - xi. The designated caregiver's height;
 - xii. The designated caregiver's weight;
 - xiii. The designated caregiver's hair color;
 - xiv. The designated caregiver's eye color; and
 - xv. The designated caregiver's place of birth; or
 - b. If the designated caregiver's fingerprints and information required in subsection (C)(1)(j)(i) were submitted as part of an application for a designated caregiver or a dispensary agent registry identification card to the Department within the previous six months, the registry identification number on the registry identification card issued to the designated caregiver as a result of the application; and
 6. The applicable fee in R9-17-102 for renewing a designated caregiver's registry identification card.

Historical Note

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2).

R9-17-205. Denial or Revocation of a Qualifying Patient's or Designated Caregiver's Registry Identification Card

- A.** The Department shall deny a qualifying patient's application for or renewal of the qualifying patient's registry identification card if the qualifying patient does not have a debilitating medical condition.
- B.** The Department shall deny a designated caregiver's application for or renewal of the designated caregiver's registry identification card if the designated caregiver does not meet the definition of "designated caregiver" in A.R.S. § 36-2801.
- C.** The Department may deny a qualifying patient's or designated caregiver's application for or renewal of the qualifying patient's or designated caregiver's registry identification card if the qualifying patient or designated caregiver:

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1. Previously had a registry identification card revoked for not complying with A.R.S. Title 36, Chapter 28.1 or this Chapter; or
 2. Provides false or misleading information to the Department.
- D.** The Department shall revoke a qualifying patient's or designated caregiver's registry identification card if the qualifying patient or designated caregiver provides medical marijuana to an individual who is not authorized to possess medical marijuana under A.R.S. Title 36, Chapter 28.1.
- E.** The Department shall revoke a designated caregiver's registry identification card if the designated caregiver has been convicted of an excluded felony offense.
- F.** The Department may revoke a qualifying patient's or designated caregiver's registry identification card if the qualifying patient or designated caregiver knowingly violates A.R.S. Title 36, Chapter 28.1 or this Chapter.
- G.** If the Department denies or revokes a qualifying patient's registry identification card, the Department shall provide written notice to the qualifying patient that includes:
1. The specific reason or reasons for the denial or revocation; and
 2. The process for requesting a judicial review of the Department's decision pursuant to A.R.S. Title 12, Chapter 7, Article 6.
- H.** If the Department denies or revokes a qualifying patient's designated caregiver's registry identification card, the Department shall provide written notice to the qualifying patient and the designated caregiver that includes:
1. The specific reason or reasons for the denial or revocation; and
 2. The process for requesting a judicial review of the Department's decision pursuant to A.R.S. Title 12, Chapter 7, Article 6.
- Historical Note**
- New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2).
- B.** For purposes of this Chapter, in addition to the individual or individuals identified in the dispensary's by-laws as board members of the dispensary, the following individuals are considered board members:
1. If a corporation is applying for a dispensary registration certificate, the officers of the corporation;
 2. If a partnership is applying for a dispensary registration certificate, the partners;
 3. If a limited liability company is applying for a dispensary registration certificate, the members of the limited liability company;
 4. If an association or cooperative is applying for a dispensary registration certificate, the members of the association or cooperative;
 5. If a joint venture is applying for a dispensary registration certificate, the individuals who signed the joint venture agreement; and
 6. If a business organization type other than the types of business organizations in subsections (B)(1) through (5), the members of the business organization.
- C.** When a dispensary is required by this Chapter to provide information, sign documents, or ensure actions are taken, the individual or individuals in subsection (A) shall comply with the requirement on behalf of the dispensary.

Historical Note

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2).

R9-17-302. Repealed**Historical Note**

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by emergency rulemaking at 18 A.A.R. 1010, effective April 11, 2012 for 180 days (Supp. 12-2). Repealed by final rulemaking at 18 A.A.R. 3354, with an immediate effective date of December 5, 2012 (Supp. 12-4).

ARTICLE 3. DISPENSARIES AND DISPENSARY AGENTS**R9-17-301. Principal Officers and Board Members**

- A.** For the purposes of this Chapter, in addition to the individual or individuals identified in the dispensary's by-laws as principal officers of the dispensary, the following individuals are considered principal officers:
1. If an individual is applying for a dispensary registration certificate, the individual;
 2. If a corporation is applying for a dispensary registration certificate, two individuals who are officers of the corporation;
 3. If a partnership is applying for a dispensary registration certificate, two of the individuals who are partners;
 4. If a limited liability company is applying for a dispensary registration certificate, a manager or, if the limited liability company does not have a manager, an individual who is a member of the limited liability company;
 5. If an association or cooperative is applying for a dispensary registration certificate, two individuals who are members of the governing board of the association or cooperative;
 6. If a joint venture is applying for a dispensary registration certificate, two of the individuals who signed the joint venture agreement; and
 7. If a business organization type other than those described in subsections (A)(2) through (6) is applying for a dispensary registration certificate, two individuals who are members of the business organization.
- B.** For purposes of this Chapter, in addition to the individual or individuals identified in the dispensary's by-laws as board members of the dispensary, the following individuals are considered board members:
1. If a corporation is applying for a dispensary registration certificate, the officers of the corporation;
 2. If a partnership is applying for a dispensary registration certificate, the partners;
 3. If a limited liability company is applying for a dispensary registration certificate, the members of the limited liability company;
 4. If an association or cooperative is applying for a dispensary registration certificate, the members of the association or cooperative;
 5. If a joint venture is applying for a dispensary registration certificate, the individuals who signed the joint venture agreement; and
 6. If a business organization type other than the types of business organizations in subsections (B)(1) through (5), the members of the business organization.
- C.** When a dispensary is required by this Chapter to provide information, sign documents, or ensure actions are taken, the individual or individuals in subsection (A) shall comply with the requirement on behalf of the dispensary.

R9-17-303. Dispensary Registration Certificate Allocation Process

- A.** Each calendar year beginning in 2013, the Department shall review current valid dispensary registration certificates to determine if the Department may issue additional dispensary registration certificates pursuant to A.R.S. § 36-2804(C).
1. If the Department determines that the Department may issue additional dispensary registration certificates, the Department shall post, on the Department's web site, the information that the Department is accepting dispensary registration certificate applications, including the deadline for accepting dispensary registration certificate applications.
 - a. The Department shall post the information in subsection (A)(1) at least 30 calendar days before the date the Department begins accepting applications.
 - b. The deadline for submission of dispensary registration certificate applications is 10 working days after the date the Department begins accepting applications.
 - c. Sixty working days after the date the Department begins accepting applications, the Department shall determine if the Department received more dispensary registration certificate applications that are complete and in compliance with A.R.S. Title 36, Chapter 28.1 and this Chapter to participate in the

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- allocation process than the Department is allowed to issue.
- i. If the Department received more dispensary registration certificate applications than the Department is allowed to issue, the Department shall allocate any available dispensary registration certificates according to the priorities established in subsection (B).
 - ii. If the Department is allowed to issue a dispensary registration certificate for each dispensary registration certificate application the Department received, the Department shall allocate the dispensary registration certificates to those applicants.
2. If the Department determines that the Department is not allowed to issue additional dispensary registration certificates, the Department shall, on the Department's web site:
 - a. Post the information that the Department is not accepting dispensary registration certificate applications, and
 - b. Maintain the information until the next review.
- B.** Beginning in 2013, if the Department receives, by 60 working days after the date the Department begins accepting applications, more dispensary registration certificate applications that are complete and are in compliance with A.R.S. Title 36, Chapter 28.1 and this Chapter to participate in the allocation process than the Department is allowed to issue, the Department shall allocate the dispensary registration certificates according to the following criteria:
1. If dispensary registration certificate applications are received for a county that does not contain a dispensary:
 - a. If only one dispensary registration certificate application for a dispensary located in the county is received, the Department shall allocate the dispensary registration certificate to that applicant; or
 - b. If more than one dispensary registration certificate application for a dispensary located in the county is received, the Department shall prioritize and allocate a dispensary registration certificate to an applicant whose proposed dispensary location will provide dispensary services to the most qualifying patients based on:
 - i. The number of registry identification cards issued to qualifying patients who reside within 10 miles of the applicant's proposed dispensary location, and
 - ii. The number of dispensaries operating within 10 miles of the applicant's proposed dispensary location;
 2. If there are additional dispensary registration certificates available after dispensary registration certificates are allocated according to subsection (B)(1), the Department shall allocate the dispensary registration certificates as follows:
 - a. The Department shall prioritize and assign a dispensary registration certificate allocation to a CHAA based on which CHAA has the most registry identification cards issued to qualifying patients who reside within the CHAA;
 - b. If the Department receives only one dispensary registration certificate application for a dispensary located in a CHAA assigned a dispensary registration certificate allocation under this subsection, the Department shall allocate the dispensary registration certificate to that applicant;
 3. If there are additional dispensary registration certificates available after dispensary registration certificates are allocated according to subsections (B)(1) and (2), for all dispensary registration certificate applications not allocated a dispensary registration certificate pursuant to subsections (B)(1) and (2) and any other dispensary registration certificate applications received, the Department shall prioritize and allocate a dispensary registration certificate to an applicant whose proposed dispensary location will provide dispensary services to the most qualifying patients based on:
 - a. The number of registry identification cards issued to qualifying patients who reside within 10 miles of the applicant's proposed dispensary location, and
 - b. The number of dispensaries operating within 10 miles of the applicant's proposed dispensary location; and
 4. If there is a tie or a margin of 0.1% or less in the scores generated by applying the criteria in subsection (B), the Department shall randomly select one dispensary registration certificate application and allocate a dispensary registration certificate to that applicant.
- C.** For purposes of subsection (B), "10 miles" includes the area contained within a circle that extends for 10 miles in all directions from a specific location.
- D.** If the Department does not allocate a dispensary registration certificate to an applicant that had submitted a dispensary registration certificate application that the Department determined was complete and in compliance with A.R.S. Title 36, Chapter 28.1 and this Chapter to participate in the allocation process, the Department shall:
1. Provide a written notice to the applicant that states that, although the applicant's dispensary registration certificate application was complete and complied with A.R.S. Title 36, Chapter 28.1 and this Chapter, the Department did not allocate the applicant a dispensary registration certificate under the processes in this Section; and
 2. Return \$1,000 of the application fee to the applicant.
- E.** If the Department receives a dispensary registration certificate application at a time other than the time stated in subsection (B), the Department shall return the dispensary registration certificate application, including the application fee, to the entity that submitted the dispensary registration certificate application.

Historical Note

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by emergency rulemaking at 18 A.A.R. 1010, effective April

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11, 2012 for 180 days (Supp. 12-2). Emergency expired (Supp. 12-4). Amended by final rulemaking at 18 A.A.R. 3354, with an immediate effective date of December 5, 2012 (Supp. 12-4).

R9-17-304. Applying for a Dispensary Registration Certificate

- A.** An individual shall not be an applicant, principal officer, or board member on:
 1. More than one dispensary registration certificate application for a location in a single CHAA, or
 2. More than five dispensary registration certificate applications for locations in different CHAAs.
- B.** If the Department determines that an individual is an applicant, principal officer, or board member on more than one dispensary registration certificate application for a CHAA or more than five dispensary registration certificate applications, the Department shall review the applications and provide the applicant on each of the dispensary registration certificate applications with a written comprehensive request for more information that includes the specific requirements in A.R.S. Title 36, Chapter 28.1 and this Chapter that the dispensary registration certificate application does not comply with.
 1. If an applicant withdraws an application to comply with this Chapter and submits information demonstrating compliance with A.R.S. Title 36, Chapter 28.1 and this Chapter, the Department shall process the applicant's remaining dispensary registration certificate applications according to this Chapter.
 2. If an applicant does not withdraw an application or submit information demonstrating compliance with A.R.S. Title 36, Chapter 28.1 and this Chapter, the Department shall issue a denial to the applicant according to R9-17-322.
 3. An application fee submitted with a dispensary registration certificate application in subsection (B) that is withdrawn is not refunded.
- C.** To apply for a dispensary registration certificate, an entity shall submit to the Department the following:
 1. An application in a Department-provided format that includes:
 - a. The legal name of the dispensary;
 - b. The physical address of the proposed dispensary;
 - c. The following information for the entity applying:
 - i. Name,
 - ii. Type of business organization,
 - iii. Mailing address,
 - iv. Telephone number, and
 - v. E-mail address;
 - d. The name of the individual designated to submit dispensary agent registry identification card applications on behalf of the dispensary;
 - e. The name and license number of the dispensary's medical director;
 - f. The name, residence address, and date of birth of each:
 - i. Principal officer, and
 - ii. Board member;
 - g. For each principal officer or board member, whether the principal officer or board member:
 - i. Has served as a principal officer or board member for a dispensary that had the dispensary registration certificate revoked;
 - ii. Is a physician currently providing written certifications for qualifying patients;
 - iii. Is a law enforcement officer; or
 - iv. Is employed by or a contractor of the Department;
 2. If the entity applying is one of the business organizations in R9-17-301(A)(2) through (7), a copy of the business organization's articles of incorporation, articles of organization, or partnership or joint venture documents that include:
 - a. The name of the business organization,
 - b. The type of business organization, and
 - c. The names and titles of the individuals in R9-17-301(A) and (B);
 3. For each principal officer and board member:
 - a. An attestation signed and dated by the principal officer or board member that the principal officer or board member has not been convicted of an excluded felony offense as defined in A.R.S. § 36-2801; and
 - b. For the Department's criminal records check authorized in A.R.S. § 36-2804.05:
 - i. The principal officer's or board member's fingerprints on a fingerprint card that includes:
 - (1) The principal officer's or board member's first name; middle initial, if applicable; and last name;
 - (2) The principal officer's or board member's signature;
 - (3) If different from the principal officer or board member, the signature of the individual physically rolling the principal officer's or board member's fingerprints;
 - (4) The principal officer's or board member's residence address;
 - (5) If applicable, the principal officer's or board member's surname before marriage and any names previously used by the principal officer or board member;
 - (6) The principal officer's or board member's date of birth;
 - (7) The principal officer's or board member's Social Security number;
 - (8) The principal officer's or board member's citizenship status;
 - (9) The principal officer's or board member's gender;
 - (10) The principal officer's or board member's race;
 - (11) The principal officer's or board member's height;
 - (12) The principal officer's or board member's weight;
 - (13) The principal officer's or board member's hair color;
 - (14) The principal officer's or board member's eye color; and

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- (15) The principal officer's or board member's place of birth; or
- ii. If the fingerprints and information required in subsection (C)(3)(b)(i) were submitted to the Department as part of an application for a designated caregiver or a dispensary agent registry identification card within the previous six months, the registry identification number on the registry identification card issued to the principal officer or board member as a result of the application;
- 4. Policies and procedures that comply with the requirements in this Chapter for:
 - a. Inventory control,
 - b. Qualifying patient recordkeeping,
 - c. Security, and
 - d. Patient education and support;
- 5. As required in A.R.S. § 36-2804(B)(1)(d), a sworn statement signed and dated by the individual or individuals in R9-17-301(A) certifying that the dispensary is in compliance with any local zoning restrictions;
- 6. Documentation from the local jurisdiction where the dispensary's proposed physical address is located that:
 - a. There are no local zoning restrictions for the dispensary's location, or
 - b. The dispensary's location is in compliance with any local zoning restrictions;
- 7. Documentation of:
 - a. Ownership of the physical address of the proposed dispensary, or
 - b. Permission from the owner of the physical address of the proposed dispensary for the entity applying for a dispensary registration certificate to operate a dispensary at the physical address;
- 8. The dispensary's by-laws including:
 - a. The names and titles of individuals designated as principal officers and board members of the dispensary;
 - b. Whether the dispensary plans to:
 - i. Cultivate marijuana;
 - ii. Acquire marijuana from qualifying patients, designated caregivers, or other dispensaries;
 - iii. Sell or provide marijuana to other dispensaries;
 - iv. Transport marijuana;
 - v. Prepare, sell, or dispense marijuana-infused edible food products;
 - vi. Prepare, sell, or dispense marijuana-infused non-edible products;
 - vii. Sell or provide marijuana paraphernalia or other supplies related to the administration of marijuana to qualifying patients and designated caregivers;
 - viii. Deliver medical marijuana to qualifying patients; or
 - ix. Provide patient support and related services to qualifying patients;
 - c. Provisions for the disposition of revenues and receipts to ensure that the dispensary operates on a not-for-profit basis; and
 - d. Provisions for amending the dispensary's by-laws;
- 9. A business plan demonstrating the on-going viability of the dispensary on a not-for-profit basis that includes:
 - a. A description and total dollar amount of expenditures already incurred to establish the dispensary or to secure a dispensary registration certificate by the

individual or business organization applying for the dispensary registration certificate,

- b. A description and total dollar amount of monies or tangible assets received for operating the dispensary from entities other than the individual applying for the dispensary registration certificate or a principal officer or board member associated with the dispensary including the entity's name and the interest in the dispensary or the benefit the entity obtained,
 - c. Projected expenditures expected before the dispensary is operational,
 - d. Projected expenditures after the dispensary is operational, and
 - e. Projected revenue; and
 - 10. The applicable fee in R9-17-102 for applying for a dispensary registration certificate.
- D.** Before an entity with a dispensary registration certificate begins operating a dispensary, the entity shall apply for and obtain an approval to operate a dispensary from the Department.

Historical Note

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by emergency rulemaking at 18 A.A.R. 1010, effective April 11, 2012 for 180 days (Supp. 12-2). Emergency expired (Supp. 12-4). Amended by final rulemaking at 18 A.A.R. 3354, with an immediate effective date of December 5, 2012 (Supp. 12-4).

R9-17-305. Applying for Approval to Operate a Dispensary

- A.** To apply for approval to operate a dispensary, a person holding a dispensary registration certificate shall submit to the Department, at least 60 calendar days before the expiration of the dispensary registration certificate, the following:
- 1. An application in a Department-provided format that includes:
 - a. The name and registry identification number of the dispensary;
 - b. The physical address of the dispensary;
 - c. The name, address, and date of birth of each dispensary agent;
 - d. The name and license number of the dispensary's medical director;
 - e. If applicable, the physical address of the dispensary's cultivation site;
 - f. The dispensary's Transaction Privilege Tax Number issued by the Arizona Department of Revenue;
 - g. The dispensary's proposed hours of operation during which the dispensary plans to be available to dispense medical marijuana to qualifying patients and designated caregivers;
 - h. Whether the dispensary agrees to allow the Department to submit supplemental requests for information;
 - i. Whether the dispensary and, if applicable, the dispensary's cultivation site are ready for an inspection by the Department;
 - j. If the dispensary and, if applicable, the dispensary's cultivation site are not ready for an inspection by the Department, the date the dispensary and, if applicable, the dispensary's cultivation site will be ready for an inspection by the Department;
 - k. An attestation that the information provided to the Department to apply for approval to operate a dispensary is true and correct; and

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1. The signatures of the principal officers of the dispensary according to R9-17-301(A) and the date the principal officers signed;
 2. A copy of documentation issued by the local jurisdiction to the dispensary authorizing occupancy of the building as a dispensary and, if applicable, as the dispensary's cultivation site, such as a certificate of occupancy, a special use permit, or a conditional use permit;
 3. A sworn statement signed and dated by the individual or individuals in R9-17-301(A) certifying that the dispensary is in compliance with local zoning restrictions;
 4. The distance to the closest private school or public school from:
 - a. The dispensary; and
 - b. If applicable, the dispensary's cultivation site;
 5. A site plan drawn to scale of the dispensary location showing streets, property lines, buildings, parking areas, outdoor areas if applicable, fences, security features, fire hydrants if applicable, and access to water mains;
 6. A floor plan drawn to scale of the building where the dispensary is located showing the:
 - a. Layout and dimensions of each room,
 - b. Name and function of each room,
 - c. Location of each hand washing sink,
 - d. Location of each toilet room,
 - e. Means of egress,
 - f. Location of each video camera,
 - g. Location of each panic button, and
 - h. Location of natural and artificial lighting sources;
 7. If applicable, a site plan drawn to scale of the dispensary's cultivation site showing streets, property lines, buildings, parking areas, outdoor areas if applicable, fences, security features, fire hydrants if applicable, and access to water mains; and
 8. If applicable, a floor plan drawn to scale of each building at the dispensary's cultivation site showing the:
 - a. Layout and dimensions of each room,
 - b. Name and function of each room,
 - c. Location of each hand washing sink,
 - d. Location of each toilet room,
 - e. Means of egress,
 - f. Location of each video camera,
 - g. Location of each panic button, and
 - h. Location of natural and artificial lighting sources.
- B.** A dispensary's cultivation site may be located anywhere in the state where a cultivation site is allowed by the local jurisdiction.

Historical Note

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2).

R9-17-306. Changes to a Dispensary Registration Certificate

- A.** A dispensary may not transfer or assign the dispensary registration certificate.
- B.** A dispensary may change the location of the:
1. Dispensary:
 - a. Within the first three years after the Department issues the dispensary's registration certificate, to another location in the CHAA where the dispensary is located; or
 - b. After the first three years after the Department issues a dispensary registration certificate to the dispensary, to another location in the state; or
 2. Dispensary's cultivation site to another location in the state.

- C.** A dispensary or the dispensary's cultivation site shall not cultivate, manufacture, distribute, dispense, or sell medical marijuana at a new location until the dispensary submits an application for a change in a dispensary location or a change or addition of a cultivation site in R9-17-307 and the Department issues an amended dispensary registration certificate or an approval for the dispensary's cultivation site's new location to the dispensary.

Historical Note

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2).

R9-17-307. Applying to Change a Dispensary's Location or Change or Add a Dispensary's Cultivation Site

- A.** To change the location of a dispensary or the dispensary's cultivation site or to add a cultivation site, the dispensary shall submit an application to the Department that includes:
1. The following information in a Department-provided format:
 - a. The legal name of the dispensary;
 - b. The registry identification number for the dispensary;
 - c. Whether the request is for:
 - i. A change of location for the dispensary,
 - ii. A change of location for the dispensary's cultivation site, or
 - iii. An addition of a cultivation site;
 - d. The current physical address of the dispensary or the dispensary's cultivation site;
 - e. The physical address of the proposed location for the dispensary or the dispensary's cultivation site;
 - f. The distance to the closest public or private school from:
 - i. The proposed location for the dispensary, or
 - ii. The proposed location for the dispensary's cultivation site;
 - g. The name of the entity applying;
 - h. If applicable, the anticipated date of the change of location;
 - i. Whether the proposed dispensary or the dispensary's proposed cultivation site is ready for an inspection by the Department;
 - j. If the proposed dispensary or the dispensary's proposed cultivation site is not ready for an inspection by the Department, the date the dispensary or the dispensary's cultivation site will be ready for an inspection by the Department;
 - k. An attestation that the information provided to the Department to apply for a change in location is true and correct; and
 - l. The signature of the individual or individuals in R9-17-301(A) and the date the individual or individuals signed;
 2. A copy of documentation issued by the local jurisdiction to the dispensary authorizing occupancy of the proposed building as a dispensary or the dispensary's cultivation site such as a certificate of occupancy, a special use permit, or a conditional use permit;
 3. A sworn statement signed by the individual or individuals in R9-17-301(A) certifying that the building where the proposed dispensary or the dispensary's proposed cultivation site will be located is in compliance with local zoning restrictions;
 4. If the change in location is for the dispensary:
 - a. A site plan drawn to scale of the proposed dispensary location showing streets, property lines, build-

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- ings, parking areas, outdoor areas if applicable, fences, security features, fire hydrants if applicable, and access to water mains; and
- b. A floor plan drawn to scale of the building where the proposed dispensary is located showing the:
 - i. Layout and dimensions of each room,
 - ii. Name and function of each room,
 - iii. Location of each hand washing sink,
 - iv. Location of each toilet room,
 - v. Means of egress,
 - vi. Location of each video camera,
 - vii. Location of each panic button, and
 - viii. Location of natural and artificial lighting sources;

- 5. If the change in location is for the dispensary's cultivation site or if adding a cultivation site:
 - a. A site plan drawn to scale of the dispensary's proposed cultivation site showing streets, property lines, buildings, parking areas, outdoor areas if applicable, fences, security features, fire hydrants if applicable, and access to water mains; and
 - b. If applicable, a floor plan drawn to scale of each building used by the dispensary's proposed cultivation site showing the:
 - i. Layout and dimensions of each room,
 - ii. Name and function of each room,
 - iii. Location of each hand washing sink,
 - iv. Location of each toilet room,
 - v. Means of egress,
 - vi. Location of each video camera,
 - vii. Location of each panic button, and
 - viii. Location of natural and artificial lighting sources; and
- 6. The applicable fee in R9-17-102 for applying for a change in location or adding a cultivation site.

- B.** If the information and documents submitted by the dispensary comply with A.R.S. Title 36, Chapter 28.1 and this Chapter, the Department shall issue an amended dispensary registration certificate that includes the new address of the new location and retains the expiration date of the previously issued dispensary registration certificate.
- C.** An application for a change in location of a dispensary or a dispensary's cultivation site or the addition of a cultivation site may not be combined with an application for renewing a dispensary registration certificate. The Department shall process each application separately according to the applicable timeframe established in R9-17-107.
- D.** A dispensary shall submit written notification to the Department when the dispensary no longer uses a previously approved cultivation site.

Historical Note

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2).

R9-17-308. Renewing a Dispensary Registration Certificate

- A.** An entity with a dispensary registration certificate that has not submitted an application for approval to operate a dispensary to the Department at least 60 calendar days before the expiration date of the dispensary registration certificate or has not obtained an approval to operate a dispensary issued by the Department is prohibited from renewing the dispensary registration certificate.
- B.** To renew a dispensary registration certificate, a dispensary that has an approval to operate a dispensary issued by the Department, shall submit to the Department, at least 30 calendar days

before the expiration date of the dispensary's current dispensary registration certificate, the following:

1. An application in a Department-provided format that includes:
 - a. The legal name of the dispensary;
 - b. The registry identification number for the dispensary;
 - c. The physical address of the dispensary;
 - d. The name of the entity applying;
 - e. The name of the individual designated to submit dispensary agent registry identification card applications on behalf of the dispensary;
 - f. The name and license number of the dispensary's medical director;
 - g. The dispensary's hours of operation during which the dispensary is available to dispense medical marijuana to qualifying patients and designated caregivers;
 - h. The name, address, date of birth, and registry identification number of each:
 - i. Principal officer,
 - ii. Board member, and
 - iii. Dispensary agent;
 - i. For each principal officer or board member, whether the principal officer or board member:
 - i. Has served as a principal officer or board member for a dispensary that had the dispensary registration certificate revoked,
 - ii. Is a physician currently providing written certifications for qualifying patients,
 - iii. Is a law enforcement officer, or
 - iv. Is employed by or a contractor of the Department;
 - j. The dispensary's Transaction Privilege Tax Number issued by the Arizona Department of Revenue;
 - k. Whether the dispensary agrees to allow the Department to submit supplemental requests for information;
 - l. An attestation that the information provided to the Department to renew the dispensary registration certificate is true and correct; and
 - m. The signature of the individual or individuals in R9-17-301(A) and the date the individual or individuals signed;
2. If the application is for renewing a dispensary registration certificate that was initially issued within the previous 12 months, a copy of the dispensary's approval to operate a dispensary issued by the Department;
3. A copy of an annual financial statement for the previous year, or for the portion of the previous year the dispensary was operational, prepared according to generally accepted accounting principles;
4. A report of an audit by an independent certified public accountant of the annual financial statement required in subsection (B)(3); and
5. The applicable fee in R9-17-102 for applying to renew a dispensary registration certificate.

Historical Note

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by emergency rulemaking at 18 A.A.R. 1010, effective April 11, 2012 for 180 days (Supp. 12-2). Emergency expired (Supp. 12-4). Amended by final rulemaking at 18 A.A.R. 3354, with an immediate effective date of December 5, 2012 (Supp. 12-4).

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R9-17-309. Inspections

- A.** Submission of an application for a dispensary registration certificate constitutes permission for entry to and inspection of the dispensary and, if applicable, the dispensary's cultivation site.
- B.** Except as provided in subsection (D), an onsite inspection of a dispensary or the dispensary's cultivation site shall occur at a date and time agreed to by the dispensary and the Department that is no later than five working days after the date the Department submits a written request to the dispensary to schedule the certification or compliance inspection, unless the Department agrees to a later date and time.
- C.** The Department shall not accept allegations of a dispensary's noncompliance with A.R.S. Title 36, Chapter 28.1 or this Chapter from an anonymous source.
- D.** If the Department receives an allegation of a dispensary's or a dispensary's cultivation site's noncompliance with A.R.S. Title 36, Chapter 28.1 or this Chapter, the Department may conduct an unannounced inspection of the dispensary or the dispensary's cultivation site.
- E.** If the Department identifies a violation of A.R.S. Title 36, Chapter 28.1 or this Chapter during an inspection of a dispensary or the dispensary's cultivation site:
 1. The Department shall provide the dispensary with a written notice that includes the specific rule or statute that was violated; and
 2. The dispensary shall notify the Department in writing, with a postmark date within 20 working days after the date of the notice of violations, identifying the corrective actions taken and the date of the correction.

Historical Note

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by final rulemaking at 18 A.A.R. 3354, with an immediate effective date of December 5, 2012 (Supp. 12-4).

R9-17-310. Administration

- A.** A dispensary shall:
 1. Ensure that the dispensary is operating and available to dispense medical marijuana to qualifying patients and designated caregivers at least 30 hours weekly between the hours of 7:00 a.m. and 10:00 p.m.;
 2. Develop, document, and implement policies and procedures regarding:
 - a. Job descriptions and employment contracts, including:
 - i. Personnel duties, authority, responsibilities, and qualifications;
 - ii. Personnel supervision;
 - iii. Training in and adherence to confidentiality requirements;
 - iv. Periodic performance evaluations; and
 - v. Disciplinary actions;
 - b. Business records, such as manual or computerized records of assets and liabilities, monetary transactions, journals, ledgers, and supporting documents, including agreements, checks, invoices, and vouchers;
 - c. Inventory control, including:
 - i. Tracking;
 - ii. Packaging;
 - iii. Accepting marijuana from qualifying patients and designated caregivers;
 - iv. Acquiring marijuana from other dispensaries; and
 - v. Disposing of unusable marijuana, which may include submitting any unusable marijuana to a local law enforcement agency;
 - d. Qualifying patient records, including purchases, denials of sale, any delivery options, confidentiality, and retention; and
 - e. Patient education and support, including:
 - i. Availability of different strains of marijuana and the purported effects of the different strains;
 - ii. Information about the purported effectiveness of various methods, forms, and routes of medical marijuana administration;
 - iii. Methods of tracking the effects on a qualifying patient of different strains and forms of marijuana; and
 - iv. Prohibition on the smoking of medical marijuana in public places;
3. Maintain copies of the policies and procedures at the dispensary and provide copies to the Department for review upon request;
4. Review dispensary policies and procedures at least once every 12 months from the issue date of the dispensary registration certificate and update as needed;
5. Employ or contract with a medical director;
6. Ensure that each dispensary agent has the dispensary agent's registry identification card in the dispensary agent's immediate possession when the dispensary agent is:
 - a. Working or providing volunteer services at the dispensary or the dispensary's cultivation site, or
 - b. Transporting marijuana for the dispensary;
7. Ensure that a dispensary agent accompanies any individual other than another dispensary agent associated with the dispensary when the individual is present in the enclosed, locked facility where marijuana is cultivated by the dispensary;
8. Not allow an individual who does not possess a dispensary agent registry identification card issued under the dispensary registration certificate to:
 - a. Serve as a principal officer or board member for the dispensary,
 - b. Serve as the medical director for the dispensary,
 - c. Be employed by the dispensary, or
 - d. Provide volunteer services at or on behalf of the dispensary;
9. Provide written notice to the Department, including the date of the event, within 10 working days after the date, when a dispensary agent no longer:
 - a. Serves as a principal officer or board member for the dispensary,
 - b. Serves as the medical director for the dispensary,
 - c. Is employed by the dispensary, or
 - d. Provides volunteer services at or on behalf of the dispensary;
10. Document and report any loss or theft of marijuana from the dispensary to the appropriate law enforcement agency;
11. Maintain copies of any documentation required in this Chapter for at least 12 months after the date on the documentation and provide copies of the documentation to the Department for review upon request;
12. Post the following information in a place that can be viewed by individuals entering the dispensary:
 - a. If applicable, the dispensary's approval to operate;
 - b. The dispensary's registration certificate;

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- c. The name of the dispensary's medical director and the medical director's license number on a sign at least 20 centimeters by 30 centimeters; and
- d. The hours of operation during which the dispensary will dispense medical marijuana to a qualifying patient or a designated caregiver;
- 13. Not lend any part of the dispensary's income or property without receiving adequate security and a reasonable rate of interest;
- 14. Not purchase property for more than adequate consideration in money or cash equivalent;
- 15. Not pay compensation for salaries or other compensation for personal services that is in excess of a reasonable allowance;
- 16. Not sell any part of the dispensary's property or equipment for less than adequate consideration in money or cash equivalent; and
- 17. Not engage in any other transaction that results in a substantial diversion of the dispensary's income or property.
- B.** If a dispensary cultivates marijuana, the dispensary shall cultivate the marijuana in an enclosed, locked facility.

Historical Note

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by final rulemaking at 18 A.A.R. 3354, with an immediate effective date of December 5, 2012 (Supp. 12-4).

R9-17-311. Submitting an Application for a Dispensary Agent Registry Identification Card

Except as provided in R9-17-107(F), to obtain a dispensary agent registry identification card for an individual serving as a principal officer or board member for the dispensary, employed by the dispensary, or providing volunteer services at or on behalf of the dispensary, the dispensary shall submit to the Department the following for each dispensary agent:

- 1. An application in a Department-provided format that includes:
 - a. The dispensary agent's first name; middle initial, if applicable; last name; and suffix, if applicable;
 - b. The dispensary agent's residence address and mailing address;
 - c. The county where the dispensary agent resides;
 - d. The dispensary agent's date of birth;
 - e. The identifying number on the applicable card or document in subsection (5)(a) through (e);
 - f. The name and registry identification number of the dispensary; and
 - g. The signature of the individual in R9-17-304(C)(1)(d) or R9-17-308(B)(1)(e), as applicable, designated to submit dispensary agent applications on the dispensary's behalf and the date the individual signed;
- 2. An attestation signed and dated by the dispensary agent that the dispensary agent has not been convicted of an excluded felony offense as defined in A.R.S. § 36-2801;
- 3. One of the following:
 - a. A statement that the dispensary agent does not currently hold a valid registry identification card, or
 - b. The assigned registry identification number for the dispensary agent for each valid registry identification card currently held by the dispensary agent;
- 4. A statement in a Department-provided format signed by the dispensary agent pledging not to divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1;
- 5. A copy of the dispensary agent's:

- a. Arizona driver's license issued on or after October 1, 1996;
- b. Arizona identification card issued on or after October 1, 1996;
- c. Arizona registry identification card;
- d. Photograph page in the dispensary agent's U.S. passport; or
- e. Arizona driver's license or identification card issued before October 1, 1996 and one of the following for the dispensary agent:
 - i. Birth certificate verifying U.S. citizenship,
 - ii. U.S. Certificate of Naturalization, or
 - iii. U.S. Certificate of Citizenship;
- 6. A current photograph of the dispensary agent;
- 7. For the Department's criminal records check authorized in A.R.S. § 36-2804.05:
 - a. The dispensary agent's fingerprints on a fingerprint card that includes:
 - i. The dispensary agent's first name; middle initial, if applicable; and last name;
 - ii. The dispensary agent's signature;
 - iii. If different from the dispensary agent, the signature of the individual physically rolling the dispensary agent's fingerprints;
 - iv. The dispensary agent's address;
 - v. If applicable, the dispensary agent's surname before marriage and any names previously used by the dispensary agent;
 - vi. The dispensary agent's date of birth;
 - vii. The dispensary agent's Social Security number;
 - viii. The dispensary agent's citizenship status;
 - ix. The dispensary agent's gender;
 - x. The dispensary agent's race;
 - xi. The dispensary agent's height;
 - xii. The dispensary agent's weight;
 - xiii. The dispensary agent's hair color;
 - xiv. The dispensary agent's eye color; and
 - xv. The dispensary agent's place of birth; or
 - b. If the dispensary agent's fingerprints and information required in subsection (7)(a) were submitted to the Department within the previous six months as part of an application for a designated caregiver registry identification card or a dispensary agent registry identification card for another dispensary, the registry identification number on the registry identification card issued to the dispensary agent as a result of the application; and
- 8. The applicable fee in R9-17-102 for applying for a dispensary agent registry identification card.

Historical Note

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by emergency rulemaking at 18 A.A.R. 1010, effective April 11, 2012 for 180 days (Supp. 12-2). Emergency expired (Supp. 12-4). Amended by final rulemaking at 18 A.A.R. 3354, with an immediate effective date of December 5, 2012 (Supp. 12-4).

R9-17-312. Submitting an Application to Renew a Dispensary Agent's Registry Identification Card

To renew a dispensary agent's registry identification card for an individual serving as a principal officer or board member for the dispensary, employed by the dispensary, or providing volunteer services at or on behalf of the dispensary, the dispensary shall submit to the Department, at least 30 calendar days before the expiration of the dispensary agent's registry identification card, the following:

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1. An application in a Department-provided format that includes:
 - a. The dispensary agent's first name; middle initial, if applicable; last name; and suffix, if applicable;
 - b. The dispensary agent's residence address and mailing address;
 - c. The county where the dispensary agent resides;
 - d. The dispensary agent's date of birth;
 - e. The registry identification number on the dispensary agent's current registry identification card;
 - f. The name and registry identification number of the dispensary; and
 - g. The signature of the individual in R9-17-304(C)(1)(d) or R9-17-308(B)(1)(e) designated to submit dispensary agent applications on the dispensary's behalf and the date the individual signed;
2. If the dispensary agent's name in subsection (1)(a) is not the same name as on the dispensary agent's current registry identification card, one of the following with the dispensary agent's new name:
 - a. An Arizona driver's license,
 - b. An Arizona identification card, or
 - c. The photograph page in the dispensary agent's U.S. passport;
3. A statement in a Department-provided format signed by the dispensary agent pledging not to divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1;
4. A current photograph of the dispensary agent;
5. For the Department's criminal records check authorized in A.R.S. § 36-2804.05:
 - a. The dispensary agent's fingerprints on a fingerprint card that includes:
 - i. The dispensary agent's first name; middle initial, if applicable; and last name;
 - ii. The dispensary agent's signature;
 - iii. If different from the dispensary agent, the signature of the individual physically rolling the dispensary agent's fingerprints;
 - iv. The dispensary agent's address;
 - v. If applicable, the dispensary agent's surname before marriage and any names previously used by the dispensary agent;
 - vi. The dispensary agent's date of birth;
 - vii. The dispensary agent's Social Security number;
 - viii. The dispensary agent's citizenship status;
 - ix. The dispensary agent's gender;
 - x. The dispensary agent's race;
 - xi. The dispensary agent's height;
 - xii. The dispensary agent's weight;
 - xiii. The dispensary agent's hair color;
 - xiv. The dispensary agent's eye color; and
 - xv. The dispensary agent's place of birth; or
 - b. If the dispensary agent's fingerprints and information required in subsection (5)(a) were submitted to the Department within the previous six months as part of an application for a designated caregiver registry identification card or a dispensary agent registry identification card for another dispensary, the registry identification number on the registry identification card issued to the dispensary agent as a result of the application; and
6. The applicable fee in R9-17-102 for applying to renew a dispensary agent's registry identification card.

734, effective April 14, 2011 (Supp. 11-2). Amended by emergency rulemaking at 18 A.A.R. 1010, effective April 11, 2012 for 180 days (Supp. 12-2). Emergency expired (Supp. 12-4). Amended by final rulemaking at 18 A.A.R. 3354, with an immediate effective date of December 5, 2012 (Supp. 12-4).

R9-17-313. Medical Director

- A.** A dispensary shall appoint an individual who is a physician to function as a medical director.
- B.** During a dispensary's hours of operation, a medical director or an individual who is a physician and is designated by the medical director to serve as medical director in the medical director's absence is:
 1. Onsite; or
 2. Able to be contacted by any means possible, such as by telephone or pager.
- C.** A medical director shall:
 1. Develop and provide training to the dispensary's dispensary agents at least once every 12 months from the initial date of the dispensary's registration certificate on the following subjects:
 - a. Guidelines for providing information to qualifying patients related to risks, benefits, and side effects associated with medical marijuana;
 - b. Guidelines for providing support to qualifying patients related to the qualifying patient's self-assessment of the qualifying patient's symptoms, including a rating scale for pain, cachexia or wasting syndrome, nausea, seizures, muscle spasms, and agitation;
 - c. Recognizing signs and symptoms of substance abuse; and
 - d. Guidelines for refusing to provide medical marijuana to an individual who appears to be impaired or abusing medical marijuana; and
 2. Assist in the development and implementation of review and improvement processes for patient education and support provided by the dispensary.
- D.** A medical director shall provide oversight for the development and dissemination of:
 1. Educational materials for qualifying patients and designated caregivers that include:
 - a. Alternative medical options for the qualifying patient's debilitating medical condition;
 - b. Information about possible side effects of and contraindications for medical marijuana including possible impairment with use and operation of a motor vehicle or heavy machinery, when caring for children, or of job performance;
 - c. Guidelines for notifying the physician who provided the written certification for medical marijuana if side effects or contraindications occur;
 - d. A description of the potential for differing strengths of medical marijuana strains and products;
 - e. Information about potential drug-to-drug interactions, including interactions with alcohol, prescription drugs, non-prescription drugs, and supplements;
 - f. Techniques for the use of medical marijuana and marijuana paraphernalia;
 - g. Information about different methods, forms, and routes of medical marijuana administration;
 - h. Signs and symptoms of substance abuse, including tolerance, dependency, and withdrawal; and
 - i. A listing of substance abuse programs and referral information;

Historical Note

New Section made by exempt rulemaking at 17 A.A.R.

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2. A system for a qualifying patient or the qualifying patient's designated caregiver to document the qualifying patient's pain, cachexia or wasting syndrome, nausea, seizures, muscle spasms, or agitation that includes:
 - a. A log book, maintained by the qualifying patient and or the qualifying patient's designated caregiver, in which the qualifying patient or the qualifying patient's designated caregiver may track the use and effects of specific medical marijuana strains and products;
 - b. A rating scale for pain, cachexia or wasting syndrome, nausea, seizures, muscles spasms, and agitation;
 - c. Guidelines for the qualifying patient's self-assessment or, if applicable, assessment of the qualifying patient by the qualifying patient's designated caregiver; and
 - d. Guidelines for reporting usage and symptoms to the physician providing the written certification for medical marijuana and any other treating physicians; and
 3. Policies and procedures for refusing to provide medical marijuana to an individual who appears to be impaired or abusing medical marijuana.
- E.** A medical director for a dispensary shall not provide a written certification for medical marijuana for any qualifying patient.

Historical Note

New Section made by exempt rulemaking at 17 A.A.R.
734, effective April 14, 2011 (Supp. 11-2).

R9-17-314. Dispensing Medical Marijuana

Before a dispensary agent dispenses medical marijuana to a qualifying patient or a designated caregiver, the dispensary agent shall:

1. Verify the qualifying patient's or the designated caregiver's identity,
2. Offer any appropriate patient education or support materials,
3. Enter the qualifying patient's or designated caregiver's registry identification number on the qualifying patient's or designated caregiver's registry identification card into the medical marijuana electronic verification system,
4. Verify the validity of the qualifying patient's or designated caregiver's registry identification card,
5. Verify that the amount of medical marijuana the qualifying patient or designated caregiver is requesting would not cause the qualifying patient to exceed the limit on obtaining no more than two and one-half ounces of medical marijuana during any 14-calendar-day period, and
6. Enter the following information into the medical marijuana electronic verification system for the qualifying patient or designated caregiver:
 - a. The amount of medical marijuana dispensed,
 - b. Whether the medical marijuana was dispensed to the qualifying patient or to the qualifying patient's designated caregiver,
 - c. The date and time the medical marijuana was dispensed,
 - d. The dispensary agent's registry identification number, and
 - e. The dispensary's registry identification number.

Historical Note

New Section made by exempt rulemaking at 17 A.A.R.
734, effective April 14, 2011 (Supp. 11-2).

R9-17-315. Qualifying Patient Records

- A.** A dispensary shall ensure that:

1. A qualifying patient record is established and maintained for each qualifying patient who obtains medical marijuana from the dispensary;
 2. An entry in a qualifying patient record:
 - a. Is recorded only by a dispensary agent authorized by dispensary policies and procedures to make an entry,
 - b. Is dated and signed by the dispensary agent,
 - c. Includes the dispensary agent's registry identification number, and
 - d. Is not changed to make the initial entry illegible;
 3. If an electronic signature is used to sign an entry, the dispensary agent whose signature the electronic code represents is accountable for the use of the electronic signature;
 4. A qualifying patient record is only accessed by a dispensary agent authorized by dispensary policies and procedures to access the qualifying patient record;
 5. A qualifying patient record is provided to the Department for review upon request;
 6. A qualifying patient record is protected from loss, damage, or unauthorized use; and
 7. A qualifying patient record is maintained for five years from the date of the qualifying patient's or, if applicable, the qualifying patient's designated caregiver's last request for medical marijuana from the dispensary.
- B.** If a dispensary maintains qualifying patient records electronically, the dispensary shall ensure that:
1. There are safeguards to prevent unauthorized access, and
 2. The date and time of an entry in a qualifying patient record is recorded electronically by an internal clock.
- C.** A dispensary shall ensure that the qualifying patient record for a qualifying patient who requests or whose designated caregiver on behalf of the qualifying patient requests medical marijuana from the dispensary contains:
1. Qualifying patient information that includes:
 - a. The qualifying patient's name;
 - b. The qualifying patient's date of birth; and
 - c. The name of the qualifying patient's designated caregiver, if applicable;
 2. Documentation of any patient education and support materials provided to the qualifying patient or the qualifying patient's designated caregiver, including a description of the materials and the date the materials were provided;
 3. For each time the qualifying patient requests and does not obtain medical marijuana or, if applicable, the designated caregiver requests on behalf of the qualifying patient and does not obtain medical marijuana from the dispensary, the following:
 - a. The date,
 - b. The name and registry identification number of the individual who requested the medical marijuana, and
 - c. The dispensary's reason for refusing to provide the medical marijuana.

Historical Note

New Section made by exempt rulemaking at 17 A.A.R.
734, effective April 14, 2011 (Supp. 11-2).

R9-17-316. Inventory Control System

- A.** A dispensary shall designate in writing a dispensary agent who has oversight of the dispensary's medical marijuana inventory control system.
- B.** A dispensary shall only acquire marijuana from:
1. The dispensary's cultivation site,

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2. Another dispensary or another dispensary's cultivation site,
 3. A qualifying patient authorized by the Department to cultivate marijuana, or
 4. A designated caregiver authorized by the Department to cultivate marijuana.
- C.** A dispensary shall establish and implement an inventory control system for the dispensary's medical marijuana that documents:
1. Each day's beginning inventory, acquisitions, harvests, sales, disbursements, disposal of unusable marijuana, and ending inventory;
 2. For acquiring medical marijuana from a qualifying patient or designated caregiver:
 - a. A description of the medical marijuana acquired including the amount and strain,
 - b. The name and registry identification number of the qualifying patient or designated caregiver who provided the medical marijuana,
 - c. The name and registry identification number of the dispensary agent receiving the medical marijuana on behalf of the dispensary, and
 - d. The date of acquisition;
 3. For acquiring medical marijuana from another dispensary:
 - a. A description of the medical marijuana acquired including the amount, strain, and batch number;
 - b. The name and registry identification number of the dispensary providing the medical marijuana;
 - c. The name and registry identification number of the dispensary agent providing the medical marijuana;
 - d. The name and registry identification number of the dispensary agent receiving the medical marijuana on behalf of the dispensary; and
 - e. The date of acquisition;
 4. For each batch of marijuana cultivated:
 - a. The batch number;
 - b. Whether the batch originated from marijuana seeds or marijuana cuttings;
 - c. The origin and strain of the marijuana seeds or marijuana cuttings planted;
 - d. The number of marijuana seeds or marijuana cuttings planted;
 - e. The date the marijuana seeds or cuttings were planted;
 - f. A list of all chemical additives, including nonorganic pesticides, herbicides, and fertilizers used in the cultivation;
 - g. The number of plants grown to maturity;
 - h. Harvest information including:
 - i. Date of harvest,
 - ii. Final processed usable marijuana yield weight, and
 - iii. Name and registry identification number of the dispensary agent responsible for the harvest, and
 - i. The disposal of medical marijuana that is not usable marijuana including the:
 - i. Description of and reason for the marijuana being disposed of including, if applicable, the number of failed or other unusable plants;
 - ii. Date of disposal;
 - iii. Method of disposal; and
 - iv. Name and registry identification number of the dispensary agent responsible for the disposal;
 5. For providing medical marijuana to another dispensary:
 - a. The amount, strain, and batch number of medical marijuana provided;
 - b. The name and registry identification number of the other dispensary;
 - c. The name and registry identification number of the dispensary agent who received the medical marijuana on behalf of the other dispensary; and
 - d. The date the medical marijuana was provided; and
 6. For receiving edible food products infused with medical marijuana from another dispensary:
 - a. A description of the edible food products received from the dispensary including total weight of each edible food product and estimated amount and batch number of the medical marijuana infused in each edible food product,
 - b. Total estimated amount and batch number of medical marijuana infused in the edible food products,
 - c. The name and registry identification number of the:
 - i. Dispensary and the dispensary agent providing the edible food products to the receiving dispensary, and
 - ii. Dispensary agent receiving the edible food products on behalf of the receiving dispensary, and
 - d. The date the edible food products were provided to the dispensary.
- D.** The individual designated in subsection (A) shall conduct and document an audit of the dispensary's inventory that is accounted for according to generally accepted accounting principles at least once every 30 calendar days.
1. If the audit identifies a reduction in the amount of medical marijuana in the dispensary's inventory not due to documented causes, the dispensary shall determine where the loss has occurred and take and document corrective action.
 2. If the reduction in the amount of medical marijuana in the dispensary's inventory is due to suspected criminal activity by a dispensary agent, the dispensary shall report the dispensary agent to the Department and to the local law enforcement authorities.
- E.** A dispensary shall:
1. Maintain the documentation required in subsections (C) and (D) at the dispensary for five years from the date on the document, and
 2. Provide the documentation required in subsections (C) and (D) to the Department for review upon request.

Historical Note

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2).

R9-17-317. Product Labeling and Analysis

- A.** A dispensary shall ensure that medical marijuana provided by the dispensary to a qualifying patient or a designated caregiver is labeled with:
1. The dispensary's registry identification number;
 2. The amount, strain, and batch number of medical marijuana;
 3. The following statement: "ARIZONA DEPARTMENT OF HEALTH SERVICES' WARNING: Marijuana use can be addictive and can impair an individual's ability to drive a motor vehicle or operate heavy machinery. Marijuana smoke contains carcinogens and can lead to an increased risk for cancer, tachycardia, hypertension, heart attack, and lung infection. KEEP OUT OF REACH OF CHILDREN";

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4. If not cultivated by the dispensary, whether the medical marijuana was obtained from a qualifying patient, a designated caregiver, or another dispensary;
 5. The date of manufacture, harvest, or sale;
 6. A list of all chemical additives, including nonorganic pesticides, herbicides, and fertilizers, used in the cultivation and production of the medical marijuana; and
 7. The registry identification number of the qualifying patient.
- B.** If a dispensary provides medical marijuana cultivated by the dispensary to another dispensary, the dispensary shall ensure that the medical marijuana is labeled with:
1. The dispensary's registry identification number;
 2. The amount, strain, and batch number of the medical marijuana;
 3. The date of harvest or sale; and
 4. A list of all chemical additives, including nonorganic pesticides, herbicides, and fertilizers, used in the cultivation of the medical marijuana.
- C.** If medical marijuana is provided as part of an edible food product, a dispensary shall, in addition to the information in subsection (A), include on the label the total weight of the edible food product.
- D.** A dispensary shall provide to the Department upon request a sample of the dispensary's medical marijuana inventory of sufficient quantity to enable the Department to conduct an analysis of the medical marijuana.

Historical Note

New Section made by exempt rulemaking at 17 A.A.R.
734, effective April 14, 2011 (Supp. 11-2).

R9-17-318. Security

- A.** Except as provided in R9-17-310(A)(7), a dispensary shall ensure that access to the enclosed, locked facility where marijuana is cultivated is limited to the dispensary's principal officers, board members, and authorized dispensary agents.
- B.** A dispensary agent may transport marijuana, marijuana plants, and marijuana paraphernalia between the dispensary and:
1. The dispensary's cultivation site,
 2. A qualifying patient, and
 3. Another dispensary.
- C.** Before transportation, a dispensary agent shall:
1. Complete a trip plan that includes:
 - a. The name of the dispensary agent in charge of transporting the marijuana;
 - b. The date and start time of the trip;
 - c. A description of the marijuana, marijuana plants, or marijuana paraphernalia being transported; and
 - d. The anticipated route of transportation; and
 2. Provide a copy of the trip plan in subsection (C)(1) to the dispensary.
- D.** During transportation, a dispensary agent shall:
1. Carry a copy of the trip plan in subsection (C)(1) with the dispensary agent for the duration of the trip;
 2. Use a vehicle without any medical marijuana identification;
 3. Have a means of communication with the dispensary; and
 4. Ensure that the marijuana, marijuana plants, or marijuana paraphernalia are not visible.
- E.** After transportation, a dispensary agent shall enter the end time of the trip and any changes to the trip plan on the trip plan required in subsection (C)(1).
- F.** A dispensary shall:
1. Maintain the documents required in subsection (C)(2) and (E), and
 2. Provide a copy of the documents required in subsection (C)(2) and (E) to the Department for review upon request.
- G.** To prevent unauthorized access to medical marijuana at the dispensary and, if applicable, the dispensary's cultivation site, the dispensary shall have the following:
1. Security equipment to deter and prevent unauthorized entrance into limited access areas that include:
 - a. Devices or a series of devices to detect unauthorized intrusion, which may include a signal system interconnected with a radio frequency method, such as cellular, private radio signals, or other mechanical or electronic device;
 - b. Exterior lighting to facilitate surveillance;
 - c. Electronic monitoring including:
 - i. At least one 19-inch or greater call-up monitor,
 - ii. A video printer capable of immediately producing a clear still photo from any video camera image,
 - iii. Video cameras:
 - (1) Providing coverage of all entrances to and exits from limited access areas and all entrances to and exits from the building, capable of identifying any activity occurring in or adjacent to the building; and
 - (2) Having a recording resolution of at least 704 x 480 or the equivalent;
 - iv. A video camera at each point of sale location allowing for the identification of any qualifying patient or designated caregiver purchasing medical marijuana,
 - v. A video camera in each grow room capable of identifying any activity occurring within the grow room in low light conditions,
 - vi. Storage of video recordings from the video cameras for at least 30 calendar days,
 - vii. A failure notification system that provides an audible and visual notification of any failure in the electronic monitoring system, and
 - viii. Sufficient battery backup for video cameras and recording equipment to support at least five minutes of recording in the event of a power outage; and
 - d. Panic buttons in the interior of each building; and
 2. Policies and procedures:
 - a. That restrict access to the areas of the dispensary that contain marijuana and if applicable, the dispensary's cultivation site to authorized individuals only;
 - b. That provide for the identification of authorized individuals;
 - c. That prevent loitering;
 - d. For conducting electronic monitoring; and
 - e. For the use of a panic button.

Historical Note

New Section made by exempt rulemaking at 17 A.A.R.
734, effective April 14, 2011 (Supp. 11-2).

R9-17-319. Edible Food Products

- A.** A dispensary that prepares, sells, or dispenses marijuana-infused edible food products shall:
1. Before preparing, selling, or dispensing marijuana-infused edible food product obtain written authorization from the Department to prepare, sell, or dispense marijuana-infused edible food products;
 2. If the dispensary prepares the marijuana-infused edible food products, ensure that the marijuana-infused edible

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food products are prepared according to the applicable requirements in 9 A.A.C. 8, Article 1;

3. If the marijuana-infused edible food products are not prepared at the dispensary, obtain and maintain at the dispensary a copy of the current written authorization to prepare marijuana-infused edible food products from the dispensary that prepares the marijuana-infused edible products; and
4. If a dispensary sells or dispenses marijuana-infused edible food products, ensure that the marijuana-infused edible food products are sold or dispensed according to applicable requirements in 9 A.A.C. 8, Article 1.

- B.** A dispensary is responsible for the content and quality of any edible food product sold or dispensed by the dispensary.

Historical Note

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2).

R9-17-320. Cleaning and Sanitation

- A.** A dispensary shall ensure that any building or equipment used by a dispensary for the cultivation, harvest, preparation, packaging, storage, infusion, or sale of medical marijuana is maintained in a clean and sanitary condition.
1. Medical marijuana in the process of production, preparation, manufacture, packing, storage, sale, distribution, or transportation is protected from flies, dust, dirt, and all other contamination.
 2. Refuse or waste products incident to the manufacture, preparation, packing, selling, distributing, or transportation of medical marijuana are removed from the building used as a dispensary and, if applicable, a building at the dispensary's cultivation site at least once every 24 hours or more often as necessary to maintain a clean condition.
 3. All trucks, trays, buckets, other receptacles, platforms, racks, tables, shelves, knives, saws, cleavers, other utensils, or the machinery used in moving, handling, cutting, chopping, mixing, canning, packaging, or other processes are cleaned daily.
 4. All stored edible food products are securely covered.
- B.** A dispensary shall ensure that a dispensary agent at the dispensary or the dispensary's cultivation site:
1. Cleans the dispensary agent's hands and exposed portions of the dispensary agent's arms in a hand washing sink:
 - a. Before preparing medical marijuana including working with food, equipment, and utensils;
 - b. During preparation, as often as necessary to remove soil and contamination and to prevent cross-contamination when changing tasks;
 - c. After handling soiled equipment or utensils;
 - d. After touching bare human body parts other than the dispensary agent's clean hands and exposed portions of arms; and
 - e. After using the toilet room;
 2. If working directly with the preparation of medical marijuana or the infusion of marijuana into non-edible products:
 - a. Keeps the dispensary agent's fingernails trimmed, filed, and maintained so that the edges and surfaces are cleanable;
 - b. Unless wearing intact gloves in good repair, does not have fingernail polish or artificial fingernails on the dispensary agent's fingernails; and
 - c. Wears protective apparel such as coats, aprons, gowns, or gloves to prevent contamination;
 3. Wears clean clothing appropriate to assigned tasks;

4. Reports to the medical director any health condition experienced by the dispensary agent that may adversely affect the safety or quality of any medical marijuana with which the dispensary agent may come into contact; and
5. If the medical director determines that a dispensary agent has a health condition that may adversely affect the safety or quality of the medical marijuana, is prohibited from direct contact with any medical marijuana or equipment or materials for processing medical marijuana until the medical director determines that the dispensary agent's health condition will not adversely affect the medical marijuana.

Historical Note

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2).

R9-17-321. Physical Plant

- A.** A dispensary or a dispensary's cultivation site shall be located at least 500 feet from a private school or a public school that existed before the date the dispensary submitted the initial dispensary registration certificate application.
- B.** A dispensary shall provide onsite parking or parking adjacent to the building used as the dispensary.
- C.** A building used as a dispensary or the location used as a dispensary's cultivation site shall have:
1. At least one toilet room;
 2. Each toilet room shall contain:
 - a. A flushable toilet;
 - b. Mounted toilet tissue;
 - c. A sink with running water;
 - d. Soap contained in a dispenser; and
 - e. Disposable, single-use paper towels in a mounted dispenser or a mechanical air hand dryer;
 3. At least one hand washing sink not located in a toilet room;
 4. Designated storage areas for medical marijuana or materials used in direct contact with medical marijuana separate from storage areas for toxic or flammable materials; and
 5. If preparation or packaging of medical marijuana is done in the building, a designated area for the preparation or packaging that:
 - a. Includes work space that can be sanitized, and
 - b. Is only used for the preparation or packaging of medical marijuana.
- D.** For each commercial device used at a dispensary or the dispensary's cultivation site, the dispensary shall:
1. Ensure that the commercial device is licensed or certified pursuant to A.R.S. § 41-2091,
 2. Maintain documentation of the commercial device's license or certification, and
 3. Provide a copy of the commercial device's license or certification to the Department for review upon request.

Historical Note

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2).

R9-17-322. Denial or Revocation of a Dispensary Registration Certificate

- A.** The Department shall deny an application for a dispensary registration certificate or a renewal if:
1. For an application for a dispensary registration certificate, the physical address of the building or, if applicable, the physical address of the dispensary's cultivation site is within 500 feet of a private school or a public school that

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- existed before the date the dispensary submitted the initial dispensary registration certificate application;
2. A principal officer or board member:
 - a. Has been convicted of an excluded felony offense;
 - b. Has served as a principal officer or board member for a dispensary that:
 - i. Had the dispensary registration certificate revoked, or
 - ii. Did not obtain an approval to operate the dispensary within the first year after the dispensary registration certificate was issued;
 - c. Is under 21 years of age;
 - d. Is a physician currently providing written certifications for medical marijuana for qualifying patients;
 - e. Is a law enforcement officer; or
 - f. Is an employee or contractor of the Department; or
 3. The application or the dispensary does not comply with the requirements in A.R.S. Title 36, Chapter 28.1 and this Chapter.
- B.** The Department may deny an application for a dispensary registration certificate if a principal officer or board member of the dispensary provides false or misleading information to the Department.
- C.** The Department shall revoke a dispensary's registration certificate if:
1. The dispensary:
 - a. Operates before obtaining approval to operate a dispensary from the Department;
 - b. Dispenses, delivers, or otherwise transfers marijuana to an entity other than another dispensary with a valid dispensary registration certificate issued by the Department, a qualifying patient with a valid registry identification card, or a designated caregiver with a valid registry identification card; or
 - c. Acquires usable marijuana or mature marijuana plants from any entity other than another dispensary with a valid dispensary registration certificate issued by the Department, a qualifying patient with a valid registry identification card, or a designated caregiver with a valid registry identification card; or
 2. A principal officer or board member has been convicted of an excluded felony offense.
- D.** The Department may revoke a dispensary registration certificate if the dispensary does not:
1. Comply with the requirements in A.R.S. Title 36, Chapter 28.1 and this Chapter; or
 2. Implement the policies and procedures or comply with the statements provided to the Department with the dispensary's application.
- E.** If the Department denies a dispensary registration certificate application, the Department shall provide notice to the applicant that includes:
1. The specific reason or reasons for the denial, and
 2. All other information required by A.R.S. § 41-1076.

- F.** If the Department revokes a dispensary registration certificate, the Department shall provide notice to the dispensary that includes:
1. The specific reason or reasons for the revocation; and
 2. The process for requesting a judicial review of the Department's decision pursuant to A.R.S. Title 12, Chapter 7, Article 6.

Historical Note

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by emergency rulemaking at 18 A.A.R. 1010, effective April 11, 2012 for 180 days (Supp. 12-2). Emergency expired (Supp. 12-4). Amended by final rulemaking at 18 A.A.R. 3354, with an immediate effective date of December 5, 2012 (Supp. 12-4).

R9-17-323. Denial or Revocation of a Dispensary Agent's Registry Identification Card

- A.** The Department shall deny a dispensary agent's application for or renewal of the dispensary agent's registry identification card if the dispensary agent:
1. Does not meet the requirements in A.R.S. § 36-2801(10); or
 2. Previously had a registry identification card revoked for not complying with A.R.S. Title 36, Chapter 28.1 or this Chapter.
- B.** The Department may deny a dispensary agent's application for or renewal of the dispensary agent's registry identification card if the dispensary agent provides false or misleading information to the Department.
- C.** The Department shall revoke a dispensary agent's registry identification card if the dispensary agent:
1. Uses medical marijuana, if the dispensary agent does not have a qualifying patient registry identification card;
 2. Diverts medical marijuana to an individual who is not authorized to possess medical marijuana under A.R.S. Title 36, Chapter 28.1; or
 3. Has been convicted of an excluded felony offense.
- D.** The Department may revoke a dispensary agent's registry identification card if the dispensary agent knowingly violates A.R.S. Title 36, Chapter 28.1 or this Chapter.
- E.** If the Department denies or revokes a dispensary agent's registry identification card, the Department shall provide notice to the dispensary agent and the dispensary agent's dispensary that includes:
1. The specific reason or reasons for the denial or revocation; and
 2. The process for requesting a judicial review of the Department's decision pursuant to A.R.S. Title 12, Chapter 7, Article 6.

Historical Note

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2).

TITLE 9. HEALTH SERVICES**CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
ADMINISTRATION**

Editor's Note: The Office of the Secretary of State prints all Code Chapters on white paper (Supp 01-3).

Editor's Note: This Chapter contains rules which were adopted or amended under an exemption from the Arizona Administrative Procedure Act (A.R.S. Title 41, Chapter 6), pursuant to Laws 1992, Ch. 301, § 61 and Ch. 302, § 13, and Laws 1993, Ch. 6, § 34. Exemption from A.R.S. Title 41, Chapter 6 means that AHCCCS did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Governor's Regulatory Review Council did not review these rules; AHCCCS was not required to hold public hearings on these rules; and the Attorney General did not certify these rules. Because this Chapter contains rules which are exempt from the regular rulemaking process, the Chapter is printed on blue paper.

ARTICLE 1. DEFINITIONS

New Article 1, consisting of Sections R9-22-101 through R9-22-103, R9-22-105, and R9-22-106 through R9-22-112 adopted effective December 8, 1997 (Supp. 97-4).

Former Article 1, consisting of Section R9-22-101, repealed effective December 8, 1997 (Supp. 97-4).

Section	
R9-22-101.	Location of Definitions
R9-22-102.	Repealed
R9-22-103.	Repealed
R9-22-104.	Reserved
R9-22-105.	Repealed
R9-22-106.	Repealed
R9-22-107.	Repealed
R9-22-108.	Repealed
R9-22-109.	Repealed
R9-22-110.	Repealed
R9-22-111.	Reserved
R9-22-112.	Repealed
R9-22-113.	Reserved
R9-22-114.	Repealed
R9-22-115.	Repealed
R9-22-116.	Repealed
R9-22-117.	Repealed
R9-22-118.	Reserved
R9-22-119.	Reserved
R9-22-120.	Repealed

ARTICLE 2. SCOPE OF SERVICES

Section	
R9-22-201.	Scope of Services-related Definitions
R9-22-202.	General Requirements
R9-22-203.	Experimental Services
R9-22-204.	Inpatient General Hospital Services
R9-22-205.	Attending Physician, Practitioner, and Primary Care Provider Services
R9-22-206.	Organ and Tissue Transplant Services
R9-22-207.	Dental Services
R9-22-208.	Laboratory, Radiology, and Medical Imaging Services
R9-22-209.	Pharmaceutical Services
R9-22-210.	Emergency Medical Services for Non-FES Members
R9-22-210.01.	Emergency Behavioral Health Services for Non-FES Members
R9-22-211.	Transportation Services
R9-22-212.	Durable Medical Equipment, Orthotic and Prosthetic Devices, and Medical Supplies
R9-22-213.	Early and Periodic Screening, Diagnosis, and Treatment Services (E.P.S.D.T.)
R9-22-214.	Repealed
R9-22-215.	Other Medical Professional Services

R9-22-216.	NF, Alternative HCBS Setting, or HCBS
R9-22-217.	Services Included in the Federal Emergency Services Program
R9-22-218.	Repealed

ARTICLE 3. REPEALED

Article 3, consisting of Sections R9-22-301 through R9-22-319 and R9-22-321 through R9-22-344, repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section R9-22-320 repealed December 13, 1993 (Supp. 93-4).

ARTICLE 4. REPEALED

Section	
R9-22-401.	Repealed
R9-22-402.	Repealed
R9-22-403.	Repealed
R9-22-404.	Repealed
R9-22-405.	Repealed
R9-22-406.	Repealed

ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

Section	
R9-22-501.	General Provisions and Standards – Related Definitions
R9-22-502.	Pre-existing Conditions
R9-22-503.	Provider Requirements Regarding Records
R9-22-504.	Marketing; Prohibition Against Inducements; Misrepresentations; Discrimination; Sanctions
R9-22-505.	Standards, Licensure, and Certification for Providers of Hospital and Medical Services
R9-22-506.	Repealed
R9-22-507.	Repealed
R9-22-508.	Repealed
R9-22-509.	Transition and Coordination of Member Care
R9-22-510.	Repealed
R9-22-511.	Repealed
R9-22-512.	Release of Safeguarded Information
R9-22-513.	Repealed
R9-22-514.	Repealed
R9-22-515.	Repealed
R9-22-516.	Renumbered
R9-22-517.	Renumbered
R9-22-518.	Information to Enrolled Members
R9-22-519.	Repealed
R9-22-520.	Expired
R9-22-521.	Program Compliance Audits
R9-22-522.	Quality Management/Utilization Management (QM/UM) Requirements
R9-22-523.	Expired
R9-22-524.	Repealed
R9-22-525.	Repealed
R9-22-526.	Renumbered
R9-22-527.	Renumbered
R9-22-528.	Renumbered

R9-22-529. Renumbered

ARTICLE 6. RFP AND CONTRACT PROCESS

Article 6, consisting of Sections R9-22-601 through R9-22-604, adopted by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1).

Article 6, consisting of Sections R9-22-601 through R9-22-605, repealed by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1).

Article 6, consisting of Sections R9-22-601 through R9-22-604, adopted effective July 16, 1985.

Former Article 6, consisting of Sections R9-22-601 through R9-22-603, repealed effective October 1, 1983.

Section

- R9-22-601. General Provisions
- R9-22-602. RFP
- R9-22-603. Contract Award
- R9-22-604. Contract or Proposal Protests; Appeals
- R9-22-605. Waiver of Contractor's Subcontract with Hospitals
- R9-22-606. Contract Compliance Sanction

ARTICLE 7. STANDARDS FOR PAYMENTS

Section

- R9-22-701. Standard for Payments Related Definitions
- R9-22-701.01. Reserved
- R9-22-701.02. Reserved
- R9-22-701.03. Reserved
- R9-22-701.04. Reserved
- R9-22-701.05. Reserved
- R9-22-701.06. Reserved
- R9-22-701.07. Reserved
- R9-22-701.08. Reserved
- R9-22-701.09. Reserved
- R9-22-701.10. Scope of the Administration's and Contractor's Liability
- R9-22-702. Charges to Members
- R9-22-703. Payments by the Administration
- R9-22-704. Repealed
- R9-22-705. Payments by Contractors
- R9-22-706. Repealed
- R9-22-707. Repealed
- R9-22-708. Payments for Services Provided to Eligible Native Americans
- R9-22-709. Contractor's Liability to Hospitals for the Provision of Emergency and Post-stabilization Care
- R9-22-710. Payments for Non-hospital Services
- R9-22-711. Copayments
- R9-22-712. Reimbursement: General
- R9-22-712.01. Inpatient Hospital Reimbursement
- R9-22-712.02. Reserved
- R9-22-712.03. Reserved
- R9-22-712.04. Reserved
- R9-22-712.05. Graduate Medical Education Fund Allocation
- R9-22-712.06. Reserved
- R9-22-712.07. Rural Hospital Inpatient Fund Allocation
- Exhibit 1. Pool Example
- R9-22-712.08. Reserved
- R9-22-712.09. Hierarchy for Tier Assignment
- R9-22-712.10. Outpatient Hospital Reimbursement: General
- R9-22-712.11. Reserved
- R9-22-712.12. Reserved
- R9-22-712.13. Reserved
- R9-22-712.14. Reserved

R9-22-712.15. Outpatient Hospital Reimbursement: Affected Hospitals

R9-22-712.16. Reserved

R9-22-712.17. Reserved

R9-22-712.18. Reserved

R9-22-712.19. Reserved

R9-22-712.20. Outpatient Hospital Reimbursement: Methodology for the AHCCCS Outpatient Capped Fee-For-Service Schedule

R9-22-712.21. Reserved

R9-22-712.22. Reserved

R9-22-712.23. Reserved

R9-22-712.24. Reserved

R9-22-712.25. Outpatient Hospital Fee Schedule Calculations: Associated Service Costs

R9-22-712.26. Reserved

R9-22-712.27. Reserved

R9-22-712.28. Reserved

R9-22-712.29. Reserved

R9-22-712.30. Outpatient Hospital Reimbursement: Payment for a Service Not Listed in the AHCCCS Outpatient Capped Fee-for-service Schedule

R9-22-712.31. Reserved

R9-22-712.32. Reserved

R9-22-712.33. Reserved

R9-22-712.34. Reserved

R9-22-712.35. Outpatient Hospital Reimbursement: Adjustments to Fees

R9-22-712.36. Reserved

R9-22-712.37. Reserved

R9-22-712.38. Reserved

R9-22-712.39. Reserved

R9-22-712.40. Outpatient Hospital Reimbursement: Annual and Periodic Update

R9-22-712.41. Reserved

R9-22-712.42. Reserved

R9-22-712.43. Reserved

R9-22-712.44. Reserved

R9-22-712.45. Outpatient Hospital Reimbursement: Outpatient Payment Restrictions

R9-22-712.46. Reserved

R9-22-712.47. Reserved

R9-22-712.48. Reserved

R9-22-712.49. Reserved

R9-22-712.50. Outpatient Hospital Reimbursement: Billing

R9-22-713. Overpayment and Recovery of Indebtedness

R9-22-714. Payments to Providers

R9-22-715. Hospital Rate Negotiations

R9-22-716. Repealed

R9-22-717. Repealed

R9-22-718. Urban Hospital Inpatient Reimbursement Program

R9-22-719. Contractor Performance Measure Outcomes

R9-22-720. Reinsurance

ARTICLE 8. REPEALED

Article 8, consisting of Sections R9-22-801 through R9-22-804 and Exhibit A, repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004. The subject matter of Article 8 is now in 9 A.A.C. 34 (Supp. 04-1).

Section

- R9-22-801. Repealed
- R9-22-802. Repealed
- R9-22-803. Repealed
- R9-22-804. Repealed
- Exhibit A. Repealed
- R9-22-805. Repealed

ARTICLE 9. REPEALED

Article 22, consisting of Sections R9-22-901 through R9-22-909, repealed by final rulemaking at 12 A.A.R. 4484, January 6, 2007 (Supp. 06-4).

Article 22, consisting of Sections R9-22-901 through R9-22-908, adopted effective August 29, 1985.

Former Article 22, consisting of Section R9-22-901, repealed effective October 1, 1983.

Section	
R9-22-901.	Repealed
R9-22-902.	Repealed
R9-22-903.	Repealed
R9-22-904.	Repealed
R9-22-905.	Repealed
R9-22-906.	Repealed
R9-22-907.	Repealed
R9-22-908.	Repealed
R9-22-909.	Repealed

ARTICLE 10. FIRST- AND THIRD-PARTY LIABILITY AND RECOVERIES

Article 10, consisting of Section R9-22-1001 through R9-22-1002, adopted effective November 7, 1997 (Supp. 97-4).

Article 10, consisting of Section R9-22-1001 through R9-22-1002, repealed effective November 7, 1997 (Supp. 97-4).

Article 10 consisting of Sections R9-22-1001 and R9-22-1002 adopted effective October 1, 1985.

Section	
R9-22-1001.	Definitions
R9-22-1002.	General Provisions
R9-22-1003.	Cost Avoidance
R9-22-1004.	Member Participation
R9-22-1005.	Collections
R9-22-1006.	AHCCCS Monitoring Responsibilities
R9-22-1007.	Notification for Perfection, Recording, and Assignment of AHCCCS Liens
R9-22-1008.	Notification Information for Liens
R9-22-1009.	Notification of Health Insurance Information

ARTICLE 11. CIVIL MONETARY PENALTIES AND ASSESSMENTS

Article 11 consisting of Sections R9-22-1101 through R9-22-1104 adopted effective October 1, 1986.

Section	
R9-22-1101.	Basis for Civil Monetary Penalties and Assessments for Fraudulent Claims; Definitions
R9-22-1102.	Determining the Amount of a Penalty and an Assessment
R9-22-1103.	Repealed
R9-22-1104.	Mitigating Circumstances
R9-22-1105.	Aggravating Circumstances
R9-22-1106.	Notice of Intent
R9-22-1107.	Reserved
R9-22-1108.	Request for a Compromise
R9-22-1109.	Failure to Respond to the Notice of Intent
R9-22-1110.	Request for State Fair Hearing
R9-22-1111.	Issues and Burden of Proof
R9-22-1112.	Withdrawal and Continuances

ARTICLE 12. BEHAVIORAL HEALTH SERVICES

Article 12, consisting of Sections R9-22-1201 through R9-22-1208, repealed; new Article 12, consisting of Sections R9-22-1201

through R9-22-1208 adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4).

Section	
R9-22-1201.	General Requirements
R9-22-1202.	ADHS and Contractor Responsibilities
R9-22-1203.	Eligibility for Covered Services
R9-22-1204.	General Service Requirements
R9-22-1205.	Scope and Coverage of Behavioral Health Services
R9-22-1206.	General Provisions and Standards for Service Providers
R9-22-1207.	General Provisions for Payment
R9-22-1208.	Repealed

ARTICLE 13. CHILDREN'S REHABILITATIVE SERVICES (CRS)

Article 13, consisting of Sections R9-22-1301 through R9-22-1306, made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3).

Article 13, consisting of Sections R9-22-1301 through R9-22-1309, repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004. The subject matter of Article 13 is now in 9 A.A.C. 34 (Supp. 04-1).

Article 13, consisting of Sections R9-22-1301 through R9-22-1309, adopted effective September 9, 1998 (Supp. 98-3).

Section	
R9-22-1301.	Children's Rehabilitative Services (CRS) Related Definitions
R9-22-1302.	Children's Rehabilitative Services (CRS) Eligibility Requirements
R9-22-1303.	Medical Eligibility
R9-22-1304.	Referral and Disposition of CRS Medical Eligibility Determination
R9-22-1305.	CRS Redetermination
R9-22-1306.	Transition or Termination
R9-22-1307.	Covered Services
R9-22-1308.	Repealed
R9-22-1309.	Repealed

ARTICLE 14. AHCCCS MEDICAL COVERAGE FOR FAMILIES AND INDIVIDUALS

Article 14, consisting of Sections R9-22-1401 through R9-22-1436, repealed; new Article 14, consisting of Sections R9-22-1401 through R9-22-1433 made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

Article 14, consisting of Sections R9-22-1401 through R9-22-1436, adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

Section	
R9-22-1401.	General Information
R9-22-1402.	Ineligible Person
R9-22-1403.	Agency Responsible for Determining Eligibility
R9-22-1404.	Assignment of Rights Under Operation of Law
R9-22-1405.	Confidentiality and Safeguarding of Information
R9-22-1406.	Application Process
R9-22-1407.	Deceased Applicants
R9-22-1408.	Applicant and Member Responsibility
R9-22-1409.	Withdrawal of Application
R9-22-1410.	Department Responsibilities
R9-22-1411.	Withdrawal from AHCCCS Medical Coverage
R9-22-1412.	Verification of Eligibility Information
R9-22-1413.	Time-frames, Approval, Discontinuance, or Denial of an Application
R9-22-1414.	Review of Eligibility

- R9-22-1415. Notice of Adverse Action
- R9-22-1416. Effective Date of Eligibility
- R9-22-1417. Social Security Number
- R9-22-1418. State Residency
- R9-22-1419. Citizenship and Immigrant Status
- R9-22-1419.01. Repealed
- R9-22-1419.02. Repealed
- R9-22-1419.03. Repealed
- R9-22-1419.04. Repealed
- R9-22-1420. Income Eligibility Criteria
- R9-22-1421. Income Eligibility
- R9-22-1422. Methods for Calculating Monthly Income
- R9-22-1423. Calculations and Use of Methods Listed in R9-22-1422 Based on Frequency of Income
- R9-22-1424. Use of Methods Listed in R9-22-1423 Based on Type of Income
- R9-22-1425. Sponsor Deemed Income
- R9-22-1426. Exemptions from Sponsor Deemed Income
- R9-22-1427. Eligibility for a Family
- R9-22-1428. Eligibility for a Person Not Eligible as a Family
- R9-22-1429. Eligibility for a Newborn
- R9-22-1430. Extended Medical Coverage for a Pregnant Woman
- R9-22-1431. Family Planning Services Extension Program (FPEP)
- R9-22-1432. Young Adult Transitional Insurance
- R9-22-1433. Special Groups for Children
- R9-22-1434. Repealed
- R9-22-1435. Eligibility for a Person With Medical Expenses Whose Income is Over 100 Percent FPL
- R9-22-1436. MED Family Unit
- R9-22-1437. MED Income Eligibility Requirements
- R9-22-1438. MED Resource Eligibility Requirements
- R9-22-1439. MED Effective Date of Eligibility
- R9-22-1440. MED Eligibility Period
- R9-22-1441. Eligibility Appeals
- R9-22-1442. Cessation of MED Coverage
- R9-22-1443. Closing New Eligibility for Persons Not Covered under the State Plan

ARTICLE 15. AHCCCS MEDICAL COVERAGE FOR PEOPLE WHO ARE AGED, BLIND, OR DISABLED

Article 15, consisting of Sections R9-22-1501 through R9-22-1508, repealed; new Article 15, consisting of Sections R9-22-1501 through R9-22-1505 made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

Article 15, consisting of Sections R9-22-1501 through R9-22-1508, adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

Section

- R9-22-1501. General Information
- R9-22-1502. General Eligibility Criteria
- R9-22-1503. Financial Eligibility Criteria
- R9-22-1504. Eligibility For A Person Who is Aged, Blind, or Disabled
- R9-22-1505. Eligibility for Special Groups
- R9-22-1506. Repealed
- R9-22-1507. Repealed
- R9-22-1508. Repealed

ARTICLE 16. SOCIAL SECURITY DISABILITY INSURANCE – TEMPORARY MEDICAL COVERAGE

Article 16, consisting of Sections R9-22-1601 through R9-22-1636, repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

Article 16, consisting of Sections R9-22-1601 through R9-22-1613, R9-22-1615 through R9-22-1620, R9-22-1622 through R9-22-1631, R9-22-1633, R9-22-1634, and R9-22-1636, adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

Section

- R9-22-1601. Expired
- R9-22-1602. Expired
- R9-22-1603. Expired
- R9-22-1604. Expired
- R9-22-1605. Expired
- R9-22-1606. Expired
- R9-22-1607. Expired
- R9-22-1608. Expired
- R9-22-1609. Expired
- R9-22-1610. Expired
- R9-22-1611. Expired
- R9-22-1612. Expired
- R9-22-1613. Repealed
- R9-22-1614. Expired
- R9-22-1615. Expired
- R9-22-1616. Expired
- R9-22-1617. Repealed
- R9-22-1618. Expired
- R9-22-1619. Expired
- R9-22-1620. Repealed
- R9-22-1621. Reserved
- R9-22-1622. Repealed
- R9-22-1623. Repealed
- R9-22-1624. Repealed
- R9-22-1625. Repealed
- R9-22-1626. Repealed
- R9-22-1627. Repealed
- R9-22-1628. Repealed
- R9-22-1629. Repealed
- R9-22-1630. Repealed
- R9-22-1631. Repealed
- R9-22-1632. Reserved
- R9-22-1633. Repealed
- R9-22-1634. Repealed
- R9-22-1635. Reserved
- R9-22-1636. Repealed

ARTICLE 17. ENROLLMENT

Article 17, consisting of Sections R9-22-1701 through R9-22-1704, adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

Section

- R9-22-1701. Enrollment-Related Definitions
- R9-22-1702. Enrollment of a Member with an AHCCCS Contractor
- R9-22-1703. Effective Date of Enrollment with a Contractor
- R9-22-1704. Newborn Enrollment
- R9-22-1705. Guaranteed Enrollment Period

ARTICLE 18. RESERVED

ARTICLE 19. FREEDOM TO WORK

Article 19, consisting of Sections R9-22-1901 through R9-22-1922, made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

Section

- R9-22-1901. General Freedom to Work Requirements
- R9-22-1902. General Administration Requirements
- R9-22-1903. Application for Coverage

Arizona Health Care Cost Containment System – Administration

R9-22-1904.	Notice of Approval or Denial	"Ancillary department"	R9-22-701
R9-22-1905.	Reporting and Verifying Changes	"Ancillary service"	R9-22-701
R9-22-1906.	Actions that Result from a Redetermination or Change	"Anticipatory guidance"	R9-22-201
		"Annual enrollment choice"	R9-22-1701
R9-22-1907.	Notice of Adverse Action Requirements	"APC"	R9-22-701
R9-22-1908.	Request for Hearing	"Appellant"	R9-22-101
R9-22-1909.	Conditions of Eligibility	"Applicant"	R9-22-101
R9-22-1910.	Repealed	"Application"	R9-22-101
R9-22-1911.	Repealed	"Assessment"	R9-22-1101
R9-22-1912.	Repealed	"Assignment"	R9-22-101
R9-22-1913.	Premium Requirements	"Attending physician"	R9-22-101
R9-22-1914.	Repealed	"Authorized representative"	R9-22-101
R9-22-1915.	Institutionalized Person	"Authorization"	R9-22-201
R9-22-1916.	Repealed	"Auto-assignment algorithm"	R9-22-1701
R9-22-1917.	Repealed	"AZ-NBCCEDP"	R9-22-2001
R9-22-1918.	Additional Eligibility Criteria for the Basic Coverage Group	"Baby Arizona"	R9-22-1401
		"Behavior management services"	R9-22-1201
R9-22-1919.	Additional Eligibility Criteria for the Medically Improved Group	"Behavioral health adult therapeutic home"	R9-22-1201
		"Behavioral health therapeutic home care services"	R9-22-1201
R9-22-1920.	Repealed	"Behavioral health evaluation"	R9-22-1201
R9-22-1921.	Enrollment	"Behavioral health medical practitioner"	R9-22-1201
R9-22-1922.	Redetermination of Eligibility	"Behavioral health professional"	A.A.C. R9-20-1201
		"Behavioral health recipient"	R9-22-201
		"Behavioral health service"	R9-22-1201
		"Behavioral health technician"	A.A.C. R9-20-1201
		"Benefit year"	R9-22-201
		"BHS"	R9-22-1401
		"Billed charges"	R9-22-701
		"Blind"	R9-22-1501
		"Burial plot"	R9-22-1401
		"Business agent"	R9-22-701 and R9-22-704
		"Calculated inpatient costs"	R9-22-712.07
		"Capital costs"	R9-22-701
		"Capped fee-for-service"	R9-22-101
		"Caretaker relative"	R9-22-1401
		"Case management"	R9-22-1201
		"Case record"	R9-22-101
		"Case review"	R9-22-101
		"Cash assistance"	R9-22-1401
		"Categorically eligible"	R9-22-101
		"CCR"	R9-22-712
		"Certified psychiatric nurse practitioner"	R9-22-1201
		"Charge master"	R9-22-712
		"Child"	R9-22-1503 and R9-22-1603
		"Children's Rehabilitative Services" or "CRS"	R9-22-101
		"Claim"	R9-22-1101
		"Claims paid amount"	R9-22-712.07
		"Clean claim"	A.R.S. § 36-2904
		"Clinical supervision"	R9-22-201
		"CMDP"	R9-22-1701
		"CMS"	R9-22-101
		"Continuous stay"	R9-22-101
		"Contract"	R9-22-101
		"Contract year"	R9-22-101
		"Contractor"	A.R.S. § 36-2901
		"Copayment"	R9-22-701, R9-22-711 and R9-22-1603
		"Cost avoid"	R9-22-1201
		"Cost-To-Charge Ratio"	R9-22-701
		"Covered charges"	R9-22-701
		"Covered services"	R9-22-101
		"CPT"	R9-22-701
		"Creditable coverage"	R9-22-2003 and 42 U.S.C. 300gg(c)
		"Critical Access Hospital"	R9-22-701
		"CRS"	R9-22-101
		"Cryotherapy"	R9-22-2001
		"Customized DME"	R9-22-212
		"Day"	R9-22-101 and R9-22-1101
		"Date of the Notice of Adverse Action"	R9-22-1441
		"DBHS"	R9-22-101
		"DCSE"	R9-22-1401
		"De novo hearing"	42 CFR 431.201
		"Dentures" and "Denture services"	R9-22-201

ARTICLE 20. BREAST AND CERVICAL CANCER TREATMENT PROGRAM

Section

R9-22-2001.	Breast and Cervical Cancer Treatment Program
	Related Definitions
R9-22-2002.	General Requirements
R9-22-2003.	Eligibility Criteria
R9-22-2004.	Treatment
R9-22-2005.	Application Process
R9-22-2006.	Approval, Denial, or Discontinuance of Eligibility
R9-22-2007.	Effective and End Date of Eligibility
R9-22-2008.	Redetermination of Eligibility

ARTICLE 21. TRAUMA AND EMERGENCY SERVICES FUND

Article 21, consisting of Sections R9-22-2101 through R9-22-2103, made by exempt rulemaking at 9 A.A.R. 4001, effective October 19, 2003 (Supp. 03-3).

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
R9-22-2104.	Additional Trauma and Emergency Services Payments under the Section 1115 Waiver

ARTICLE 1. DEFINITIONS

R9-22-101. Location of Definitions

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

Definition	Section or Citation
"Accommodation"	R9-22-701
"Act"	R9-22-101
"ADHS"	R9-22-101
"Administration"	A.R.S. § 36-2901
"Adverse action"	R9-22-101
"Affiliated corporate organization"	R9-22-101
"Aged"	42 U.S.C. 1382c(a)(1)(A) and R9-22-1501
"Aggregate"	R9-22-701
"AHCCCS"	R9-22-101
"AHCCCS inpatient hospital day or days of care"	R9-22-701
"AHCCCS registered provider"	R9-22-101
"Ambulance"	A.R.S. § 36-2201

"Ancillary department"	R9-22-701
"Ancillary service"	R9-22-701
"Anticipatory guidance"	R9-22-201
"Annual enrollment choice"	R9-22-1701
"APC"	R9-22-701
"Appellant"	R9-22-101
"Applicant"	R9-22-101
"Application"	R9-22-101
"Assessment"	R9-22-1101
"Assignment"	R9-22-101
"Attending physician"	R9-22-101
"Authorized representative"	R9-22-101
"Authorization"	R9-22-201
"Auto-assignment algorithm"	R9-22-1701
"AZ-NBCCEDP"	R9-22-2001
"Baby Arizona"	R9-22-1401
"Behavior management services"	R9-22-1201
"Behavioral health adult therapeutic home"	R9-22-1201
"Behavioral health therapeutic home care services"	R9-22-1201
"Behavioral health evaluation"	R9-22-1201
"Behavioral health medical practitioner"	R9-22-1201
"Behavioral health professional"	A.A.C. R9-20-1201
"Behavioral health recipient"	R9-22-201
"Behavioral health service"	R9-22-1201
"Behavioral health technician"	A.A.C. R9-20-1201
"Benefit year"	R9-22-201
"BHS"	R9-22-1401
"Billed charges"	R9-22-701
"Blind"	R9-22-1501
"Burial plot"	R9-22-1401
"Business agent"	R9-22-701 and R9-22-704
"Calculated inpatient costs"	R9-22-712.07
"Capital costs"	R9-22-701
"Capped fee-for-service"	R9-22-101
"Caretaker relative"	R9-22-1401
"Case management"	R9-22-1201
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Arizona Health Care Cost Containment System – Administration

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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:

“Act” means the Social Security Act.

“ADHS” means the Arizona Department of Health Services.

“Adverse action” means an action taken by the Department or Administration to deny, discontinue, or reduce medical assistance.

“Affiliated corporate organization” means any organization that has ownership or control interests as defined in 42 CFR 455.101, and includes a parent and subsidiary corporation.

“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 covered services.

“Appellant” means an applicant or member who is appealing an adverse action by the Department or Administration.

“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.

“Authorized representative” means a person who is authorized to apply for medical assistance or act on behalf of another person.

“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 covered service or equipment provided to a member. A payment is made in accordance with an upper or capped limit established by the Director. This capped limit can either be a specific dollar amount or a percentage of billed charges.

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

“Case review” means the Administration’s evaluation of an individual’s or family’s circumstances and case record in a review month.

“Categorically eligible” means a person who is eligible under A.R.S. §§ 36-2901(6)(a)(i), (ii), or (iii) or 36-2934.

“Children’s Rehabilitative Services” or “CRS” means the program that provides covered medical services and covered support services in accordance with A.R.S. § 36-261.

“CMS” means the Centers for Medicare and Medicaid Services.

“Continuous stay” means a 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.

“Contract year” means the period beginning on October 1 of a year and continuing until September 30 of the following year.

“Covered services” means the health and medical services described in Articles 2 and 12 of this Chapter as being eligible for reimbursement by AHCCCS.

“Day” means a calendar day unless otherwise specified.

“DBHS” means the Division of Behavioral Health Services within the Arizona Department of Health Services.

“DES” means the Department of Economic Security.

“Diagnostic services” means services provided for the purpose of determining the nature and cause of a condition, illness, or injury.

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

“Discussion” means an oral or written exchange of information or any form of negotiation.

“DME” means durable medical equipment, which is an item or appliance that can withstand repeated use, is designed to serve a medical purpose, and is not generally useful to a person in the absence of a medical condition, illness, or injury.

“Enumeration” means the assignment of a nine-digit identification number to a person by the Social Security Administration.

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

“Facility” means a building or portion of a building licensed or certified by the Arizona Department of Health Services as a health care institution under A.R.S. Title 36, Chapter 4, to provide a medical service, a nursing service, or other health care or health-related service.

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

“Fee-For-Service” or “FFS” means a method of payment by the AHCCCS Administration to a registered provider on an amount-per-service basis for a member not enrolled with a contractor.

“FES member” means a person who is eligible to receive emergency medical and behavioral health services through the FESP under R9-22-217.

“FESP” means the federal emergency services program under R9-22-217 which covers services to treat an emergency medical or behavioral health 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 the 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.

“IHS” means Indian Health Service.

“IMD” or “Institution for Mental Diseases” means an Institution for Mental Diseases as described in 42 CFR 435.1010 that is licensed by ADHS.

“Interested party” means an actual or prospective offeror whose economic interest may be directly affected by the issuance of an RFP, the award of a contract, or by the failure to award a contract.

“Legal representative” means a custodial parent of a child under 18, a guardian, or a conservator.

“License” or “licensure” means a nontransferable authorization that is granted based on established standards in law by a state or a county regulatory agency or board and allows a health care provider to lawfully render a health care service.

“Mailing date” when used in reference to a document sent first class, postage prepaid, through the United States mail, means the date:

Shown on the postmark;

Shown on the postage meter mark of the envelope, if no postmark; or

Entered as the date on the document, if there is no legible postmark or postage meter mark.

“Medical record” means a document that relates to medical or behavioral health services provided to a member by a physician or other licensed practitioner of the healing arts and that is kept at the site of the provider.

“Medical supplies” means consumable items that are designed specifically to meet a medical purpose.

“Medically necessary” means a covered service is 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 to prolong life.

“Medicare claim” means a claim for Medicare-covered services for a member with Medicare coverage.

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

“Non-FES member” means an eligible person who is entitled to full AHCCCS services.

“Offeror” means an individual or entity that submits a proposal to the Administration in response to an RFP.

“Physician” means a person licensed as an allopathic or osteopathic physician under A.R.S. Title 32, Chapter 13 or Chapter 17.

“Practitioner” means a physician assistant licensed under A.R.S. Title 32, Chapter 25, or a registered nurse practitioner certified under A.R.S. Title 32, Chapter 15.

“Prescription” means an order to provide covered services that is signed or transmitted by a provider authorized to prescribe the services.

“Primary care provider” or “PCP” means an individual who meets the requirements of A.R.S. § 36-2901(12) or (13), and who is responsible for the management of a member’s health care.

“Prior authorization” means the process by which the Administration or contractor, whichever is applicable, authorizes, in advance, the delivery of covered services based on factors including but not limited to medical necessity, cost effectiveness, compliance with this Article and any applicable contract provisions. Prior authorization is not a guarantee of payment.

“Prior period coverage” means the period prior to the member’s enrollment during which a member is eligible for cov-

ered services. PPC begins on the first day of the month of application or the first eligible month, whichever is later, and continues until the day the member is enrolled with a contractor.

“Proposal” means all documents, including best and final offers, submitted by an offeror in response to an RFP by the Administration.

“Radiology” means professional and technical services rendered to provide medical imaging, radiation oncology, and radioisotope services.

“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.

“Rehabilitation services” means physical, occupational, and speech therapies, and items to assist in improving or restoring a person’s functional level.

“Responsible offeror” means an individual or entity that has the capability to perform the requirements of a contract and that ensures good faith performance.

“Responsive offeror” means an individual or entity that submits a proposal that conforms in all material respects to an RFP.

“Review” means a review of all factors affecting a member’s eligibility.

“Review month” means the month in which the individual’s or family’s circumstances and case record are reviewed.

“RFP” means Request for Proposals, including all documents, whether attached or incorporated by reference, that are used by the Administration for soliciting a proposal under 9 A.A.C. 22, Article 6.

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

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

“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).

“Specialist” means a Board-eligible or certified physician who declares himself or herself as a specialist and practices a specific medical specialty. For the purposes of this definition, Board-eligible means a physician who meets all the requirements for certification but has not tested for or has not been issued certification.

“Spouse” means a person who has entered into a contract of marriage recognized as valid by this state.

“SSN” means Social Security number.

“Standard of care” means a medical procedure or process that is accepted as treatment for a specific illness, injury, or 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 that agrees to perform any administrative function or service for the contractor specifically related to securing or fulfilling the contractor’s obligation to the Administration under the terms of a contract..

“Taxi” is as defined in A.R.S. § 28-2515.

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-101 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-101 repealed, former Sections R9-22-102 and R9-22-301 renumbered as Section R9-22-101 and amended effective October 1, 1983 (Supp. 83-5). Adopted as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency by adding new paragraphs (24), (46), (84) and (91) and renumbering accordingly effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Amended as an emergency by adding new paragraphs (2) and (15) and renumbering accordingly effective October 25, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-5). Emergency expired. Permanent amendment added paragraphs (2) and (15) and renumbered accordingly effective February 1, 1985 (Supp. 85-1). Amended effective October 1, 1985 (Supp. 85-5). Amended paragraphs (10) and (15) effective October 1, 1986 (Supp. 86-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective October 1, 1987; amended effective December 22, 1987 (Supp. 87-4). Amended by deleting paragraphs (39) and (62) and renumbering accordingly effective July 1, 1988 (Supp. 88-3). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Amended effective December 13, 1993 (Supp. 93-4). Amended effective January 14, 1997 (Supp. 97-1). Section repealed; new Section adopted effective December 8, 1997 (Supp. 97-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). Amended by final rulemaking at 5 A.A.R. 867, effective March 4, 1999 (Supp. 99-1). Amended by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). Amended by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by exempt rulemaking at 7 A.A.R. 5701, effective December 1, 2001 (Supp. 01-4). Amended by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Amended by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final

rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Amended by exempt rulemaking at 9 A.A.R. 4001, effective October 19, 2003 (Supp. 03-3). Amended by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4). Amended by final rulemaking at 11 A.A.R. 3830, effective November 12, 2005 (Supp. 05-3). Amended by final rulemaking at 11 A.A.R. 5467, effective December 6, 2005 (Supp. 05-4). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1). Amended by final rulemaking at 13 A.A.R. 3351, effective November 10, 2007 (Supp. 07-3). Amended by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2). Amended by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by exempt rulemaking at 18 A.A.R. 461, effective April 1, 2012 (Supp. 12-1).

R9-22-102. Repealed**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-102 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1092 (Supp. 82-4). Former Section R9-22-102 renumbered together with former Section R9-22-301 as Section R9-22-101 and amended effective October 1, 1983 (Supp. 83-5). New Section adopted effective December 8, 1997 (Supp. 97-4). Amended by exempt rulemaking at 7 A.A.R. 5701, effective December 1, 2001 (Supp. 01-4). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 11 A.A.R. 5467, effective December 6, 2005 (Supp. 05-4). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1). Section repealed by final rulemaking at 13 A.A.R. 3351, effective November 10, 2007 (Supp. 07-3).

R9-22-103. Repealed**Historical Note**

Adopted effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-104. Reserved**R9-22-105. Repealed****Historical Note**

Adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

R9-22-106. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by final rulemaking at 11 A.A.R. 5467, effective December 6, 2005 (Supp. 05-4).

R9-22-107. Repealed**Historical Note**

Adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Section repealed by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2).

R9-22-108. Repealed**Historical Note**

Adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

R9-22-109. Repealed**Historical Note**

Adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. effective 4484, effective January 6, 2007 (Supp. 06-4).

R9-22-110. Repealed**Historical Note**

Adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1).

R9-22-111. Reserved**R9-22-112. Repealed****Historical Note**

Adopted effective December 8, 1997 (Supp. 97-4). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Repealed by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1).

R9-22-113. Reserved**R9-22-114. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 11 A.A.R. 5467, effective December 6, 2005 (Supp. 05-4).

R9-22-115. Repealed**Historical Note**

Final Section adopted at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 11 A.A.R. 5467, effective December 6, 2005 (Supp. 05-4).

R9-22-116. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-117. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2).

R9-22-118. Reserved**R9-22-119. Reserved****R9-22-120. Repealed****Historical Note**

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Section repealed by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

ARTICLE 2. SCOPE OF SERVICES**R9-22-201. Scope of Services-related Definitions**

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

“Anticipatory guidance” means a person responsible for a child receives information and guidance of what the person should expect of the child’s development and how to help the child stay healthy.

“Behavioral health recipient” means a Title XIX or Title XXI acute care member who is eligible for, and is receiving, behavioral health services through ADHS/DBHS.

“Benefit year” means a one-year time period of October 1st through September 30th.

“Clinical supervision” means a Clinical Supervisor under 9 A.A.C. 20, Article 2 reviews the skills and knowledge of the individual supervised and provides guidance in improving or developing the skills and knowledge.

“Emergency behavioral health condition for a non-FES member” means a condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

Placing the health of the person, including mental health, in serious jeopardy;

Serious impairment to bodily functions;

Serious dysfunction of any bodily organ or part; or

Serious physical harm to another person.

“Emergency behavioral health services for a non-FES member” means those behavioral health services provided for the treatment of an emergency behavioral health condition.

“Emergency medical condition for a non-FES member” means treatment for a medical condition, including labor and delivery, that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine,

could reasonably expect the absence of immediate medical attention to result in:

Placing the member’s health in serious jeopardy,

Serious impairment to bodily functions, or

Serious dysfunction of any bodily organ or part.

“Emergency medical services for non-FES member” means services provided for the treatment of an emergency medical condition.

“Hearing aid” means an instrument or device designed for, or represented by the supplier as aiding or compensating for impaired or defective human hearing, and includes any parts, attachments, or accessories of the instrument or device.

“Home health services” means services and supplies that are provided by a home health agency that coordinates in-home intermittent services for curative, habilitative care, including home-health aide services, licensed nurse services, and medical supplies, equipment, and appliances.

“Occupational therapy” means medically prescribed treatment provided by or under the supervision of a licensed occupational therapist, to restore or improve an individual’s ability to perform tasks required for independent functioning.

“Pharmaceutical service” means medically necessary medications that are prescribed by a physician, practitioner, or dentist under R9-22-209.

“Physical therapy” means treatment services to restore or improve muscle tone, joint mobility, or physical function provided by or under the supervision of a registered physical therapist.

“Post-stabilization services” means covered services related to an emergency medical or behavioral health condition provided after the condition is stabilized.

“Primary care provider services” means healthcare services provided by and within the scope of practice, as defined by law, of a licensed physician, certified nurse practitioner, or licensed physician assistant.

“Psychosocial rehabilitation services” means services that provide education, coaching, and training to address or prevent residual functional deficits and may include services that may assist a member to secure and maintain employment. Psychosocial rehabilitation services may include:

Living skills training,

Cognitive rehabilitation,

Health promotion,

Supported employment, and

Other services that increase social and communication skills to maximize a member’s ability to participate in the community and function independently.

“RBHA” or “Regional Behavioral Health Authority” means the same as in A.R.S. § 36-3401.

“Residual functional deficit” means a member’s inability to return to a previous level of functioning, usually after experiencing a severe psychotic break or state of decompensation.

“Respiratory therapy” means treatment services to restore, maintain, or improve respiratory functions that are provided by, or under the supervision of, a respiratory therapist licensed according to A.R.S. Title 32, Chapter 35.

“Scope of services” means the covered, limited, and excluded services under Articles 2 and 12 of this Chapter.

“Speech therapy” means medically prescribed diagnostic and treatment services provided by or under the supervision of a certified speech therapist.

“Sterilization” means a medically necessary procedure, not for the purpose of family planning, to render an eligible person or member barren in order to:

Prevent the progression of disease, disability, or adverse health conditions; or

Prolong life and promote physical health.

“Substance abuse” means the chronic, habitual, or compulsive use of any chemical matter that, when introduced into the body, is capable of altering human behavior or mental functioning and, with extended use, may cause psychological dependence and impaired mental, social or educational functioning. Nicotine addiction is not considered substance abuse for adults who are 21 years of age or older.

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-201 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B) effective May 30, 1989 (Supp. 89-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4). Amended by final rulemaking at 11 A.A.R. 3217, effective October 1, 2005 (Supp. 05-3). Section repealed; new Section made by final rulemaking at 13 A.A.R. 3351, effective November 10, 2007 (Supp. 07-3). Amended by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by exempt rulemaking at 17 A.A.R. 1707, effective October 1, 2011 (Supp. 11-3).

R9-22-202. General Requirements

- A.** For the purposes of this Article, the following definitions apply:
- “Authorization” means written, verbal, or electronic authorization by:
 - The Administration for services rendered to a fee-for-service member, or
 - The contractor for services rendered to a prepaid capitated member.
 - Use of the phrase “attending physician” applies only to the fee-for-service population.
- B.** In addition to other requirements and limitations specified in this Chapter, the following general requirements apply:
- Only medically necessary, cost effective, and federally-reimbursable and state-reimbursable services are covered services.
 - Covered services for the federal emergency services program (FESP) are under R9-22-217.
 - The Administration or a contractor may waive the covered services referral requirements of this Article.
 - Except as authorized by the Administration or a contractor, a primary care provider, attending physician, practi-

tioner, or a dentist shall provide or direct the member’s covered services. Delegation of the provision of care to a practitioner does not diminish the role or responsibility of the primary care provider.

- A contractor shall offer a female member direct access to preventive and routine services from gynecology providers within the contractor’s network without a referral from a primary care provider.
- A member may receive behavioral health services as specified in Articles 2 and 12.
- AHCCCS or a contractor shall provide services under the Section 1115 Waiver as defined in A.R.S. § 36-2901.
- An AHCCCS registered provider shall provide covered services within the provider’s scope of practice.
- In addition to the specific exclusions and limitations otherwise specified under this Article, the following are not covered:
 - A service that is determined by the AHCCCS Chief Medical Officer to be experimental or provided primarily for the purpose of research;
 - Services or items furnished gratuitously, and
 - Personal care items except as specified under R9-22-212.
- Medical or behavioral health services are not covered services if provided to:
 - An inmate of a public institution;
 - A person who is in residence at an institution for the treatment of tuberculosis; or
 - A person age 21 through 64 who is in an IMD, unless the service is covered under Article 12 of this Chapter.
- The Administration or a contractor may deny payment of non-emergency services if prior authorization is not obtained as specified in this Article and Article 7 of this Chapter. The Administration or a contractor shall not provide prior authorization for services unless the provider submits documentation of the medical necessity of the treatment along with the prior authorization request.
- Services under A.R.S. § 36-2908 provided during the prior period coverage do not require prior authorization.
- Prior authorization is not required for services necessary to evaluate and stabilize an emergency medical condition. The Administration or a contractor shall not reimburse services that require prior authorization unless the provider documents the diagnosis and treatment.
- A service is not a covered service if provided outside the GSA unless one of the following applies:
 - A member is referred by a primary care provider for medical specialty care outside the GSA. If a member is referred outside the GSA to receive an authorized medically necessary service, the contractor shall also provide all other medically necessary covered services for the member;
 - There is a net savings in service delivery costs as a result of going outside the GSA that does not require undue travel time or hardship for a member or the member’s family;
 - The contractor authorizes placement in a nursing facility located out of the GSA; or
 - Services are provided during prior period coverage.
- If a member is traveling or temporarily residing outside of the GSA, covered services are restricted to emergency care services, unless otherwise authorized by the contractor.
- A contractor shall provide at a minimum, directly or through subcontracts, the covered services specified in this Chapter and in contract.

- I. The Administration shall determine the circumstances under which a FFS member may receive services, other than emergency services, from service providers outside the member's county of residence or outside the state. Criteria considered by the Administration in making this determination shall include availability and accessibility of appropriate care and cost effectiveness.
- J. The restrictions, limitations, and exclusions in this Article do not apply to the following:
 - 1. Public and private employers selecting AHCCCS as a health care option for their employees according to 9 A.A.C. 27, and
 - 2. A contractor electing to provide noncovered services.
 - a. The Administration shall not consider the costs of providing a noncovered service to a member in the development or negotiation of a capitation rate.
 - b. A contractor shall pay for noncovered services from administrative revenue or other contractor funds that are unrelated to the provision of services under this Chapter.
- K. Subject to CMS approval, the restrictions, limitations, and exclusions specified in the following subsections do not apply to American Indians receiving services through IHS or a tribal health program operating under P.L. 93-638 when those services are eligible for 100 percent federal financial participation:
 - 1. R9-22-205(A)(8),
 - 2. R9-22-205(B)(4)(f),
 - 3. R9-22-206,
 - 4. R9-22-207,
 - 5. R9-22-212(C),
 - 6. R9-22-212(D),
 - 7. R9-22-212(E)(8),
 - 8. R9-22-215(C)(2), and
 - 9. R9-22-215(C)(5).

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-202 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1987; amended effective December 22, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2).

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

Amended effective December 13, 1993 (Supp. 93-4).

Amended effective July 1, 1995, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1994, Ch. 322, § 21; filed with the Office of the Secretary of State June 22, 1995 (Supp. 95-3). Amended effective January 1, 1996, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Third Special Session, Ch. 1, § 5; filed with the Office of the Secretary of State December 28, 1995 (Supp. 95-4). Section repealed effective September 22, 1997 (Supp. 97-3). New Section made by final rulemaking at 13 A.A.R. 3351, effective November 10, 2007 (Supp. 07-3). Amended by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3).

R9-22-203. Experimental Services

- A. Experimental services are not covered. A service is not experimental if:
 - 1. It is generally and widely accepted as a standard of care in the practice of medicine in the United States and is a

safe and effective treatment for the condition for which it is intended or used.

- 2. The service does not meet the standard in subsection (A)(1), but the service has been demonstrated to be safe and effective for the condition for which it is intended or used based on the weight of the evidence in peer-reviewed articles in medical journals published in the United States.
- 3. The service does not meet the standard in subsection (A)(2) because the condition for which the service is intended or used is rare, but the service has been demonstrated to be safe and effective for the condition for which it is intended or used based on the weight of opinions from specialists who provide the service or related services.
- B. The following factors shall be considered when evaluating the weight of peer-reviewed articles or the opinions of specialists:
 - 1. The mortality rate and survival rate of the service as compared to the rates for alternative non-experimental services.
 - 2. The types, severity, and frequency of complications associated with the services as compared with the complications associated with alternative non-experimental services.
 - 3. The frequency with which the service has been performed in the past.
 - 4. Whether there is sufficient historical information regarding the service to provide reliable data regarding risks and benefits.
 - 5. The reputation and experience of the authors and/or specialists and their record in related areas.
 - 6. The extent to which medical science in the area develops rapidly and the probability that more definite data will be available in the foreseeable future.
 - 7. Whether the peer reviewed article describes a random controlled trial or an anecdotal clinical case study.

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-203 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1987; amended effective December 22, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2).

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

Amended effective September 29, 1992 (Supp. 92-3).

Amended under an exemption from the provisions of the Administrative Procedure Act effective March 22, 1993; received in the Office of the Secretary of State March 24, 1993 (Supp. 93-1). Amended effective December 13, 1993 (Supp. 93-4). Section repealed effective September 22, 1997 (Supp. 97-3). New Section made by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3).

R9-22-204. Inpatient General Hospital Services

- A. A contractor, fee-for-service provider or noncontracting provider shall render inpatient general hospital services including:
 - 1. Hospital accommodations and appropriate staffing, supplies, equipment, and services for:
 - a. Maternity care, including labor, delivery, and recovery room, birthing center, and newborn nursery;
 - b. Neonatal intensive care unit (NICU);
 - c. Intensive care unit (ICU);
 - d. Surgery, including surgery room and recovery room;

- e. Nursery and related services;
 - f. Routine care; and
 - g. Emergency behavioral health services provided under Article 12 of this Chapter for a member eligible under A.R.S. § 36-2901(6)(a).
2. Ancillary services as specified by the Director and included in contract:
- a. Laboratory services;
 - b. Radiological and medical imaging services;
 - c. Anesthesiology services;
 - d. Rehabilitation services;
 - e. Pharmaceutical services and prescription drugs;
 - f. Respiratory therapy;
 - g. Blood and blood derivatives; and
 - h. Central supply items, appliances, and equipment that are not ordinarily furnished to all patients and customarily reimbursed as ancillary services.
- B.** The following limitations apply to inpatient general hospital services that are provided by FFS providers.
1. Providers shall obtain prior authorization from the Administration for the following inpatient hospital services:
 - a. Nonemergency and elective admission, including psychiatric hospitalization;
 - b. Elective surgery; and
 - c. Services or items provided to cosmetically reconstruct or improve personal appearance after an illness or injury.
 2. The Administration or a contractor may deny a claim if a provider fails to obtain prior authorization.
 3. Providers are not required to obtain prior authorization from the Administration for the following inpatient hospital services:
 - a. Voluntary sterilization,
 - b. Dialysis shunt placement,
 - c. Arteriovenous graft placement for dialysis,
 - d. Angioplasties or thrombectomies of dialysis shunts,
 - e. Angioplasties or thrombectomies of arteriovenous graft for dialysis,
 - f. Hospitalization for vaginal delivery that does not exceed 48 hours,
 - g. Hospitalization for cesarean section delivery that does not exceed 96 hours, and
 - h. Other services identified by the Administration through the Provider Participation Agreement.
 4. The Administration may perform concurrent review for hospitalizations of non-FES members to determine whether there is medical necessity for the hospitalization. A provider shall notify the Administration no later than 72 hours after an emergency admission.
- C.** Coverage of in-state and out-of-state inpatient hospital services is limited to 25 days per benefit year for members age 21 and older. The limit applies for all inpatient hospital services with dates of service during the benefit year regardless of whether the member is enrolled in Fee for Service, is enrolled with one or more contractors, or both, during the benefit year.
1. For purposes of calculating the limit:
 - a. Inpatient days are counted towards the limit if paid by the Administration or a contractor;
 - b. Inpatient days will be counted toward the limit in the order of the adjudication date of a paid claim;
 - c. Paid inpatient days are allocated to the benefit year in which the date of service occurs;
 - d. Each 24 hours of paid observation services is counted as one inpatient day if the patient is not admitted to the same hospital directly following the observation services;
 - e. Observation services, which are directly followed by an inpatient admission to the same hospital are not counted towards the inpatient limit; and
 - f. After 25 days of inpatient hospital services have been paid as provided for in this Section:
 - i. Outpatient services that are directly followed by an inpatient admission to the same hospital, including observation services, are not covered.
 - ii. Continuous periods of observation services of less than 24 hours that are not directly followed by an inpatient admission to the same hospital are covered.
 - iii. For continuous periods of observation services of 24 hours or more that are not directly followed by an inpatient admission to the same hospital, 23 hours of observations services are covered.
 2. The following inpatient days are not included in the inpatient hospital limitation described in this Section:
 - a. Days reimbursed under specialty contracts between AHCCCS and a transplant facility that are included within the component pricing referred to in the contract;
 - b. Days related to Behavioral Health:
 - i. Inpatient days that qualify for the psychiatric tier under R9-22-712.09 and reimbursed by the Administration or its contractors, or
 - ii. Inpatient days with a primary psychiatric diagnosis code reimbursed by the Administration or its contractors, or
 - iii. Inpatient days paid by the Arizona Department of Health Services Division of Behavioral Health Services or a RBHA or TRBHA.
 - c. Days related to treatment for burns and burn late effects at an American College of Surgeons verified burn center;
 - d. Same Day Admit Discharge services are excluded from the 25 day limit; and
 - e. Subject to approval by CMS, days for which the state claims 100% FFP, such as payments for days provided by IHS or 638 facilities.

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-204 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) effective December 22, 1987 (Supp. 87-4). Amended effective December 13, 1993 (Supp. 93-4). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by exempt rulemaking at 17 A.A.R. 1707, effective October 1, 2011 (Supp. 11-3). Amended by exempt rulemaking at 18 A.A.R. 1745, effective October 1, 2012 (Supp. 12-2).

R9-22-205. Attending Physician, Practitioner, and Primary Care Provider Services

A. A primary care provider, attending physician, or practitioner shall provide primary care provider services within the provider's scope of practice under A.R.S. Title 32. A member may receive primary care provider services in an inpatient or outpatient setting including at a minimum:

1. Periodic health examination and assessment;
2. Evaluation and diagnostic workup;
3. Medically necessary treatment;
4. Prescriptions for medication and medically necessary supplies and equipment;
5. Referral to a specialist or other health care professional if medically necessary;
6. Patient education;
7. Home visits if medically necessary; and
8. Except as provided in subsection (B), preventive health services, such as, immunizations, colonoscopies, mammograms and PAP smears.

B. The following limitations and exclusions apply to attending physician and practitioner services and primary care provider services:

1. Specialty care and other services provided to a member upon referral from a primary care provider, or to a member upon referral from the attending physician or practitioner are limited to the service or condition for which the referral is made, or for which authorization is given by the Administration or a contractor.
2. A member's physical examination is not covered if the sole purpose is to obtain documentation for one or more of the following:
 - a. Qualification for insurance,
 - b. Pre-employment physical evaluation,
 - c. Qualification for sports or physical exercise activities,
 - d. Pilot's examination for the Federal Aviation Administration,
 - e. Disability certification to establish any kind of periodic payments,
 - f. Evaluation to establish third-party liabilities, or
 - g. Physical ability to perform functions that have no relationship to primary objectives of the services listed in subsection (A).
3. Orthognathic surgery is covered only for a member who is less than 21 years of age;
4. The following services are excluded from AHCCCS coverage:
 - a. Infertility services, reversal of surgically induced infertility (sterilization), and gender reassignment surgeries;
 - b. Pregnancy termination counseling services;
 - c. Pregnancy terminations, unless required by state or federal law.
 - d. Services or items furnished solely for cosmetic purposes;
 - e. Hysterectomies unless determined medically necessary; and
 - f. Preventive services not covered are well exams, meaning physical examinations in the absence of any known disease or symptom or any specific medical complaint by the patient precipitating the examination.

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-

3). Former Section R9-22-205 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A), paragraph (15) and added paragraph (20) effective December 22, 1987 (Supp. 87-4). Amended subsection (C)(2) effective May 30, 1989 (Supp. 89-2). Amended under an exemption from the provisions of the Administrative Procedure Act effective March 22, 1993; received in the Office of the Secretary of State March 24, 1993 (Supp. 93-1). Amended effective December 13, 1993 (Supp. 93-4). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4). Amended by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3).

Editor's Note: The following Section was renumbered and a new Section adopted under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not published as a proposed rule in the Arizona Administrative Register; the rule was not reviewed or approved by the Governor's Regulatory Review Council; and the agency was not required to hold public hearings on the rule. This Section was subsequently amended through the regular rulemaking process.

R9-22-206. Organ and Tissue Transplant Services

A. Organ and tissue transplant services are covered for a member if prior authorized and coordinated with the member's contractor, or the Administration. Only the following transplants are covered for individuals 21 years of age or older:

1. Heart, including transplants for the treatment of non-ischemic cardiomyopathy;
2. Liver, including transplants for patients with hepatitis C;
3. Kidney (cadaveric and live donor),
4. Simultaneous Pancreas/Kidney (SPK),
5. Autologous and Allogeneic related and unrelated Hematopoietic Cell transplants;
6. Cornea;
7. Bone;
8. Lung; and
9. Pancreas after a kidney transplant (PAK).

B. The following transplants are not covered for members 21 years of age or older:

1. Pancreas only transplants if it is not performed simultaneously with or following a kidney transplant. Partial pancreas transplants and autologous and allogeneic pancreas islet cell transplants are not covered even if performed simultaneously with or following a kidney transplant,
2. Intestine transplants, and
3. Any other type of transplant not specifically listed in subsection (A).

C. When there is a transplant of multiple organs, reimbursement will only be made for those covered.

D. Organ and tissue transplant services are not covered for non-qualified aliens or noncitizens members of FESP under A.R.S. § 36-2903.03(D).

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-206 adopted as an emergency now adopted and amended as a permanent rule effective

August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended effective December 13, 1993 (Supp. 93-4). Former Section R9-22-206 renumbered to R9-22-218, new Section R9-22-206 adopted effective January 1, 1996, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Third Special Session, Ch. 1, § 5; filed with the Office of the Secretary of State December 28, 1995 (Supp. 95-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by exempt rulemaking at 7 A.A.R. 5701, effective December 1, 2001 (Supp. 01-4). Amended by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4). Amended by exempt rulemaking at 16 A.A.R. 1386, effective July 15, 2010 (Supp. 10-3). Amended by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3). Amended by exempt rulemaking at 17 A.A.R. 1122, April 1, 2011 (Supp. 11-2).

R9-22-207. Dental Services

- A.** The Administration or a contractor shall cover dental services for a member less than 21 years of age under R9-22-213.
- B.** For individuals age 21 years of age or older, the Administration or a contractor shall cover medical and surgical services furnished by a dentist only to the extent such services may be performed under state law either by a physician or by a dentist and such services would be considered a physician service if furnished by a physician.
 1. Except as specified in subsection (C), such services must be related to the treatment of a medical condition such as acute pain, infection, or fracture of the jaw. Covered dental services include examination of the oral cavity, radiographs, complex oral surgical procedures such as treatment of maxillofacial fractures, administration of an appropriate level of anesthesia and the prescription of pain medication and antibiotics.
 2. Such services do not include services that physicians are not generally competent to perform such as dental cleanings, routine dental examinations, dental restorations including crowns and fillings, extractions, pulpotomies, root canals, and the construction or delivery of complete or partial dentures. Diagnosis and treatment of temporomandibular joint dysfunction are not covered except for the reduction of trauma.
- C.** For the purposes of this subsection, simple restorations means silver amalgam or composite resin fillings, stainless steel crowns or preformed crowns. In addition, dental services for an individual 21 years of age or older include:
 1. The elimination of oral infections and the treatment of oral disease, which includes dental cleanings, treatment of periodontal disease, medically necessary extractions and the provision of simple restorations as a medically necessary pre-requisite to covered transplantation; and
 2. Prophylactic extraction of teeth in preparation for covered radiation treatment of cancer of the jaw, neck or head.

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-207 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-207 repealed, new Section R9-22-207 adopted effective October 1, 1985 (Supp. 85-5). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3).

Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3).

R9-22-208. Laboratory, Radiology, and Medical Imaging Services

Laboratory, radiology, and medical imaging services are covered services if:

1. Prescribed by the member's attending physician, practitioner, primary care provider or a dentist, or prescribed by a physician or practitioner upon referral from the primary care provider or dentist.
2. Provided by licensed health care providers in a:
 - a. Hospital,
 - b. Clinic,
 - c. Physician's office, or
 - d. Other health care facility.

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-208 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-208 repealed, new Section R9-22-208 adopted effective October 1, 1985 (Supp. 85-5). Amended subsection (C) effective December 22, 1987 (Supp. 87-4). Amended effective December 13, 1993 (Supp. 93-4). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2).

R9-22-209. Pharmaceutical Services

- A.** An inpatient or outpatient provider, including a hospital, clinic, other appropriately licensed health care facility, and pharmacy may provide covered pharmaceutical services.
- B.** The Administration or a contractor shall require a provider to make pharmaceutical services:
 1. Available during customary business hours, and
 2. Located within reasonable travel distance of a member's residence.
- C.** Pharmaceutical services are covered if:
 1. Prescribed for a member by the member's primary care provider, attending physician, practitioner, or dentist;
 2. Prescribed by a specialist upon referral from the primary care provider or attending physician; or
 3. The contractor or its designee authorizes the service.
- D.** The following limitations apply to pharmaceutical services:
 1. A medication personally dispensed by a physician, dentist, or a practitioner within the individual's scope of practice is not covered, except in geographically remote areas where there is no participating pharmacy or if accessible pharmacies are closed.
 2. A prescription or refill in excess of 100-unit doses is not covered. A prescription or refill in excess of a 30 day supply is not covered unless specified in subsection (D)(3).
 3. A prescription or refill in excess of a 30-day supply is covered if:
 - a. The medication is prescribed for chronic illness and the prescription is limited to no more than a 100-day supply or 100-unit doses, whichever is greater.
 - b. The member will be out of the provider's service area for an extended period of time and the prescription is limited to the extended time period, not to exceed 100 day supply or 100-unit doses, whichever is greater.

- c. The medication is prescribed for contraception and the prescription is limited to no more than a 100-day supply.
 - 4. An over-the-counter medication, in place of a covered prescription medication, is covered only if the over-the-counter medication is appropriate, equally effective, safe, and less costly than the covered prescription medication.
- E. A contractor shall monitor and ensure sufficient services to prevent any gap in the pharmaceutical regimen of a member who requires a continuing or complex regimen of pharmaceutical treatment to restore, improve, or maintain physical well being.

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-209 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended effective September 24, 1986 (Supp. 86-5). Amended subsections (A) and (C) effective December 22, 1987 (Supp. 87-4). Amended subsection (C)(3), effective May 30, 1989 (Supp. 89-2). Amended under an exemption from the Administrative Procedure Act effective March 22, 1993; received in the Office of the Secretary of State March 24, 1993 (Supp. 93-1). Amended effective December 13, 1993 (Supp. 93-4). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2).

R9-22-210. Emergency Medical Services for Non-FES Members

A. General provisions.

1. Applicability. This Section applies to emergency medical services for non-FES members. Provisions regarding emergency behavioral health services for non-FES members are in R9-22-210.01. Provisions regarding emergency medical and behavioral health services for FES members are in R9-22-217.
2. Definitions.
 - a. For the purposes of this Section, “contractor” has the same meaning as in A.R.S. § 36-2901. Contractor does not include ADHS/DBHS or a subcontractor of ADHS/DBHS, or Children’s Rehabilitative Services.
 - b. For the purposes of this Section and R9-22-210.01, “fiscal agent” means a person who bills and accepts payment for a hospital or emergency room provider.
3. Verification. A provider of emergency medical services shall verify a person’s eligibility status with AHCCCS, and if eligible, determine whether the person is enrolled with AHCCCS as non-FES FFS or is enrolled with a contractor.
4. Prior authorization.
 - a. Emergency medical services. A provider is not required to obtain prior authorization for emergency medical services.
 - b. Non-emergency medical services. If a non-FES member’s medical condition does not require emergency medical services, the provider shall obtain prior authorization as required by the terms of the provider agreement under R9-22-714(A) or the provider’s subcontract with the contractor, whichever is applicable.

5. Prohibition against denial of payment. Neither the Administration nor a contractor shall:
 - a. Limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms,
 - b. Deny or limit payment because the provider failed to obtain prior authorization for emergency services,
 - c. Deny or limit payment because the provider does not have a subcontract.
 6. Grounds for denial. The Administration and a contractor may deny payment for emergency medical services for reasons including but not limited to:
 - a. The claim was not a clean claim;
 - b. The claim was not submitted timely; and
 - c. The provider failed to provide timely notification under subsection (B)(4) to the contractor or the Administration, as appropriate, and the contractor does not have actual notice from any other source that the member has presented for services.
- B. Additional requirements for emergency medical services for non-FES members enrolled with a contractor.**
1. Responsible entity. A contractor is responsible for the provision of all emergency medical services to non-FES members enrolled with the contractor.
 2. Prohibition against denial of payment. A contractor shall not limit or deny payment for emergency medical services when an employee of the contractor instructs the member to obtain emergency medical services.
 3. Contractor notification. A contractor shall not deny payment to a hospital, emergency room provider, or fiscal agent for an emergency medical service rendered to a non-FES member based on the failure of the hospital, emergency room provider, or fiscal agent to notify the member’s contractor within 10 days from the day that the member presented for the emergency medical service.
 4. Contractor notification. A hospital, emergency room provider, or fiscal agent shall notify the contractor no later than the 11th day after presentation of the non-FES member for emergency inpatient medical services. A contractor may deny payment for a hospital’s, emergency room provider’s, or fiscal agent’s failure to provide timely notice, under this subsection.
- C. Post-stabilization services for non-FES members enrolled with a contractor.**
1. After the emergency medical condition of a member enrolled with a contractor is stabilized, a provider shall request prior authorization from the contractor for post-stabilization services.
 2. The contractor is financially responsible for medical post-stabilization services obtained within or outside the network that have been prior authorized by the contractor.
 3. The contractor is financially responsible for medical post-stabilization services obtained within or outside the network that are not prior authorized by the contractor, but are administered to maintain the member’s stabilized condition within one hour of a request to the contractor for prior authorization of further post-stabilization services;
 4. The contractor is financially responsible for medical post-stabilization services obtained within or outside the network that are not prior authorized by the contractor, but are administered to maintain, improve, or resolve the member’s stabilized condition if:
 - a. The contractor does not respond to a request for prior authorization within one hour;
 - b. The contractor authorized to give the prior authorization cannot be contacted; or

- c. The contractor representative and the treating physician cannot reach an agreement concerning the member's care and the contractor physician is not available for consultation. In this situation, the contractor shall give the treating physician the opportunity to consult with a contractor physician. The treating physician may continue with care of the member until the contractor physician is reached or:
 - i. A contractor physician with privileges at the treating hospital assumes responsibility for the member's care,
 - ii. A contractor physician assumes responsibility for the member's care through transfer,
 - iii. The contractor's representative and the treating physician reach agreement concerning the member's care, or
 - iv. The member is discharged.
 5. Transfer or discharge. The attending physician or practitioner actually treating the member for the emergency medical condition shall determine when the member is sufficiently stabilized for transfer or discharge and that decision shall be binding on the contractor.
- D. Additional requirements for FFS members.**
1. Responsible entity. The Administration is responsible for the provision of all emergency medical services to non-FES FFS members.
 2. Grounds for denial. The Administration may deny payment for emergency medical services if a provider fails to provide timely notice to the Administration.
 3. Notification. A provider shall notify the Administration no later than 72 hours after a FFS member receiving emergency medical services presents to a hospital for inpatient services. The Administration may deny payment for failure to provide timely notice.
- Historical Note**
- Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-210 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-210 repealed, new Section R9-22-210 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B), paragraph (1) effective October 1, 1987 (Supp. 87-4). Amended effective December 13, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 5 A.A.R. 867, effective March 4, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 11 A.A.R. 5480, effective December 6, 2005 (Supp. 05-4). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3).
- R9-22-210.01. Emergency Behavioral Health Services for Non-FES Members**
- A. General provisions.**
1. Applicability. This Section applies to emergency behavioral health services for non-FES members. Provisions regarding emergency medical services for non-FES members are in R9-22-210. Provisions regarding emergency medical and behavioral health services for FES members are in R9-22-217.
2. Definition. For the purposes of this Section, "contractor" has the same meaning as in A.R.S. § 36-2901. Contractor does not include ADHS/DBHS, a subcontractor of ADHS/DBHS, or Children's Rehabilitative Services.
 3. Responsible entity for inpatient emergency behavioral health services.
 - a. Members enrolled with a contractor.
 - i. ADHS/DBHS. ADHS/DBHS or a subcontractor of ADHS/DBHS is responsible for providing all inpatient emergency behavioral health services to non-FES members with psychiatric or substance abuse diagnoses who are enrolled with the contractor, from one of the following time periods, whichever comes first:
 - (1) The date on which the member becomes a behavioral health recipient, or
 - (2) The 73rd hour after admission for inpatient emergency behavioral health services.
 - ii. Contractors. Contractors are responsible for providing inpatient emergency behavioral health services to non-FES members with psychiatric or substance abuse diagnoses who are enrolled with a contractor and are not behavioral health recipients, for the first 72 hours after admission.
 - b. FFS members. ADHS/DBHS or a subcontractor of ADHS/DBHS is responsible for providing all inpatient emergency behavioral health services for non-FES FFS members with psychiatric or substance abuse diagnoses.
 4. Responsible entity for non-inpatient emergency behavioral health services for non-FES members. ADHS/DBHS or a subcontractor of ADHS/DBHS is responsible for providing all non-inpatient emergency behavioral health services for non-FES members.
 5. Verification. A provider of emergency behavioral health services shall verify a person's eligibility status with AHCCCS, and if eligible, determine whether the person is a member enrolled with AHCCCS as non-FES FFS or is enrolled with a contractor, and determine whether the member is a behavioral health recipient as defined in R9-22-102.
 6. Prior authorization.
 - a. Emergency behavioral health services. A provider is not required to obtain prior authorization for emergency behavioral health services.
 - b. Non-emergency behavioral health services. When a non-FES member's behavioral health condition is determined by the provider not to require emergency behavioral health services, the provider shall follow the prior authorization requirements of a contractor and ADHS/DBHS or a subcontractor of ADHS/DBHS.
 7. Prohibition against denial of payment. A contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS shall not limit or deny payment to an emergency behavioral health provider for emergency behavioral health services to a non-FES member for the following reasons:
 - a. On the basis of lists of diagnoses or symptoms;
 - b. Prior authorization was not obtained;
 - c. The provider does not have a contract;
 - d. An employee of the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS instructs the member to obtain emergency behavioral health services; or

- e. The failure of a hospital, emergency room provider, or fiscal agent to notify the member's contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS within 10 days from the day the member presented for the emergency service.
- 8. Grounds for denial. A contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS may deny payment for emergency behavioral health services for reasons including but not limited to the following:
 - a. The claim was not a clean claim;
 - b. The claim was not submitted timely; or
 - c. The provider failed to provide timely notification under subsection (A)(9) to the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS.
- 9. Notification. A hospital, emergency room provider, or fiscal agent shall notify a contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, whichever is appropriate, no later than the 11th day from presentation of the non-FES member for emergency inpatient behavioral health services.
- 10. Behavioral health evaluation. An emergency behavioral health evaluation is covered as an emergency behavioral health service for a non-FES member under this Section if:
 - a. Required to evaluate or stabilize an acute episode of mental disorder or substance abuse, and
 - b. Provided by a qualified provider who is:
 - i. A behavioral health medical practitioner as defined in R9-22-112, including a licensed psychologist, a licensed clinical social worker, a licensed professional counselor, and a licensed marriage and family therapist; or
 - ii. An ADHS/DBHS-contracted provider.
- 11. Transfer or discharge. The attending physician or the provider actually treating the non-FES member for the emergency behavioral health condition shall determine when the member is sufficiently stabilized for transfer or discharge and that decision shall be binding on the contractor and ADHS/DBHS or a subcontractor of ADHS/DBHS.

B. Post-stabilization requirements for non-FES members.

- 1. A contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, as appropriate, is financially responsible for behavioral health post-stabilization services obtained within or outside the network that have been prior authorized by the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS.
- 2. The contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, as appropriate, is financially responsible for behavioral health post-stabilization services obtained within or outside the network that are not prior authorized by the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, but are administered to maintain the member's stabilized condition within one hour of a request to the contractor, ADHS/DBHS, or a subcontractor for prior authorization of further post-stabilization services;
- 3. The contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, as appropriate, is financially responsible for behavioral health post-stabilization services obtained within or outside the network that are not prior authorized by the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, but are administered to maintain, improve, or resolve the member's stabilized condition if:
 - a. The contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, does not respond to a request for prior authorization within one hour;
 - b. The contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS authorized to give the prior authorization cannot be contacted; or
 - c. The representative of the contractor, ADHS/DBHS, or the subcontractor and the treating physician cannot reach an agreement concerning the member's care and the contractor's, ADHS/DBHS' or the subcontractor's physician, is not available for consultation. The treating physician may continue with care of the member until ADHS/DBHS', the contractor's, or the subcontractor's physician is reached, or:
 - i. A contractor physician with privileges at the treating hospital assumes responsibility for the member's care;
 - ii. ADHS/DBHS', a contractor's, or a subcontractor's physician assumes responsibility for the member's care through transfer;
 - iii. A representative of the contractor, ADHS/DBHS, or the subcontractor and the treating physician reach agreement concerning the member's care; or
 - iv. The member is discharged.

Historical Note

New Section made by final rulemaking at 11 A.A.R.

5480, effective December 6, 2005 (Supp. 05-4).

Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3).

R9-22-211. Transportation Services

A. Emergency ambulance services.

- 1. A member shall receive medically necessary emergency transportation in a ground or air ambulance:
 - a. To the nearest appropriate provider or medical facility capable of meeting the member's medical needs, and
 - b. If no other appropriate means of transportation is available.
- 2. The Administration or a member's contractor shall reimburse a ground or air ambulance transport that originates in response to a 911 call or other emergency response system:
 - a. If the member's medical condition justifies the medical necessity of the type of ambulance transportation received,
 - b. The transport is to the nearest appropriate provider or medical facility capable of meeting the member's medical needs, and
 - c. No prior authorization is required for reimbursement of these transports.
- 3. The member's medical condition at the time of transport determines whether the transport is medically necessary.
- 4. A ground or air ambulance provider furnishing transport in response to a 911 call or other emergency response system shall notify the member's contractor within 10 working days from the date of transport. Failure of the provider to provide notification is cause for denial.
- 5. Notification to the Administration of emergency transportation provided to a FFS member is not required, but the provider shall submit documentation with the claim that justifies the service.

B. The Administration or a contractor covers air ambulance services only if at least one criterion in subsection (B)(1) is met and at least one criterion in subsection (B)(2), or the criterion in subsection (B)(3) is met. The criteria are:

- 1. The air ambulance transport is initiated at the request of:
 - a. An emergency response unit,

- b. A law enforcement official,
 - c. A clinic or hospital medical staff member, or
 - d. A physician or practitioner, and
 - 2. The point of pickup:
 - a. Is inaccessible by ground ambulance, or
 - b. Is a great distance from the nearest hospital or other provider with appropriate facilities to treat the member's condition and ground ambulance service will not suffice, or
 - 3. The medical condition of the member requires immediate intervention from emergency ambulance personnel or providers with the appropriate facilities to treat the member's condition.
- C.** Coverage of medically necessary nonemergency transportation is limited to the cost of transporting the member to an appropriate provider capable of meeting the member's medical needs.
- 1. As specified in contract, a contractor shall arrange or provide medically necessary nonemergency transportation services for a member who is unable to arrange transportation to a service site or location.
 - 2. For a fee-for-service member, the Administration shall authorize medically necessary nonemergency transportation for a member who is unable to arrange transportation to a service site or location.
- D.** For the purposes of this subsection, an individual means a person who is not in the business of providing transportation services such as a family or household member, friend, or neighbor. The Administration or a contractor shall cover expenses for transportation in traveling to and returning from an approved and prior authorized health care service site provided by an individual if:
- 1. The transportation services are authorized by the Administration or the member's contractor or designee,
 - 2. The individual is an AHCCCS registered provider, and
 - 3. No other means of appropriate transportation is available.
- E.** The Administration or a contractor shall cover expenses for meals, lodging, and transportation for a member traveling to and returning from an approved health care service site outside of the member's service area or county of residence.
- F.** The Administration or a contractor shall cover the expense of meals, lodging, and transportation for:
- 1. A family member accompanying a member if:
 - a. The member is traveling to or returning from an approved health care service site outside of the member's service area or county of residence; and
 - b. The meals, lodging, and transportation services are authorized by the Administration or the member's contractor or designee.
 - 2. An escort who is not a family member as follows:
 - a. If the member is travelling to or returning from an approved and prior authorized health care service site, including an inpatient facility, outside of the member's service area or county of residence;
 - b. If the escort services are authorized by the Administration or the member's contractor or designee; and
 - c. Wage paid to an escort as reimbursement shall not exceed the federal minimum wage.
- G.** A provider shall obtain prior authorization from the Administration for transportation services provided for a member for the following:
- 1. Medically necessary nonemergency transportation services not originated through a 911 call or other emergency response system when the distance traveled exceeds 100 miles (whether one way or round trip); and

- 2. All meals, lodging, and services of an escort accompanying the member under this Section.

- H.** A charitable organization routinely providing transportation service at no cost to an ambulatory or chairbound person shall not charge or seek reimbursement from the Administration or a contractor for the provision of the service to a member but may enter into a subcontract with a contractor for medically necessary transportation services provided to a member.

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-211 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) effective October 1, 1986 (Supp. 86-5). Amended effective December 13, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3).

R9-22-212. Durable Medical Equipment, Orthotic and Prosthetic Devices, and Medical Supplies

- A.** Durable medical equipment, orthotic and prosthetic devices, and medical supplies, including incontinence briefs as specified in subsection (E), are covered services to the extent permitted in this Section if provided in compliance with requirements of this Chapter; and
- 1. Prescribed by the primary care provider, attending physician, or practitioner; or
 - 2. Prescribed by a specialist upon referral from the primary care provider, attending physician, or practitioner; and
 - 3. Authorized as required by the Administration, contractor, or contractor's designee.
- B.** Covered medical supplies are consumable items that are designed specifically to meet a medical purpose, are disposable, and are essential for the member's health.
- C.** Covered DME is any item, appliance, or piece of equipment that is not a prosthetic or orthotic; and
- 1. Is designed for a medical purpose, and is generally not useful to a person in the absence of an illness or injury, and
 - 2. Can withstand repeated use, and
 - 3. Is generally reusable by others.
- D.** Prosthetics are devices prescribed by a physician or other licensed practitioner to artificially replace missing, deformed or malfunctioning portion of the body. Only those prosthetics that are medically necessary for rehabilitation are covered, except as otherwise provided in R9-22-215.
- E.** The following limitations on coverage apply:
- 1. The DME is furnished on a rental or purchase basis, whichever is less expensive. The total expense of renting the DME does not exceed the cost of the DME if purchased.
 - 2. Reasonable repair or adjustment of purchased DME is covered if necessary to make the DME serviceable and if the cost of repair or adjustment is less than the cost of renting or purchasing another unit.
 - 3. A change in, or addition to, an original order for DME is covered if approved by the prescriber in subsection (A), or prior authorized by the Administration or contractor, and the change or addition is indicated clearly on the order and initialed by the vendor. No change or addition to the original order for DME may be made after a claim for services is submitted to the member's contractor, or

- the Administration, without prior written notification of the change or addition to the Administration or the contractor.
4. Reimbursement for rental fees shall terminate:
 - a. No later than the end of the month in which the prescriber in subsection (A) certifies that the member no longer needs the DME;
 - b. If the member is no longer eligible for AHCCCS services; or
 - c. If the member is no longer enrolled with a contractor, with the exception of transitions of care as specified in R9-22-509.
 5. Except for incontinence briefs for persons over 3 years old and under 21 years old as provided in subsection (E)(6), personal care items including items for personal cleanliness, body hygiene, and grooming are not covered unless needed to treat a medical condition. Personal care items are not covered services if used solely for preventive purposes.
 6. Incontinence briefs, including pull-ups are covered to prevent skin breakdown and enable participation in social, community, therapeutic and educational activities under the following circumstances:
 - a. The member is over 3 years old and under 21 years old;
 - b. The member is incontinent due to a documented disability that causes incontinence of bowel or bladder, or both;
 - c. The PCP or attending physician has issued a prescription ordering the incontinence briefs;
 - d. Incontinence briefs do not exceed 240 briefs per month unless the prescribing physician presents evidence of medical necessity for more than 240 briefs per month for a member diagnosed with chronic diarrhea or spastic bladder;
 - e. The member obtains incontinence briefs from providers in the contractor's network;
 - f. Prior authorization has been obtained as required by the Administration, contractor, or contractor's designee. Contractors may require a new prior authorization to be issued no more frequently than every 12 months. Prior authorization for a renewal of an existing prescription may be provided by the physician through telephone contact with the member rather than an in-person physician visit. Prior authorization will be permitted to ascertain that:
 - i. The member is over age 3 and under age 21;
 - ii. The member has a disability that causes incontinence of bladder or bowel, or both;
 - iii. A physician has prescribed incontinence briefs as medically necessary. A physician prescription supporting medical necessity may be required for specialty briefs or for briefs different from the standard briefs supplied by the contractor; and
 - iv. The prescription is for 240 briefs or fewer per month, unless evidence of medical necessity for over 240 briefs is provided.
 7. First aid supplies are not covered unless they are provided in accordance with a prescription.
 8. The following services are not covered for individuals 21 years of age or older:
 - a. Hearing aids;
 - b. Prescriptive lenses unless they are the sole visual prosthetic device used by the member after a cataract extraction;
 - c. Bone Anchor Hearing Aid (BAHA);
 - d. Cochlear implant;
 - e. Percussive vest;
 - f. Insulin pump;
 - g. Microprocessor-controlled lower limbs or microprocessor-controlled joints for lower limbs; and
 - h. Orthotics, which are defined as devices that are prescribed by a physician or other licensed practitioner of the healing arts to support a weak or deformed portion of the body.
- F. Liability and ownership.**
1. Purchased DME that is provided to a member and no longer needed by the member may be disposed of in accordance with each contractor's policy.
 2. The Administration shall retain title to purchased DME provided to a member who becomes ineligible or no longer requires use of the DME.
 3. If customized DME is purchased by the Administration or contractor for a member, the equipment shall remain with the person during times of transition to a different contractor, or upon loss of eligibility. For purposes of this subsection, customized DME refers to equipment that is altered or built to specifications unique to a member's medical needs and that, most likely, cannot be used or reused to meet the needs of another individual.
 4. A member shall return DME obtained fraudulently to the Administration or the contractor.

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-212 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-212 repealed, new Section R9-22-212 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B), paragraph (2), and deleted subsection (C) effective October 1, 1986 (Supp. 86-5). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 13 A.A.R. 3272, effective September 11, 2007 (Supp. 07-3). Amended by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3).

R9-22-213. Early and Periodic Screening, Diagnosis, and Treatment Services (E.P.S.D.T.)

- A.** The following E.P.S.D.T. services are covered for a member less than 21 years of age:
1. Screening services including:
 - a. Comprehensive health and developmental history;
 - b. Comprehensive unclothed physical examination;
 - c. Appropriate immunizations according to age and health history;
 - d. Laboratory tests; and
 - e. Health education, including anticipatory guidance;
 2. Vision services including:
 - a. Diagnosis and treatment for defects in vision;
 - b. Eye examinations for the provision of prescriptive lenses; and
 - c. Prescriptive lenses;
 3. Hearing services including:
 - a. Diagnosis and treatment for defects in hearing;
 - b. Testing to determine hearing impairment; and
 - c. Hearing aids;
 4. Dental services including:

- a. Emergency dental services as specified in R9-22-207;
- b. Preventive services including screening, diagnosis, and treatment of dental disease; and
- c. Therapeutic dental services including fillings, crowns, dentures, and other prosthetic devices;
5. Orthognathic surgery;
6. Nutritional assessment and nutritional therapy as specified in contract to provide complete daily dietary requirements or supplement a member's daily nutritional and caloric intake;
7. Behavioral health services under 9 A.A.C. 22, Article 12;
8. Hospice services as follows:
 - a. Hospice services are covered only for a member who is in the final stages of a terminal illness and has a prognosis of death within six months;
 - b. Services available to a member receiving hospice care are limited to those allowable under 42 CFR 418.202, October 1, 2006, incorporated by reference and on file with the Administration. This incorporation by reference contains no future editions or amendments.
 - c. Hospice services do not include:
 - i. Medical services provided that are not related to the terminal illness; or
 - ii. Home-delivered meals; and
 - d. Hospice services that are provided and covered through Medicare are not covered by AHCCCS;
9. Incontinence briefs as specified under R9-22-212; and
10. Other necessary health care, diagnostic services, treatment, and measures required by 42 U.S.C. 1396d(r)(5).
- B.** Providers of E.P.S.D.T. services shall meet the following standards:
 1. Ensure that services are provided by or under the direction of the member's primary care provider, attending physician, practitioner, or dentist.
 2. Perform tests and examinations under 42 CFR 441 Subpart B, October 1, 2006, which is incorporated by reference and on file with the Administration. This incorporation by reference contains no future editions or amendments.
 3. Refer a member as necessary for dental diagnosis and treatment and necessary specialty care.
 4. Refer a member as necessary for behavioral health evaluation and treatment services.
- C.** Contractors shall meet other E.P.S.D.T. requirements as specified in contract.
- D.** A primary care provider, attending physician, or practitioner shall refer a member with special health care needs under R9-7-301 to CRS.

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-213 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-213 repealed, new Section R9-22-213 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended effective December 13, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 13 A.A.R. 3272, effective September 11, 2007 (Supp. 07-3).

R9-22-214. Repealed

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-214 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-214 repealed, new Section R9-22-214 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B), paragraph (4) and added subsection (C), paragraph (2) effective October 1, 1986 (Supp. 86-5). Correction to subsection (C), paragraph (2) (Supp. 87-4). Section repealed effective September 22, 1997 (Supp. 97-3).

R9-22-215. Other Medical Professional Services

- A.** The following medical professional services are covered services if a member receives these services in an inpatient, outpatient, or office:
 1. Dialysis;
 2. The following family planning services if provided to delay or prevent pregnancy:
 - a. Medications,
 - b. Supplies,
 - c. Devices, and
 - d. Surgical procedures;
 3. Family planning services are limited to:
 - a. Contraceptive counseling, medications, supplies, and associated medical and laboratory examinations, including HIV blood screening as part of a package of sexually transmitted disease tests provided with a family planning service;
 - b. Sterilization; and
 - c. Natural family planning education or referral;
 4. Midwifery services provided by a certified nurse practitioner in midwifery;
 5. Midwifery services for low-risk pregnancies and home deliveries provided by a licensed midwife;
 6. Respiratory therapy;
 7. Ambulatory and outpatient surgery facilities services;
 8. Home health services under A.R.S. § 36-2907(D);
 9. Private or special duty nursing services;
 10. Rehabilitation services including physical therapy, occupational therapy, speech therapy, and audiology within limitations in subsection (C);
 11. Total parenteral nutrition services, which are the provision of total caloric needs by intravenous route for individuals with severe pathology of the alimentary tract;
 12. Inpatient chemotherapy; and
 13. Outpatient chemotherapy.
- B.** Prior authorization from the Administration for a member is required for services listed in subsections (A)(3)(b), and (A)(4) through (11); except for:
 1. Voluntary sterilization;
 2. Dialysis shunt placement;
 3. Arteriovenous graft placement for dialysis;
 4. Angioplasties or thrombectomies of dialysis shunts;
 5. Angioplasties or thrombectomies of arteriovenous grafts for dialysis;
 6. Eye surgery for the treatment of diabetic retinopathy;
 7. Eye surgery for the treatment of glaucoma;
 8. Eye surgery for the treatment of macular degeneration;
 9. Home health visits following an acute hospitalization (limited up to five visits);

10. Hysteroscopies (up to two, one before and one after) when associated with a family planning diagnosis code and done within 90 days of hysteroscopic sterilization;
 11. Physical therapy subject to the limitation in subsection (C);
 12. Facility services related to wound debridement,
 13. Apnea management and training for premature babies up to the age of 1; and
 14. Other services identified by the Administration through the Provider Participation Agreement.
- C. The following are not covered services:
1. Occupational and speech therapies provided on an outpatient basis for a member age 21 or older;
 2. Physical therapy provided only as a maintenance regimen;
 3. Abortion counseling;
 4. Services or items furnished solely for cosmetic purposes;
 5. Services provided by a podiatrist; or
 6. More than 15 outpatient physical therapy visits per benefit year with the exception of the required Medicare coinsurance and deductible payment as described in 9 A.A.C. 29, Article 3.
- j. Thermometer;
 - k. Ice bags;
 - l. Rubber sheeting;
 - m. Passive restraints;
 - n. Glycerin swabs;
 - o. Facial tissue;
 - p. Enemas;
 - q. Heating pad; and
 - r. Incontinence briefs.
3. Dietary services including preparation and administration of special diets, and adaptive tools for eating;
 4. Any service that is included in a NF's room and board charge or a service that is required of the NF to meet a federal or state licensure standard or county certification requirement;
 5. Physician visits made solely for the purpose of meeting state licensure standards or county certification requirements;
 6. Physical therapy prescribed only as a maintenance regimen; and
 7. Assistive devices and non-customized durable medical equipment.
- C. A provider shall obtain prior authorization from the Administration for a NF admission for a FFS member.

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-215 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3).

R9-22-216. NF, Alternative HCBS Setting, or HCBS

- A. Services provided in a NF, including room and board, an alternative HCBS setting as defined in R9-28-101, or a HCBS as defined in A.R.S. § 36-2939 are covered for a maximum of 90 days per contract year if the member's medical condition would otherwise require hospitalization.
- B. Except as otherwise provided in 9 A.A.C. 28, the following services are not itemized for separate billing if provided in a NF, alternative HCBS setting, or HCBS:
1. Nursing services, including:
 - a. Administering medication;
 - b. Tube feedings;
 - c. Personal care services, including but not limited to assistance with bathing and grooming;
 - d. Routine testing of vital signs; and
 - e. Maintenance of a catheter;
 2. Basic patient care equipment and sickroom supplies, including:
 - a. First aid supplies such as bandages, tape, ointments, peroxide, alcohol, and over-the-counter remedies;
 - b. Bathing and grooming supplies;
 - c. Identification device;
 - d. Skin lotion;
 - e. Medication cup;
 - f. Alcohol wipes, cotton balls, and cotton rolls;
 - g. Rubber gloves (non-sterile);
 - h. Laxatives;
 - i. Bed and accessories;

Historical Note

Adopted effective October 1, 1985 (Supp. 85-5). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Subsection (C) amended to correct a typographical error (Supp. 00-4). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 13 A.A.R. 3272, effective September 11, 2007 (Supp. 07-3). Amended by final rulemaking at 13 A.A.R. 4122, effective November 6, 2007 (Supp. 07-4).

Editor's Note: The following Section was adopted and amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General has not certified this rule. This Section was subsequently repealed and a new Section adopted under the regular rulemaking process.

R9-22-217. Services Included in the Federal Emergency Services Program

- A. Definition. For the purposes of this Section, an emergency medical or behavioral health condition for a FES member means a medical condition or a behavioral health condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:
1. Placing the member's health in serious jeopardy,
 2. Serious impairment to bodily functions,
 3. Serious dysfunction of any bodily organ or part, or
 4. Serious physical harm to another person.
- B. Services. "Emergency services for a FES member" mean those medical or behavioral health services provided for the treatment of an emergency condition. Emergency services include outpatient dialysis services for a FES member with End Stage Renal Disease (ESRD) where a treating physician has certified

for the month in which services are received that in the physician's opinion the absence of receiving dialysis at least three times per week would reasonably be expected to result in:

1. Placing the member's health in serious jeopardy, or
 2. Serious impairment of bodily function, or
 3. Serious dysfunction of a bodily organ or part.
- C.** Covered services. Services are considered emergency services if all of the criteria specified in subsection (A) are satisfied at the time the services are rendered. The Administration shall determine whether an emergency condition exists on a case-by-case basis.
- D.** Prior authorization. A provider is not required to obtain prior authorization for emergency services for FES members. Prior authorization for outpatient dialysis services is met when the treating physician has completed and signed a monthly certification as described in subsection (B).
- E.** Services rendered through the Federal Emergency Services Program are subject to all exclusions and limitation on services in this Article including but not limited to the limitations on inpatient hospital services in R9-22-204.

Historical Note

Adopted under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by exempt rulemaking at 7 A.A.R. 5701, effective December 1, 2001 (Supp. 01-4). Amended by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4). Amended by final rulemaking at 11 A.A.R. 5480, effective December 6, 2005 (Supp. 05-4). Amended by final rulemaking at 13 A.A.R. 3351, effective November 10, 2007 (Supp. 07-3). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by exempt rulemaking at 17 A.A.R. 1868, effective October 1, 2011 (Supp. 11-3).

R9-22-218. Repealed

Historical Note

Section R9-22-218 renumbered from R9-22-206 effective January 1, 1996, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Third Special Session, Ch. 1, § 5; filed with the Office of the Secretary of State December 28, 1995 (Supp. 95-4). Section repealed effective September 22, 1997 (Supp. 97-3).

ARTICLE 3. REPEALED

R9-22-301. Repealed

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-301 renumbered together with former Section R9-22-102 as Section R9-22-101 and amended effective October 1, 1983 (Supp. 83-5). New Section R9-22-301 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B), paragraph (8), subsection (E), paragraph (3), and subsection (J), paragraph (5) effective October 1, 1986 (Supp. 86-5). Amended subsections (C) and (E) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsections (B) and (C) effective October 1, 1987; amended subsection (D) effective December 22, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective September

29, 1992 (Supp. 92-3). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-302. Repealed

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-302 repealed, new Section R9-22-302 adopted effective November 20, 1984 (Supp. 84-6). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-303. Repealed

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-303 repealed, new Section R9-22-303 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (A) effective February 26, 1988 (Supp. 88-1). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-304. Repealed

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-304 repealed, new Section R9-22-304 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-305. Repealed

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-305 repealed, new Section R9-22-305 adopted effective November 20, 1984 (Supp. 84-6). Amended subsection (A) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (A) effective February 26, 1988 (Supp. 88-1). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-306. Repealed

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-306 repealed, new Section R9-22-306 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B), paragraphs (1) and (6) effective October 1, 1986 (Supp. 86-5). Amended subsection (B), paragraph (1) and added a new subsection (N) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (B) effective October 1, 1987; amended subsection (N) effective December 22, 1987 (Supp. 87-4). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the pro-

visions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-307. Repealed

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Amended subsections (A) and (C), added subsection (G) and (H) effective October 1, 1983 (Supp. 83-5). Former Section R9-22-307 repealed, new Section R9-22-307 adopted effective November 20, 1984 (Supp. 84-6).

Amended effective October 1, 1985 (Supp. 85-5).

Amended subsection (A) as an emergency effective December 4, 1985 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 85-6). Permanent amendment to subsection (A) effective February 5, 1986 (Supp. 86-1). Amended subsections (E) and (F) effective October 1, 1986 (Supp. 86-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (A) effective February 26, 1988 (Supp. 88-1).

Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 8, 1996; filed with the Office of the Secretary of State November 6, 1996 (Supp. 96-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-308. Repealed

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4).

Amended effective October 1, 1983 (Supp. 83-5).

Amended by adding subsection (C) effective March 2, 1984 (Supp. 84-2). Former Section R9-22-308 repealed, new Section R9-22-308 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Change in heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-309. Repealed

Historical Note

Adopted effective August 30, 1984 (Supp. 82-4).

Amended (D)(1)(d) effective October 1, 1983 (Supp. 83-5). Former Section R9-22-309 repealed, new Section R9-22-309 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5).

Amended effective October 1, 1986 (Supp. 86-5).

Amended subsection (F) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsections (A), (B) and (C) effective October 1, 1987 (Supp. 87-4).

Amended effective May 30, 1989 (Supp. 89-2). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-310. Repealed

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4).

Amended (B)(7) and added subsections (C) and (D) effective October 1, 1983 (Supp. 83-5). Former Section R9-22-310 repealed, new Section R9-22-310 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B) and deleted subsection (C) effective October 1, 1986 (Supp. 86-5). Amended subsection (B), paragraph (7) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (B) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-311. Repealed

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-311 repealed, new Section R9-22-311 adopted effective November 20, 1984 (Supp. 84-6).

Amended effective October 1, 1985 (Supp. 85-5). Change in heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective April 13, 1990 (Supp. 90-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-312. Repealed

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4).

Amended subsections (A) and (B), added subsection (D) effective October 1, 1983 (Supp. 83-5). Former Section R9-22-312 repealed, new Section R9-22-312 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) effective October 1, 1986 (Supp. 86-5). Change in heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (A) effective October 1, 1987 (Supp. 87-4). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-313. Repealed

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4).

Amended effective October 1, 1983 (Supp. 83-5).

Amended subsections (C) and (D) as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended subsections (D) and (E) as an emergency effective August 16, 1984, pursuant

to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-313 repealed, new Section R9-22-313 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended subsections (B), (C), (E) and (G) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsections (B) and (C) effective December 22, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Amended effective December 13, 1993 (Supp. 93-4). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 8, 1996; filed with the Office of the Secretary of State November 6, 1996 (Supp. 96-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-314. Repealed

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Amended subsection (A) and added subsection (F) as an emergency effective February 28, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Amended subsection (A) and added subsection (F) as a permanent rule effective May 16, 1983; text of the amended rule identical to the emergency (Supp. 83-3). Former Section R9-22-314 repealed, new Section R9-22-314 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-315. Repealed

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-315 repealed, new Section R9-22-315 adopted effective November 20, 1984 (Supp. 84-6). Repealed effective October 1, 1985 (Supp. 85-5). New Section R9-22-315 adopted effective February 5, 1986 (Supp. 86-1). Amended effective February 26, 1988 (Supp. 88-1). Amended effective April 13, 1990 (Supp. 90-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-316. Repealed

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-316 repealed, new Section R9-22-316 adopted as an emergency effective February 9, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Former Section R9-22-316 repealed, new Section R9-22-316 adopted as a permanent rule effective May 16, 1983; text of permanent rule identical to the emergency (Supp. 83-3). Amended effective October 1, 1983 (Supp. 83-5). Correction subsection (A), paragraph (1) amended

effective October 1, 1983, (Supp. 83-6). Amended as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-316 repealed, new Section R9-22-316 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (C) effective October 1986 (Supp. 86-5). Change in heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective April 13, 1990 (Supp. 90-2). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-317. Repealed

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-317 repealed, new Section R9-22-317 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1986 (Supp. 86-5). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-318. Repealed

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1983 (Supp. 83-5). Amended as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-318 repealed, new Section R9-22-318 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) and added subsection (C) effective October 1, 1986 (Supp. 86-5). Amended subsection (A) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (B) effective October 1, 1987; amended subsection (A) effective December 22, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended effective December 13, 1993 (Supp. 93-4). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 8, 1996; filed with the Office of the Secretary of State November 6, 1996 (Supp. 96-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-319. Repealed

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Amended as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-319 repealed, new Section R9-22-319 adopted effective November 20, 1984 (Supp. 84-6). Amended effective May 30, 1989 (Supp. 89-2). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by

final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-320. Repealed**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-320 repealed, new Section R9-22-320 adopted effective November 20, 1984 (Supp. 84-6). Amended effective April 13, 1990 (Supp. 90-2). Repealed effective December 13, 1993 (Supp. 93-4).

R9-22-321. Repealed**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-321 repealed, new Section R9-22-321 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsections (B) through (E) effective October 1, 1986 (Supp. 86-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective October 1, 1987 (Supp. 87-4). Amended subsections (B) and (D) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-322. Repealed**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Amended as an emergency effective May 27, 1983 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-3). Former Section R9-22-322 repealed, new Section R9-22-322 adopted effective October 1, 1983 (Supp. 83-5). Amended as an emergency effective May 18, 1984 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-322 repealed, new Section R9-22-322 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Change in heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective September 29, 1992 (Supp. 92-3). Amended December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-323. Repealed**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-323 repealed, new Section R9-22-323 adopted effective October 1, 1983 (Supp. 83-5). Amended as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-323 repealed, new Section R9-22-323 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsections (B) through (D) effective October 1, 1986 (Supp. 86-5). Amended subsections (A), (B) and (D) effective January

1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsections (B), (D) and (E) effective October 1, 1987 (Supp. 87-4). Amended subsections (B) and (D) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-324. Repealed**Historical Note**

Adopted as an emergency effective July 27, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-4). Former Section R9-22-324 adopted as an emergency renumbered as Section R9-22-327. New Section R9-22-324 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-324 repealed, former Section R9-22-323 renumbered as Section R9-22-324 and adopted as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Former Section R9-22-324 repealed, new Section R9-22-324 adopted as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-324 repealed, new Section R9-22-324 adopted effective November 20, 1984 (Supp. 84-6). Change in heading only effective October 1, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-325. Repealed**Historical Note**

Adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-325 repealed, new Section R9-22-325 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1987 (Supp. 87-4). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-326. Repealed**Historical Note**

Adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-326 repealed, new Section R9-22-326 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) effective October 1, 1986 (Supp. 86-5). Amended subsection (A) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Change in heading only effective October 1, 1987 (Supp. 87-4). Amended subsection (A) effective May 30, 1989 (Supp. 89-2). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-327. Repealed**Historical Note**

Former Section R9-22-324 adopted as an emergency effective July 27, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days renumbered as Section R9-22-327 and adopted as a permanent rule effective October 1, 1983 (Supp. 83-5). Former Section R9-22-327 repealed, new Section R9-22-327 adopted effective November 20,

1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsections (A), (D), (E), (G), (H), and (I) effective October 1, 1986 (Supp. 86-5). Amended subsection (D) and added a new subsection (J) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsections (A) and (E) effective October 1, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-328. Repealed**Historical Note**

Adopted as an emergency effective October 6, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-5). Emergency Expired. New Section R9-22-328 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsections (A) and (E) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (D) effective October 1, 1987 (Supp. 87-4). Amended subsection (D) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-329. Repealed**Historical Note**

Adopted as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Adopted as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. New Section R9-22-329 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-330. Repealed**Historical Note**

Adopted as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. New Section R9-22-330 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) effective October 1, 1986 (Supp. 86-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (A) effective October 1, 1987 (Supp. 87-4). Amended subsection (A) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-331. Repealed**Historical Note**

Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended effective January 1, 1987, filed December 31,

1986 (Supp. 86-6). Amended effective October 1, 1987 (Supp. 87-4). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-332. Repealed**Historical Note**

Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-333. Repealed**Historical Note**

Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-334. Repealed**Historical Note**

Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-335. Repealed**Historical Note**

Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended by adding subsection (C) effective October 1, 1986 (Supp. 86-5). Amended subsection (B) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-336. Repealed**Historical Note**

Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended by adding subsection (C) effective September 16, 1987 (Supp. 87-3). Amended subsection (A) effective October 1, 1987 (Supp. 87-4). Amended effective April 13, 1990 (Supp. 90-2). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-337. Repealed**Historical Note**

Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Correction to subsection (B), paragraph (1) (Supp. 87-3). Amended subsection (C) effective December 22, 1987 (Supp. 87-4). Amended subsection (C) effective December 22, 1987 (Supp. 87-4). Amended effective April 13, 1990 (Supp. 90-2). Section repealed

by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-338. Repealed

Historical Note

Adopted effective November 20, 1984 (Supp. 84-6). Heading changed effective October 1, 1985 (Supp. 85-5). Change in heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-339. Repealed

Historical Note

Adopted effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended subsection (B) effective October 1, 1987 (Supp. 87-4). Amended effective January 14, 1997 (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-340. Repealed

Historical Note

Adopted effective October 1, 1986 (Supp. 86-5). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-341. Repealed

Historical Note

Adopted effective March 1, 1987, filed December 31, 1986 (Supp. 86-6). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-342. Repealed

Historical Note

Adopted effective September 29, 1992 (Supp. 92-3). Amended effective September 22, 1997 (Supp. 97-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-343. Repealed

Historical Note

Adopted under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-344. Repealed

Historical Note

Adopted under an exemption from the provisions of the Administrative Procedure Act, effective October 8, 1996; filed with the Office of the Secretary of State November 6, 1996 (Supp. 96-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

ARTICLE 4. REPEALED

R9-22-401. Repealed

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-401 adopted as an emergency now adopted as a permanent rule effective August 30,

1982 (Supp. 82-4). Amended effective January 31, 1986 (Supp. 86-1). Amended effective January 31, 1997 (Supp. 97-1). Amended by final rulemaking at 5 A.A.R. 867, effective March 4, 1999 (Supp. 99-1). Section repealed by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1).

R9-22-402. Repealed

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-402 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective January 31, 1986 (Supp. 86-1). Amended effective January 14, 1997 (Supp. 97-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1).

R9-22-403. Repealed

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-403 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective January 31, 1986 (Supp. 86-1). Amended by adding subsection (C) effective October 1, 1987 (Supp. 87-4). Amended effective January 14, 1997 (Supp. 97-1). Section repealed by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1).

R9-22-404. Repealed

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-404 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective January 31, 1986 (Supp. 86-1). Amended effective January 14, 1997 (Supp. 97-1). Section repealed by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1).

R9-22-405. Repealed

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-405 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended as an emergency effective February 23, 1983 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Amended as a permanent rule effective May 16, 1983; text of the amended rule similar to the emergency (Supp. 83-3). Amended effective January 31, 1986 (Supp. 86-1). Amended effective January 14, 1997 (Supp. 97-1). Section repealed by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1).

R9-22-406. Repealed

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-406 adopted as an emergency

now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-406 repealed, new Section R9-22-406 adopted as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Former Section R9-22-316 repealed, new Section R9-22-316 adopted as a permanent rule effective May 16, 1983; text of the Section identical to the emergency (Supp. 83-3). Amended effective January 31, 1986 (Supp. 86-1). Amended effective January 14, 1997 (Supp. 97-1). Section repealed by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1).

ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

R9-22-501. General Provisions and Standards – Related Definitions

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

“Quality management” means a process used by professional health personnel through a formal program involving multiple organizational components and committees to:

Assess the degree to which services provided conform to desired medical standards and practices; and

Quality improvement or maintenance of care and services.

“Quality Improvement” means a process designed to achieve, through ongoing measurements and intervention, significant improvement that is sustained over time, in the areas of clinical care and non-clinical care and is expected to have a favorable effect on health outcomes and member satisfaction. Quality Improvement includes focusing organizational efforts on improving performance and utilizing data to develop intervention strategies to improve performance and outcomes.

“Utilization management/review” means a methodology used by professional health personnel to assess the medical indications, appropriateness, and efficiency of care provided. Utilization management applies to a contractor’s process to evaluate and approve or deny the medical necessity, appropriateness, efficacy and efficiency of health care services, procedures, or settings. Utilization review includes processes for prior authorization, concurrent review, retrospective review, and case management.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-501 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-501 repealed, former Section R9-22-502 renumbered and adopted without change as Section R9-22-501 effective October 1, 1983 (Supp. 83-5). Former Section R9-22-501 repealed, former Section R9-22-526 renumbered and amended as Section R9-22-501 effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

R9-22-502. Pre-existing Conditions

A. Except as otherwise provided in Article 2 of this Chapter, a contractor shall be responsible for providing the full scope of covered services to each member from the effective date of eligibility until the termination of enrollment or transfer of the

member to another contractor. A contractor shall not impose a pre-existing condition exclusion with respect to covered services.

B. A contractor or subcontractor shall not adopt or use any procedure to identify a person who has an existing or anticipated medical or psychiatric condition in order to discourage or exclude the person from enrolling in the contractor’s health plan or encourage the person to enroll in another health plan.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-502 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-502 renumbered without change as Section R9-22-501, former Section R9-22-503 renumbered and amended as Section R9-22-502 effective October 1, 1983 (Supp. 83-5). Former Section R9-22-502 repealed, new Section R9-22-502 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

R9-22-503. Provider Requirements Regarding Records

The provider shall maintain records that meet uniform accounting standards and generally accepted practices for maintenance of medical records, including detailed specification of all patient services delivered, the rationale for delivery, and the service date. A provider shall maintain and upon request, make available to a contractor and to the Administration, financial and medical records relating to payment for not less than five years from the date of final payment, or for records relating to costs and expenses to which the Administration has taken exception, five years after the date of final disposition or resolution of the exception. Providers shall provide one copy of a medical record at no cost if requested by the member.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-503 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-503 renumbered and amended as Section R9-22-502, new Section R9-22-503 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended effective May 30, 1986 (Supp. 86-3). Amended subsection (D) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsections (F) and (G) effective December 22, 1987 (Supp. 87-4). Amended subsection (I) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). New Section made by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

R9-22-504. Marketing; Prohibition Against Inducements; Misrepresentations; Discrimination; Sanctions

A. A contractor or the contractor’s marketing representative shall not offer or give any form of compensation or reward, or engage in any behavior or activity that may be reasonably construed as coercive, to induce or procure AHCCCS enrollment

with the contractor. Any marketing solicitation offering a benefit, good, or service in excess of the covered services in Article 2 is deemed an inducement.

- B.** A marketing representative shall not misrepresent itself, the contracting health plan represented, or the AHCCCS program, through false advertising, false statements, or in any other manner to induce a member of another contractor to enroll in the represented health plan. Violations of this subsection include, but are not limited to, false or misleading claims, inferences, or representations such as:
1. A member will lose benefits under the AHCCCS program or lose any other health or welfare benefits to which a member is legally entitled, if the member does not enroll in the represented contracting health plan;
 2. Marketing representatives are employees of the state or representatives of the Administration, a county, or any health plan other than the health plan by which they are employed, or by which they are reimbursed; and
 3. The represented health plan is recommended or endorsed as superior to its competition by any state or county agency, or any organization, unless the organization has certified its endorsement in writing to the health plan and the Administration.
- C.** A marketing representative shall not engage in any marketing or pre-enrollment practice that discriminates against a member because of race, creed, age, color, sex, religion, national origin, ancestry, marital status, sexual preference, physical or mental disability, or health status.
- D.** The Administration shall hold a contractor responsible for a violation of this Section resulting from the performance of any marketing representative, subcontractor, agent, program, or process under the contractor's employ or direction and shall impose contract sanctions on the contractor as specified in contract.
- E.** A contractor shall produce and distribute informational materials that are approved by the Administration to each enrolled member or designated representative after the contractor receives notification of enrollment from the Administration. The contractor shall ensure that the informational materials include, at a minimum:
1. A description of all covered services as specified in contract;
 2. An explanation of service limitations and exclusions;
 3. An explanation of the procedure for obtaining services;
 4. An explanation of the procedure for obtaining emergency services;
 5. An explanation of the procedure for filing a grievance and appeal; and
 6. An explanation of when plan changes may occur as specified in contract.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-504 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-504 repealed, former Section R9-22-505 renumbered and adopted without change as Section R9-22-504 effective October 1, 1983 (Supp. 83-5). Former Section R9-22-504 repealed, former Section R9-22-528 renumbered and amended as Section R9-22-504 effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

R9-22-505. Standards, Licensure, and Certification for Providers of Hospital and Medical Services

A provider shall not provide hospital or medical services to a member unless the provider is licensed by the Arizona Department of Health Services and meets the requirements in 42 CFR 441 and 482, as of October 1, 2007, and 42 CFR 456 Subpart C, as of October 1, 2007, incorporated by reference, on file with the Administration and available from the U.S. Government Printing Office, 732 N. Capitol St., N.W., Washington, D.C. 20401. This incorporation contains no future editions or amendments. An Indian Health Service (IHS) hospital and a Veterans Administration hospital shall not provide services to a member unless accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-505 adopted as an emergency expired, former Section R9-22-506 adopted as an emergency now adopted, amended and renumbered as Section R9-22-505 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-505 renumbered without change as Section R9-22-504, new Section R9-22-505 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-505 renumbered and amended as Section R9-22-509, former Section R9-22-527 renumbered and amended as Section R9-22-505 effective October 1, 1985 (Supp. 85-5). Editorial correction, spelling of "paraphernalia" in subsection (A) (Supp. 87-4). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). New Section made by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

R9-22-506. Repealed

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-506 adopted as an emergency adopted, amended and renumbered as Section R9-22-505, former Section R9-22-507 adopted as an emergency now adopted, amended and renumbered as Section R9-22-506 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-506 repealed, new Section R9-22-506 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-506 repealed, new Section R9-22-506 adopted effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended subsection (D) effective December 22, 1987 (Supp. 87-4). Repealed effective April 13, 1990 (Supp. 90-2). New Section adopted effective December 13, 1993 (Supp. 93-4). Repealed effective December 8, 1997 (Supp. 97-4).

R9-22-507. Repealed

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-507 adopted as an emergency adopted, amended and renumbered as Section R9-22-506, former Section R9-22-508 adopted as an emergency now adopted, amended and renumbered as Section R9-22-507 as a permanent rule effective August 30, 1982 (Supp. 82-3).

- 4). Former Section R9-22-507 repealed, new Section R9-22-507 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

R9-22-508. Repealed

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-508 adopted as an emergency adopted, amended and renumbered as Section R9-22-507, former Section R9-22-509 adopted as an emergency now adopted, amended and renumbered as Section R9-22-508 as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

R9-22-509. Transition and Coordination of Member Care

A. A contractor shall assist in the transition of members to and from other AHCCCS contractors.

1. Both the receiving and relinquishing contractor shall:
 - a. Coordinate with the other contractor to facilitate and schedule appointments for medically necessary services for the transitioned member within the Administration's timelines specified in the contract. If requested by the Administration, a contractor shall submit the policies and procedures regarding transition of members to the Administration for review and approval;
 - b. Assist in the referral of transitioned members to other community health agencies or county medical assistance programs for medically necessary services not covered by the Administration, as appropriate; and
 - c. Develop policies and procedures to be followed when transitioning members who have significant medical conditions; are receiving ongoing services; or have, at the time of the transition, received prior authorization or approval for undelivered, specific services.
2. The relinquishing contractor shall notify the receiving contractor of relevant information about the member's medical condition and current treatment regimens within the timelines defined in contract;
3. The relinquishing contractor shall forward medical records and other relevant materials to the receiving contractor. The relinquishing contractor shall bear the cost of reproducing and forwarding medical records and other relevant materials;
4. Within the timelines specified in contract, the receiving contractor shall ensure that the member selects or is assigned to a primary care provider, and provide the member with:
 - a. Information regarding the contractor's providers,
 - b. Emergency numbers, and
 - c. Instructions about how to obtain services.

B. A contractor shall not use a county or noncontracting provider health resource alternative to diminish the contractor's contractual responsibility or accountability for providing the full scope of covered services. The Administration may impose sanctions as described in contract if a contractor makes referrals to other agencies or programs to reduce expenses incurred by the contractor on behalf of its members.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-509 adopted as an emergency adopted, amended and renumbered as Section R9-22-508, former Section R9-22-510 adopted as an emergency now adopted and renumbered as Section R9-22-509 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-509 repealed, former Section R9-22-505 renumbered and amended as Section R9-22-509 effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

R9-22-510. Repealed

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-510 adopted as an emergency adopted and renumbered as Section R9-22-509, former Section R9-22-511 adopted as an emergency now adopted, amended and renumbered as Section R9-22-510 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-510 repealed, new Section R9-22-510 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

R9-22-511. Repealed

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-511 adopted as an emergency adopted, amended and renumbered as Section R9-22-510, former Section R9-22-512 adopted as an emergency now adopted, amended and renumbered as Section R9-22-511 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-511 repealed, new Section R9-22-511 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

R9-22-512. Release of Safeguarded Information

- ##### **A. The Administration, contractors, providers, and noncontracting providers shall limit the release of safeguarded information to persons or agencies for the following purposes in accordance with 45 CFR 160 and 45 CFR 164, October 1, 2004, and 42 CFR 431.300 through 431.307, October 1, 2004, incorporated by reference, on file with the Administration and available from the U.S. Government Printing Office, 732 N. Capitol St., N.W., Washington, D.C. 20401. This incorporation by reference contains no future editions or amendments:**
1. Official purposes directly related to the administration of the AHCCCS program including:
 - a. Establishing eligibility and post-eligibility treatment of income, as applicable;
 - b. Determining the amount of medical assistance;
 - c. Providing services for members;
 - d. Performing evaluations and analysis of AHCCCS operations;
 - e. Filing liens on property as applicable;
 - f. Filing claims on estates, as applicable; and

- g. Filing, negotiating, and settling medical liens and claims.
- 2. Law enforcement. The Administration may release safeguarded information without the applicant's or member's written or verbal consent, for the purpose of conducting or assisting an investigation, prosecution, or criminal or civil proceeding related to the administration of the AHC-CCS program.
- 3. The Administration may release safeguarded member information to a review committee in accordance with the provisions of A.R.S. § 36-2917, without the consent of the applicant or member.
- B.** Except as provided in subsection (A), the Administration, contractors, providers, and noncontracting providers shall disclose safeguarded information only to:
 - 1. An applicant;
 - 2. A member;
 - 3. An unemancipated minor, with written permission of a parent, custodial relative, or designated representative, if:
 - a. An Administration employee, authorized representative, or responsible caseworker is present during the examination of the safeguarded information; or
 - b. After written notification to the provider, and at a reasonable time and place.
 - 4. Persons authorized by the applicant or member; or
 - 5. A court order or subpoena compliant with 45 CFR 164.512(e), October 1, 2004, incorporated by reference, on file with the Administration and available from the U.S. Government Printing Office, 732 N. Capitol St., N.W., Washington, D.C. 20401. This incorporation by reference contains no future editions or amendments.
- C.** The Administration, contractors, providers, and noncontracting providers shall safeguard identifiable information, protected health information as specified in 45 CFR 160, and information obtained in the course of application for or re-determination of eligibility concerning an applicant or member, that includes, but is not limited to the following:
 - 1. Name and address;
 - 2. Social Security number;
 - 3. Social and economic conditions or circumstances;
 - 4. Agency evaluation of personal information;
 - 5. Medical data and information concerning medical services received, including diagnosis and history of disease or disability;
 - 6. State Data Exchange (SDX) tapes, and other types of information received from outside sources for the purpose of verifying income eligibility and amount of medical assistance payments; and
 - 7. Any information received in connection with the identification of legally liable third-party resources.
- D.** The restriction upon disclosure of information in this Section does not apply to:
 - 1. De-identified information as described by 45 CFR 164.514, October 1, 2004, incorporated by reference in subsection (A); or
 - 2. A disclosure, in response to a request for information, that complies with 45 CFR 160 and 45 CFR 164, October 1, 2004, and 42 CFR 431.300 through 431.307, October 1, 2004, incorporated by reference in subsection (A).
- E.** A provider shall furnish records requested by the Administration or a contractor to the Administration or the contractor at no charge.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-

3). Former Section R9-22-512 adopted as an emergency adopted, amended and renumbered as Section R9-22-511, former Section R9-22-513 adopted as an emergency now adopted and renumbered as Section R9-22-512 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-512 repealed, new Section R9-22-512 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 13, 1993 (Supp. 93-4). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

R9-22-513. Repealed**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-513 adopted as an emergency adopted and renumbered as Section R9-22-512, former Section R9-22-514 adopted as an emergency now adopted, amended and renumbered as Section R9-22-513 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-513 repealed, former Section R9-22-526 renumbered and amended as Section R9-22-513 effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

R9-22-514. Repealed**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-514 adopted as an emergency adopted, amended and renumbered as Section R9-22-513, former Section R9-22-515 adopted as an emergency now adopted, amended and renumbered as Section R9-22-514 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-514 repealed, former Section R9-22-517 renumbered and amended as Section R9-22-514 effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

R9-22-515. Repealed**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-515 adopted as an emergency adopted, amended and renumbered as Section R9-22-514, former Section R9-22-517 adopted as an emergency now adopted, amended and renumbered as Section R9-22-515 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-515 repealed, former Section R9-22-522 renumbered and amended as Section R9-22-515 effective October 1, 1985 (Supp. 85-5). Repealed effective December 8, 1997 (Supp. 97-4).

R9-22-516. Renumbered**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-516 adopted as an emergency expired, former Section R9-22-518 adopted as an emer-

agency now adopted, amended and renumbered as Section R9-22-516 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-516 renumbered as Section R9-22-513 effective October 1, 1985 (Supp. 85-5).

R9-22-517. Renumbered

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-517 adopted as an emergency adopted, amended and renumbered as Section R9-22-515, former Section R9-22-519 adopted as an emergency now adopted and renumbered and amended as Section R9-22-517 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-517 renumbered and amended as Section R9-22-514 effective October 1, 1985 (Supp. 85-5).

R9-22-518. Information to Enrolled Members

- A. Each contractor shall produce and distribute printed informational materials to each member or family unit no later than 10 days of receipt of notification of enrollment from the Administration. The contractor shall ensure that the informational materials meet the requirements specified in the contractor's current contract.
- B. A contractor shall provide a member with the name, address, and telephone number of the member's primary care provider no later than 10 days from the date of enrollment. The contractor shall include information on how the member may change primary care providers.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-518 adopted as an emergency adopted, amended and renumbered as Section R9-22-516, former Section R9-22-520 adopted as an emergency now adopted, amended and renumbered as Section R9-22-518 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-518 repealed, new Section R9-22-518 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

R9-22-519. Repealed

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-519 adopted as an emergency adopted, amended and renumbered as Section R9-22-517, former Section R9-22-521 adopted as an emergency now adopted, amended and renumbered as Section R9-22-519 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-519 repealed, new Section R9-22-519 adopted effective October 1, 1985 (Supp. 85-5). Repealed effective December 8, 1997 (Supp. 97-4).

R9-22-520. Expired

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-520 adopted as an emergency adopted, amended and renumbered as Section R9-22-518, former Section R9-22-522 adopted as an emergency now

adopted, amended and renumbered as Section R9-22-520 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-520 repealed, new Section R9-22-520 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 13, 1993 (Supp. 93-4).

Amended effective December 8, 1997 (Supp. 97-4). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 4851, effective October 9, 2002 (Supp. 02-4).

R9-22-521. Program Compliance Audits

- A. The Administration shall conduct an onsite program compliance audit of a contractor at least once every three years during the term of the Administration's contract with the contractor. The Administration may conduct, without prior notice, inspections of contractor facilities or perform other elements of a program compliance audit.
- B. An audit team may perform any or all of the following procedures:
 1. Conduct private interviews and group conferences with members, physicians, other health professionals, and members of the contractor's administrative staff including, but not limited to, the contractor's principal management persons;
 2. Examine records, books, reports, and papers of the contractor and any management company, and all providers or subcontractors providing health care and other services. The examination may include, but need not be limited to: minutes of medical staff meetings, peer review and quality of care review records, duty rosters of medical personnel, appointment records, written procedures for the internal operation of the health plan, contracts and correspondence with members and with providers of health care services and other services to the plan, and additional documentation deemed necessary by the Administration to review the quality of medical care.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-521 adopted as an emergency adopted, amended and renumbered as Section R9-22-519, former Section R9-22-523 adopted as an emergency now adopted, amended and renumbered as Section R9-22-521 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-521 repealed, new Section R9-22-521 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General has not certified this rule. This Section was subsequently amended through the regular rulemaking process.

R9-22-522. Quality Management/Utilization Management (QM/UM) Requirements

- A. A contractor shall comply with Quality Management/Utilization Management (QM/UM) requirements specified in this Section and in contract. The contractor shall ensure compli-

ance with QM/UM requirements that are accomplished through delegation or subcontract with another party.

B. In addition to any requirements specified in contract, a contractor shall:

1. Submit to the Administration a written QM/UM plan that includes a description of the systems, methodologies, protocols, and procedures to be used in:
 - a. Monitoring and evaluating the types of services provided,
 - b. Identifying the numbers and costs of services provided,
 - c. Assessing and improving the quality and appropriateness of care and services,
 - d. Evaluating the outcome of care provided to members, and
 - e. Determining the actions necessary to improve service delivery;
2. Submit the QM/UM plan to the Administration on an annual basis within timelines specified in contract. If the QM/UM plan is changed during the year, the contractor shall submit the revised plan to the Administration before implementation;
3. Receive approval from the Administration before implementing the initial or revised QM/UM plan;
4. Ensure that a QM/UM committee operates under the control of the contractor's medical director and includes representation from medical and executive management personnel. The committee shall:
 - a. Oversee the development, revision, and implementation of the QM/UM plan; and
 - b. Ensure that there are qualified QM/UM personnel and sufficient resources to implement the contractor's QM/UM activities; and
5. Ensure that the QM/UM activities include at least:
 - a. Prior authorization for non-emergency or scheduled hospital admissions;
 - b. Concurrent review of inpatient hospitalization;
 - c. Retrospective review of hospital claims;
 - d. Program and provider audits designed to detect over- or under-utilization, service delivery effectiveness, and outcome;
 - e. Medical records audits;
 - f. Surveys to determine satisfaction of members;
 - g. Assessment of the adequacy and qualifications of the contractor's provider network;
 - h. Review and analysis of QM/UM data;
 - i. Measurement of performance using objective quality indicators;
 - j. Ensuring individual and systemic quality of care;
 - k. Integrating quality throughout the organization;
 - l. Process improvement;
 - m. Credentialing a provider network;
 - n. Resolving quality of care grievances; and
 - o. Quality improvement activities focused on improving the quality of care and the efficient, cost-effective delivery and utilization of services.

C. A member's primary care provider shall maintain medical records that:

1. Conform to professional medical standards and practices for documentation of medical diagnostic and treatment data;
2. Facilitate follow-up treatment; and
3. Permit professional medical review and medical audit processes.

D. Within 30 days following termination of the contract between a subcontractor and a contractor, the subcontractor or the subcontractor's designee shall forward to the primary care provider medical records or copies of medical records of all members assigned to the subcontractor or for whom the subcontractor has provided services.

E. The Administration shall monitor each contractor and the contractor's providers to ensure compliance with Administration QM/UM requirements and adherence to the contractor's QM/UM plan.

1. A contractor and the contractor's providers shall cooperate with the Administration in the performance of the Administration's QM/UM monitoring activities; and
2. A contractor and the contractor's providers shall develop and implement mechanisms for correcting deficiencies identified through the Administration's QM/UM monitoring.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-522 adopted as an emergency adopted, amended and renumbered as Section R9-22-520, former Section R9-22-524 adopted as an emergency now adopted and renumbered as Section R9-22-522 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-522 renumbered and amended as Section R9-22-515, new Section R9-22-522 adopted effective October 1, 1985 (Supp. 85-5). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective December 13, 1993 (Supp. 93-4). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

R9-22-523. Expired

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-523 adopted as an emergency adopted, amended and renumbered as Section R9-22-521, former Section R9-22-525 adopted as an emergency now adopted, amended and renumbered as Section R9-22-523 as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 4851, effective October 9, 2002 (Supp. 02-4).

R9-22-524. Repealed

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-524 adopted as an emergency adopted and renumbered as Section R9-22-522, former Section R9-22-526 adopted as an emergency now adopted, amended and renumbered as Section R9-22-524 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-524 repealed, new Section R9-22-524 adopted effective October 1, 1985 (Supp. 85-4). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

R9-22-525. Repealed**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-525 adopted as an emergency adopted, amended and renumbered as Section R9-22-523, former Section R9-22-527 adopted as an emergency now adopted, amended and renumbered as Section R9-22-525 as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective October 1, 1985 (Supp. 85-5).

R9-22-526. Renumbered**Historical Note**

Adopted as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Adopted as a permanent rule effective May 16, 1983; text of the permanent rule identical to the emergency (Supp. 83-3). Former Section R9-22-526 repealed, new Section R9-22-526 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-526 renumbered and amended as Section R9-22-501 effective October 1, 1985 (Supp. 85-1).

R9-22-527. Renumbered**Historical Note**

Adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-527 renumbered and amended as Section R9-22-505 effective October 1, 1985 (Supp. 85-5).

R9-22-528. Renumbered**Historical Note**

Adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-528 renumbered and amended as Section R9-22-504 effective October 1, 1985 (Supp. 85-5).

R9-22-529. Renumbered**Historical Note**

Adopted as Section R9-22-529 effective October 1, 1985, then renumbered as Section R9-22-1002 effective October 1, 1985 (Supp. 85-5).

ARTICLE 6. RFP AND CONTRACT PROCESS**R9-22-601. General Provisions**

- A.** The Director has full operational authority to adopt rules for the RFP process and the award of contracts under A.R.S. § 36-2906.
- B.** This Article applies to the award of contracts under A.R.S. §§ 36-2904 and 36-2906 to provide services under A.R.S. § 36-2907 and the expenditure of public monies by the Administration pertaining to covered services when the procurement so states. The Administration shall establish conflict-of-interest safeguards for officers and employees of this state with responsibilities relating to contracts that comply with 42 U.S.C. 1396u-2(d)(3).
- C.** The Administration is exempt from the procurement code under A.R.S. § 41-2501.
- D.** The Administration and contractors shall retain all contract records for five years under A.R.S. § 36-2903 and dispose of the records under A.R.S. § 41-2550.
- E.** The following terms are defined as related to this Article: "Procurement file" means the official records file of the Director whether located in the Office of the Director or at the public procurement unit. The procurement file shall include in electronic or paper form a list of notified vendors, final solicitation, solicitation amendments, bids/offers, final proposal revisions, clarifications, and final evaluation report.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-601 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective October 1, 1983 (Supp. 83-5). Adopted effective July 16, 1985 (Supp. 85-4). Amended effective December 13, 1993 (Supp. 93-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). Amended by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 18 A.A.R. 2340, effective November 11, 2012 (Supp. 12-3).

R9-22-602. RFP

- A.** RFP content. The Administration shall include the following items in any RFP under this Article:
 1. Instructions and information to an offeror concerning the proposal submission including:
 - a. The deadline for submitting a proposal,
 - b. The address of the office at which a proposal is to be received,
 - c. The period during which the RFP remains open, and
 - d. Any special instructions and information;
 2. The scope of covered services under Article 2 of this Chapter and A.R.S. §§ 36-2906 and 36-2907, covered populations, geographic coverage, service and performance requirements, and a delivery or performance schedule;
 3. The contract terms and conditions, including bonding or other security requirements, if applicable;
 4. The factors used to evaluate a proposal;
 5. The location and method of obtaining documents that are incorporated by reference in the RFP;
 6. A requirement that the offeror acknowledge receipt of all RFP amendments issued by the Administration;
 7. The type of contract to be used and a copy of a proposed contract form or provisions;
 8. The length of the contract service;
 9. A requirement for cost or pricing data;
 10. The minimum RFP requirements; and
 11. A provision requiring an offeror to certify that a submitted proposal does not involve collusion or other anti-competitive practices.
- B.** Proposal process.
 1. After the deadline for submitting proposals, the Administration may open a proposal publicly and announce and record the name of the offeror. The Administration shall keep all other information contained in a proposal confidential. The Administration shall open a proposal for public inspection after contract award unless the Administration determines that disclosure is not in the best interest of the state.
 2. The Administration shall evaluate a proposal based on the GSA and the evaluation factors listed in the RFP.
 3. The Administration may initiate discussions with a responsive and responsible offeror to clarify and assure full understanding of an offeror's proposal. The Administration shall provide an offeror fair treatment with respect to discussion and revision of a proposal. The Administration shall not disclose information derived from a proposal submitted by a competing offeror.
 4. The Administration shall allow for the adjustment of covered services by expansion, deletion, segregation, or combination in order to secure the most financially advantageous proposals for the state.

5. The Administration may conduct an investigation of a person or organization who has ownership or management interests in corporate offerors or affiliated corporate organizations of an offeror.
6. The Administration may issue a written request for best and final offers. The Administration shall state in the request the date, time, and place for the submission of best and final offers.
7. The Administration shall not request best and final offers more than once unless the Administration determines that it is advantageous to the state to request additional best and final offers. The Administration shall state in the written request for best and final offers that if the offeror does not submit a notice of withdrawal or a best and final offer, the Administration shall take the most recent offer as the offeror's best and final offer.

C. Proposal rejection.

1. The Administration may reject an offeror's proposal if the offeror fails to supply the information requested by the Administration.
2. The offeror shall not disclose information pertaining to its proposal to any other offeror prior to contract award. The offeror may disclose proposal information to a person other than another offeror if the recipient agrees to keep the information confidential until contract award. Disclosure in violation of this subsection may be grounds for rejecting a proposal.
3. The Administration shall provide written notification to an offeror whose proposal is rejected. The rejection notice shall be part of the contract file and a public record.
4. If the Administration determines that it is in the best interest of the state, the Administration may reject any and all proposals, in whole or in part, under the RFP. The reasons for rejection shall be part of the contract file. An offeror shall have no right to damages for any claims against the state, the state's employees, or agents if a proposal is rejected in whole or in part.

- D. Proposal cancellation.** If the Administration determines that it is in the best interest of the state, the Administration may cancel a RFP. The reasons for cancellation shall be part of the contract file. An offeror shall have no right to damages for any claims against the state, the state's employees, or agents if a RFP is cancelled.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-602 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective October 1, 1983 (Supp. 83-5). Adopted effective July 16, 1985 (Supp. 85-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1).

R9-22-603. Contract Award

The Administration shall award a contract to the responsible and responsive offeror whose proposal is determined most advantageous to the state under A.R.S. § 36-2906. If the Administration determines that multiple contracts are in the best interest of the state, the Administration may award multiple contracts. The contract file shall contain the basis on which the award is made.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-603 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective October 1, 1983 (Supp. 83-5). Adopted effective July 16, 1985 (Supp. 85-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1).

R9-22-604. Contract or Proposal Protests; Appeals

- A.** Disputes related to contract performance. This Section does not apply to a dispute related to contract performance. A contract performance dispute is governed by 9 A.A.C. 34.
- B.** Resolution of a proposal protest. The procurement officer issuing a RFP shall have the authority to resolve proposal protests. An appeal from the decision of the procurement officer shall be made to the Director.
- C.** Filing of a protest.
1. A person may file a protest with the procurement officer regarding:
 - a. A RFP issued by the Administration,
 - b. A proposed award, or
 - c. An award of a contract.
 2. A protester shall submit a written protest and include the following information:
 - a. The name, address, and telephone number of the protester;
 - b. The signature of the protester or protester's representative;
 - c. Identification of a RFP or contract number;
 - d. A detailed statement of the legal and factual grounds of the protest including copies of any relevant documents; and
 - e. The relief requested.
- D.** Time for filing a protest.
1. A protester filing a protest alleging improprieties in an RFP or an amendment to an RFP shall file the protest at least 14 days before the due date of receipt of proposals.
 2. Any protest alleging improprieties in an amendment issued 14 or fewer days before the due date of the proposal shall be filed before the due date for receipt of proposals.
 3. In cases other than those covered in subsections (D)(1) and (2), a protester shall file a protest no later than 10 days after the procurement officer makes the procurement file available for public inspection.
- E.** Stay of procurement during the protest. If a protester files a protest before the contract award, the procurement officer may issue a written stay of the contract award. In considering whether to issue a written stay of contract, the procurement officer shall consider but is not limited to considering whether:
1. A reasonable probability exists that the protest will be sustained, and
 2. The stay of the contract award is in the best interest of the state.
- F.** Stay of contract award during an appeal to the Director. The Director shall automatically continue the stay of a contract award if:
1. An appeal is filed before a contract award, and
 2. The procurement officer issues a stay of the contract award under subsection (E), unless

3. The Director issues a written determination that the contract award is necessary to protect the best interest of the state.
- G. Decision by the procurement officer.**
 1. The procurement officer shall issue a written decision no later than 14 days after a protest has been filed. The decision shall contain an explanation of the basis of the decision.
 2. The procurement officer shall furnish a copy of the decision to the protester by:
 - a. Certified mail, return receipt requested; or
 - b. Any other method that provides evidence of receipt.
 3. The Administration may extend, for good cause, the time-limit for decisions in subsection (G)(1) for a time not to exceed 30 days. The procurement officer shall notify the protester in writing that the time for the issuance of a decision has been extended and the date by which a decision shall be issued.
 4. If the procurement officer fails to issue a decision within the time-limits in subsection (G)(1) or (G)(3), the protester may proceed as if the procurement officer issued an adverse decision.
- H. Remedies.**
 1. If the procurement officer sustains the protest in whole or in part and determines that the RFP, proposed contract award, or contract award does not comply with applicable statutes and rules, the procurement officer shall order an appropriate remedy.
 2. In determining an appropriate remedy, the procurement officer shall consider all the circumstances of the procurement or proposed procurement, including:
 - a. Seriousness of the procurement deficiency,
 - b. Degree of prejudice to other interested parties or to the integrity of the RFP process,
 - c. Good faith of the parties,
 - d. Extent of performance,
 - e. Costs to the state, and
 - f. Urgency of the procurement.
 - g. Best interest of the state.
 3. An appropriate remedy may include one or more of the following:
 - a. Terminating the contract;
 - b. Reissuing the RFP;
 - c. Issuing a new RFP;
 - d. Awarding a contract consistent with statutes, rules, and the terms of the RFP; or
 - e. Any relief determined necessary to ensure compliance with applicable statutes and rules.
- I. Appeals to the Director.**
 1. A person may file an appeal of a procurement officer's decision with both the Director and the procurement officer no later than five days from the date the decision is received. The date the decision is received shall be determined under subsection (G)(2).
 2. The appeal shall contain:
 - a. The information required in subsection (C)(2),
 - b. A copy of the procurement officer's decision,
 - c. The alleged factual or legal error in the decision of the procurement officer on which the appeal to the Director is based, and
 - d. A request for hearing unless the person requests that the Director's decision be based solely upon the procurement file.
- J. Dismissal.** The Director shall not schedule a hearing and shall dismiss an appeal with a written determination if:
 1. The appeal does not state a basis for protest,

2. The appeal is untimely under subsection (I)(1), or
3. The appeal is moot.

- K. Hearing.** Hearings under this Section shall be conducted using the Arizona Administrative Procedure Act under A.R.S. Title 41, Ch. 6.

Historical Note

Adopted effective July 16, 1985 (Supp. 85-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). Amended by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 18 A.A.R. 2340, effective November 11, 2012 (Supp. 12-3).

R9-22-605. Waiver of Contractor's Subcontract with Hospitals

If a contractor is unable to obtain a subcontract with a hospital as contractually required, the contractor may request in writing a waiver from the Administration as allowed by A.R.S. § 36-2906. The contractor shall state in the request the reasons a waiver is believed to be necessary and all efforts the contractor has made to secure a subcontract.

Historical Note

Adopted effective January 31, 1986 (Supp. 86-1). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). New Section made by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 18 A.A.R. 2340, effective November 11, 2012 (Supp. 12-3).

R9-22-606. Contract Compliance Sanction

- A.** The Director may impose sanctions upon a contractor for violation of any provision of this Chapter or of a contract. Sanctions include but are not limited to:
1. Suspension of any or all further member enrollment, by choice and/or assignment for a period of time.
 2. Imposition of a monetary sanction.
- B.** The Director shall consider the nature, severity, and length of the violation when determining a sanction.
- C.** The Director shall provide a contractor with written notice specifying grounds and terms for the sanction.
- D.** Nothing contained in this Section shall be construed to prevent the Administration from imposing sanctions as provided in contract under A.R.S. § 36-2903.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 18 A.A.R. 2340, effective November 11, 2012 (Supp. 12-3).

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-22-701. Standard for Payments Related Definitions

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

"Accommodation" means room and board services provided to a patient during an inpatient hospital stay and includes all staffing, supplies, and equipment. The accommodation is semi-private except when the member must be isolated for medical reasons. Types of accommodation include hospital routine medical/surgical units, intensive care units, and any other specialty care unit in which room and board are provided.

“Aggregate” means the combined amount of hospital payments for covered services provided within and outside the GSA.

“AHCCCS inpatient hospital day or days of care” means each day of an inpatient stay for a member beginning with the day of admission and including the day of death, if applicable, but excluding the day of discharge, provided that all eligibility, medical necessity, and medical review requirements are met.

“Ancillary service” means all hospital services for patient care other than room and board and nursing services, including but not limited to, laboratory, radiology, drugs, delivery room (including maternity labor room), operating room (including postanesthesia and postoperative recovery rooms), and therapy services (physical, speech, and occupational).

“APC” means the Ambulatory Payment Classification system under 42 CFR 419.31 used by Medicare for grouping clinically and resource-similar procedures and services.

“Billed charges” means charges for services provided to a member that a hospital includes on a claim consistent with the rates and charges filed by the hospital with Arizona Department of Health Services (ADHS).

“Business agent” means a company such as a billing service or accounting firm that renders billing statements and receives payment in the name of a provider.

“Capital costs” means costs as reported by the hospital to CMS as required by 42 CFR 413.20.

“Copayment” means a monetary amount, specified by the Director, that a member pays directly to a contractor or provider at the time covered services are rendered.

“Cost-to-charge ratio” (CCR) means a hospital’s costs for providing covered services divided by the hospital’s charges for the same services. The CCR is the percentage derived from the cost and charge data for each revenue code provided to AHCCCS by each hospital.

“Covered charges” means billed charges that represent medically necessary, reasonable, and customary items of expense for covered services that meet medical review criteria of AHCCCS or a contractor.

“CPT” means Current Procedural Terminology, published and updated by the American Medical Association. CPT is a nationally-accepted listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians that provide a uniform language to accurately designate medical, surgical, and diagnostic services.

“Critical Access Hospital” is a hospital certified by Medicare under 42 CFR 485 Subpart F and 42 CFR 440.170(g).

“Direct graduate medical education costs” or “direct program costs” means the costs that are incurred by a hospital for the education activities of an approved graduate medical education program that are the proximate result of training medical residents in the hospital, including resident salaries and fringe benefits, the portion of teaching physician salaries and fringe benefits that are related to the time spent in teaching and supervision of residents, and other related GME overhead costs.

“DRI inflation factor” means Global Insights Prospective Hospital Market Basket.

“Eligibility posting” means the date a member’s eligibility information is entered into the AHCCCS Pre-paid Medical Management Information System (PMMIS).

“Encounter” means a record of a medically-related service rendered by an AHCCCS-registered provider to a member enrolled with a contractor on the date of service.

“Existing outpatient service” means a service provided by a hospital before the hospital files an increase in its charge master as defined in R9-22-712(G), regardless of whether the service was explicitly described in the hospital charge master before filing the increase or how the service was described in the charge master before filing the increase.

“Expansion funds” means funds appropriated to support GME program expansions as described under A.R.S. § 36-2903.01(H)(9)(b) and (c)(i).

“Factor” means a person or an organization, such as a collection agency or service bureau, that advances money to a provider for accounts receivable that the provider has assigned, sold, or transferred to the organization for an added fee or a deduction of a portion of the accounts receivable. Factor does not include a business agent.

“Fiscal intermediary” means an organization authorized by CMS to make determinations and payments for Part A and Part B provider services for a given region.

“Freestanding Children’s Hospital” means a separately standing hospital with at least 120 pediatric beds that is dedicated to provide the majority of the hospital’s services to children.

“GME program approved by the Administration” or “approved GME program” means a graduate medical education program that has been approved by a national organization as described in 42 CFR 415.152.

“Graduate medical education (GME) program” means an approved residency program that prepares a physician for independent practice of medicine by providing didactic and clinical education in a medical environment to a medical student who has completed a recognized undergraduate medical education program.

“HCPCS” means the Health Care Procedure Coding System, published and updated by Center for Medicare and Medicaid Services (CMS). HCPCS is a listing of codes and descriptive terminology used for reporting the provision of physician services, other health care services, and substances, equipment, supplies or other items used in health care services.

“HIPAA” means the Health Insurance Portability and Accountability Act of 1996, as specified under 45 CFR 162, that establishes standards and requirements for the electronic transmission of certain health information by defining code sets used for encoding data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes.

“ICU” means the intensive care unit of a hospital.

“Indirect program costs” means the marginal increase in operating costs that a hospital experiences as a result of having an approved graduate medical education program and that is not accounted for by the hospital’s direct program costs.

“Intern and Resident Information System” means a software program used by teaching hospitals and the provider community for collecting and reporting information on resident training in hospital and non-hospital settings.

“Medical education costs” means direct hospital costs for intern and resident salaries, fringe benefits, program costs, nursing school education, and paramedical education, as described in the Medicare Provider Reimbursement Manual.

“Medical review” means a clinical evaluation of documentation conducted by AHCCCS or a contractor for purposes of

prior authorization, concurrent review, post-payment review, or determining medical necessity. The criteria for medical review are established by AHCCCS or a contractor based on medical practice standards that are updated periodically to reflect changes in medical care.

“Medicare Urban or Rural Cost-to-Charge Ratio (CCR)” means statewide average capital cost-to-charge ratio published annually by CMS added to the urban or rural statewide average operating cost-to-charge ratio published annually by CMS.

“National Standard code sets” means codes that are accepted nationally in accordance with federal requirements under 45 CFR 160 and 45 CFR 164.

“New hospital” means a hospital for which Medicare Cost Report claim and encounter data are not available for the fiscal year used for initial rate setting or rebasing.

“NICU” means the neonatal intensive care unit of a hospital that is classified as a Level II or Level III perinatal center by the Arizona Perinatal Trust.

“Non-IHS Acute Hospital” means a hospital that is not run by Indian Health Services, is not a free-standing psychiatric hospital, such as an IMD, and is paid under ADHS rates.

“Observation day” means a physician-ordered evaluation period of less than 24 hours to determine whether a person needs treatment or needs to be admitted as an inpatient.

“Operating costs” means AHCCCS-allowable accommodation costs and ancillary department hospital costs excluding capital and medical education costs.

“Organized health care delivery system” means a public or private organization that delivers health services. It includes, but is not limited to, a clinic, a group practice prepaid capitation plan, and a health maintenance organization.

“Outlier” means a hospital claim or encounter in which the operating costs per day for an AHCCCS inpatient hospital stay meet the criteria described under this Article and A.R.S. § 36-2903.01(H).

“Outpatient hospital service” means a service provided in an outpatient hospital setting that does not result in an admission.

“Ownership change” means a change in a hospital’s owner, lessor, or operator under 42 CFR 489.18(a).

“Participating institution” means an institution at which portions of a graduate medical education program are regularly conducted and to which residents rotate for an educational experience for at least one month.

“Peer group” means hospitals that share a common, stable, and independently definable characteristic or feature that significantly influences the cost of providing hospital services, including specialty hospitals that limit the provision of services to specific patient populations, such as rehabilitative patients or children.

“PPC” means prior period coverage. PPC is the period of time, prior to the member’s enrollment, during which a member is eligible for covered services. The time-frame is the first day of the month of application or the first eligible month, whichever is later, until the day a member is enrolled with a contractor.

“PPS bed” means Medicare-approved Prospective Payment beds for inpatient services as reported in the Medicare cost reports for the most recent fiscal year for which the Administration has a complete set of Medicare cost reports for every rural hospital as determined as of the first of February of each year.

“Procedure code” means the numeric or alphanumeric code listed in the CPT or HCPCS manual by which a procedure or service is identified.

“Prospective rates” means inpatient or outpatient hospital rates set by AHCCCS in advance of a payment period and representing full payment for covered services excluding any quick-pay discounts, slow-pay penalties, and first-and third-party payments regardless of billed charges or individual hospital costs.

“Public hospital” means a hospital that is owned and operated by county, state, or hospital health care district.

“Rebase” means the process by which the most currently available and complete Medicare Cost Report data for a year and AHCCCS claim and encounter data for the same year are collected and analyzed to reset the Inpatient Hospital Tiered per diem rates, or the Outpatient Hospital Capped Fee-For-Service Schedule.

“Reinsurance” means a risk-sharing program provided by AHCCCS to contractors for the reimbursement of specified contract service costs incurred by a member beyond a certain monetary threshold.

“Remittance advice” means an electronic or paper document submitted to an AHCCCS-registered provider by AHCCCS to explain the disposition of a claim.

“Resident” means a physician engaged in postdoctoral training in an accredited graduate medical education program, including an intern and a physician who has completed the requirements for the physician’s eligibility for board certification.

“Revenue code” means a numeric code, that identifies a specific accommodation, ancillary service, or billing calculation, as defined by the National Uniform Billing committee for UB-92 forms.

“Specialty facility” means a facility where the service provided is limited to a specific population, such as rehabilitative services for children.

“Sponsoring institution” means the institution or entity that is recognized by the GME accrediting organization and designated as having ultimate responsibility for the assurance of academic quality and compliance with the terms of accreditation.

“Tier” means a grouping of inpatient hospital services into levels of care based on diagnosis, procedure, or revenue codes, peer group, NICU classification level, or any combination of these items.

“Tiered per diem” means an AHCCCS capped fee schedule in which payment is made on a per-day basis depending upon the tier (or tiers) into which an AHCCCS inpatient hospital day of care is assigned.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-701 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-701 repealed, new Section R9-22-701 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Section repealed; new Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2). Amended by final rulemaking at 12 A.A.R. 2188, effective

tive June 6, 2006 (Supp. 06-2). Amended by final rulemaking at 13 A.A.R. 662, effective April 7, 2007 (Supp. 07-1). Amended by final rulemaking at 13 A.A.R. 1782, effective June 30, 2007 (Supp. 07-2). Amended by exempt rulemaking at 13 A.A.R. 3190, effective October 1, 2007 (Supp. 07-3). Amended by exempt rulemaking at 13 A.A.R. 4032, effective November 1, 2007 (Supp. 07-4).

R9-22-701.01. Reserved**R9-22-701.02. Reserved****R9-22-701.03. Reserved****R9-22-701.04. Reserved****R9-22-701.05. Reserved****R9-22-701.06. Reserved****R9-22-701.07. Reserved****R9-22-701.08. Reserved****R9-22-701.09. Reserved****R9-22-701.10 Scope of the Administration's and Contractor's Liability**

The Administration shall bear no liability for providing covered services for any member beyond the date of termination of the member's eligibility or during the member's enrollment with a contractor. A contractor has no financial responsibility for services provided to a member beyond the last date of enrollment except as provided in Articles 2 and 5 of this Chapter and as specified in contract.

Historical Note

New Section made by final rulemaking at 13 A.A.R. 662, effective April 7, 2007 (Supp. 07-1).

R9-22-702. Charges to Members

- A. For purposes of this subsection, the term "member" includes the member's financially responsible representative as described under A.R.S. § 36-2903.01.
- B. Registered providers must accept payment from the Administration or a contractor as payment in full.
- C. Except as provided in subsection (D) a registered provider shall not request or collect payment from, refer to a collection agency, or report to a credit reporting agency an eligible person or a person claiming to be an eligible person.
- D. An AHCCCS registered provider may charge, submit a claim to, or demand or collect payment from a member:
 1. To collect the copayment described in R9-22-711;
 2. To recover from a member that portion of a payment made by a third party to the member for an AHCCCS covered service if the member has not transferred the payment to the Administration or the contractor as required by the statutory assignment of rights to AHCCCS;
 3. To obtain payment from a member for medical expenses incurred during a period when the member intentionally withheld information or intentionally provided inaccurate information pertaining to the member's AHCCCS eligibility or enrollment that caused payment to the provider to be reduced or denied;
 4. For a service that is excluded by statute or rule, or provided in an amount that exceeds a limitation in statute or rule, if the member signs a document in advance of receiving the service stating that the member understands the service is excluded or is subject to a limit and that the member will be financially responsible for payment for the excluded service or for the services in excess of the limit;

5. When the contractor or the Administration has denied authorization for a service if the member signs a document in advance of receiving the service stating that the member understands that authorization has been denied and that the member will be financially responsible for payment for the service;
 6. For services requested for a member enrolled with a contractor, and rendered by a noncontracting provider under circumstances where the member's contractor is not responsible for payment of "out of network" services under R9-22-705(A), if the member signs a document in advance of receiving the service stating that the member understands the provider is out of network, that the member's contractor is not responsible for payment, and that the member will be financially responsible for payment for the excluded service;
 7. For services rendered to a person eligible for the FESP if the provider submits a claim to the Administration in the reasonable belief that the service is for treatment of an emergency medical condition and the Administration denies the claim because the service does not meet the criteria of R9-22-217; or
 8. If the provider has received verification from the Administration that the person was not an eligible person on the date of service.
- E. The signature requirement of subsections (D)(4), (5), and (6) do not apply if:
1. The member is unable or incompetent to sign such a document, or
 2. When services are rendered for the purpose of treating an emergency medical condition as defined in R9-22-217 and a delay in providing treatment to obtain a signature would have a significant adverse affect on the member's health.
- F. Except as provided for in this Section, registered providers shall not bill a member when the provider could have received reimbursement from the Administration or a contractor but for the provider's failure to file a claim in accordance with the requirements of AHCCCS statutes, rules, the provider agreement, or contract, such as, but not limited to, requirements to request and obtain prior authorization, timely filing, and clean claim requirements.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-702 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Amended as a permanent rule effective May 16, 1983; text identical to the emergency (Supp. 83-3). Former Section R9-22-702 repealed, new Section R9-22-702 adopted effective October 1, 1983 (Supp. 83-5). Amended by adding subsection (B) effective October 1, 1985 (Supp. 85-5). Amended by adding subsection (C) effective October 1, 1987 (Supp. 87-4). Amended effective April 13, 1990 (Supp. 90-2). Amended effective December 13, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Amended by final rulemaking at 11 A.A.R. 3217, effective October 1, 2005 (Supp. 05-3). Amended by exempt rulemaking at 17 A.A.R. 1707, effective October 1, 2011 (Supp. 11-3).

R9-22-703. Payments by the Administration

A. General requirements. A provider shall enter into a provider agreement with the Administration that meets the requirements of A.R.S. § 36-2904 and 42 CFR 431.107(b) as of March 6, 1992, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.

B. Timely submission of claims.

1. Under A.R.S. § 36-2904, the Administration shall deem a paper or electronic claim to be submitted on the date that it is received by the Administration. The Administration shall do one or more of the following for each claim it receives:
 - a. Place a date stamp on the face of the claim,
 - b. Assign a system-generated claim reference number, or
 - c. Assign a system-generated date-specific number.
2. Unless a shorter time period is specified in contract, the Administration shall not pay a claim for a covered service unless the claim is initially submitted within one of the following time limits, whichever is later:
 - a. Six months from the date of service or for an inpatient hospital claim, six months from the date of discharge; or
 - b. Six months from the date of eligibility posting.
3. Unless a shorter time period is specified in contract, the Administration shall not pay a claim for a covered service unless the claim is submitted within one of the following time limits, whichever is later:
 - a. Twelve months from the date of service or for an inpatient hospital claim, 12 months from the date of discharge; or
 - b. Twelve months from the date of eligibility posting.
4. Unless a shorter time period is specified in contract, the Administration shall not pay a claim submitted by an IHS or tribal facility for a covered service unless the claim is initially submitted within 12 months from the date of service, date of discharge, or eligibility posting, whichever is later.

C. Claims processing.

1. The Administration shall notify the AHCCCS-registered provider with a remittance advice when a claim is processed for payment.
2. The Administration shall reimburse a hospital for inpatient hospital admissions and outpatient hospital services rendered on or after March 1, 1993, as follows and in the manner and at the rate described in A.R.S. § 36-2903.01:
 - a. If the hospital bill is paid within 30 days from the date of receipt, the claim is paid at 99 percent of the rate.
 - b. If the hospital bill is paid between 30 and 60 days from the date of receipt, the claim is paid at 100 percent of the rate.
 - c. If the hospital bill is paid after 60 days from the date of receipt, the claim is paid at 100 percent of the rate plus a fee of one percent per month for each month or portion of a month following the 60th day of receipt of the bill until date of payment.
3. A claim is paid on the date indicated on the disbursement check.
4. A claim is denied as of the date of the remittance advice.
5. The Administration shall process a hospital claim under this Article.

D. Prior authorization.

1. An AHCCCS-registered provider shall:
 - a. Obtain prior authorization from the Administration for non-emergency hospital admissions and covered services as specified in Articles 2 and 12 of this Chapter,
 - b. Notify the Administration of hospital admissions under Article 2 of this Chapter, and
 - c. Make records available for review by the Administration upon request.
2. The Administration may deny a claim if the provider fails to comply with subsection (D)(1).
3. If the Administration issues prior authorization for a specific level of care but subsequent medical review indicates that a different level of care was medically appropriate, the Administration shall adjust the claim to pay for the cost of the appropriate level of care.

E. Review of claims and coverage for hospital supplies.

1. The Administration may conduct prepayment and post-payment review of any claims, including but not limited to hospital claims.
2. Personal care items supplied by a hospital, including but not limited to the following, are not covered services:
 - a. Patient care kit,
 - b. Toothbrush,
 - c. Toothpaste,
 - d. Petroleum jelly,
 - e. Deodorant,
 - f. Septi soap,
 - g. Razor or disposable razor,
 - h. Shaving cream,
 - i. Slippers,
 - j. Mouthwash,
 - k. Shampoo,
 - l. Powder,
 - m. Lotion,
 - n. Comb, and
 - o. Patient gown.
3. The following hospital supplies and equipment, if medically necessary and used by the member, are covered services:
 - a. Arm board,
 - b. Diaper,
 - c. Underpad,
 - d. Special mattress and special bed,
 - e. Gloves,
 - f. Wrist restraint,
 - g. Limb holder,
 - h. Disposable item used instead of a durable item,
 - i. Universal precaution,
 - j. Stat charge, and
 - k. Portable charge.
4. The Administration shall determine in a hospital claims review whether services rendered were:
 - a. Covered services as defined in R9-22-102;
 - b. Medically necessary;
 - c. Provided in the most appropriate, cost-effective, and least restrictive setting; and
 - d. For claims with dates of admission on and after March 1, 1993, substantiated by the minimum documentation specified in A.R.S. § 36-2903.01.
5. If the Administration adjudicates a claim, a person may file a claim dispute challenging the adjudication under 9 A.A.C. 34.

F. Overpayment for AHCCCS services.

1. An AHCCCS-registered provider shall notify the Administration when the provider discovers the Administration made an overpayment.
 2. The Administration shall recoup an overpayment from a future claim cycle if an AHCCCS-registered provider fails to return the overpaid amount to the Administration.
 3. The Administration shall document any recoupment of an overpayment on a remittance advice.
 4. An AHCCCS-registered provider may file a claim dispute under 9 A.A.C. 34 if the AHCCCS-registered provider disagrees with a recoupment action.
- G.** For services subject to limitations or exclusions such as the number of hours, days, or visits covered as described in Article 2 of this Chapter, once the limit is reached the Administration will not reimburse the services.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R-22-703 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-703 repealed, new Section R9-22-703 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended subsection (B), paragraph (1) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (A) effective September 16, 1987 (Supp. 87-3). Amended effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Amended by final rulemaking at 11 A.A.R. 3222, effective October 1, 2005 (Supp. 05-3). Amended by final rulemaking at 13 A.A.R. 662, effective April 7, 2007 (Supp. 07-1). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by exempt rulemaking at 17 A.A.R. 1707, effective October 1, 2011 (Supp. 11-3).

R9-22-704. Repealed

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-704 adopted as an emergency now adopted and amended as a permanent rule effective August 30 1982 (Supp. 82-4). Amended effective October 1, 1983 (Supp. 83-5). Amended subsection A., Paragraph 2. effective October 1, 1985 (Supp. 85-5). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Section repealed by final rulemaking at 13 A.A.R. 662, effective April 7, 2007 (Supp. 07-1).

R9-22-705. Payments by Contractors

- A.** General requirements. A contractor shall contract with providers to provide covered services to members enrolled with the contractor. The contractor is responsible for reimbursing providers and coordinating care for services provided to a member. Except as provided in subsection (A)(2), a contractor is not required to reimburse a noncontracting provider for services rendered to a member enrolled with the contractor.
1. Providers. A provider shall enter into a provider agreement with the Administration that meets the requirements of A.R.S. § 36-2904 and 42 CFR 431.107(b) as of March 6, 1992, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
 2. A contractor shall reimburse a noncontracting provider for services rendered to a member enrolled with the contractor as specified in this Article if:
 - a. The contractor referred the member to the provider or authorized the provider to render the services and the claim is otherwise payable under this Chapter, or
 - b. The service is emergent under Article 2 of this Chapter.
- B.** Timely submission of claims.
1. Under A.R.S. § 36-2904, a contractor shall deem a paper or electronic claim as submitted on the date that the claim is received by the contractor. The contractor shall do one or more of the following for each claim the contractor receives:
 - a. Place a date stamp on the face of the claim,
 - b. Assign a system-generated claim reference number, or
 - c. Assign a system-generated date-specific number.
 2. Unless a shorter time period is specified in subcontract, a contractor shall not pay a claim for a covered service unless the claim is initially submitted within one of the following time limits, whichever is later:
 - a. Six months from the date of service or for an inpatient hospital claim, six months from the date of discharge; or
 - b. Six months from the date of eligibility posting.
 3. Unless a shorter time period is specified in subcontract, a contractor shall not pay a claim for a covered service unless the claim is submitted within one of the following time limits, whichever is later:
 - a. Twelve months from the date of service or for an inpatient hospital claim, 12 months from the date of discharge; or
 - b. Twelve months from the date of eligibility posting.
- C.** Date of claim.
1. A contractor's date of receipt of an inpatient or an outpatient hospital claim is the date the claim is received by the contractor as indicated by the date stamp on the claim, the system-generated claim reference number, or the system-generated date-specific number assigned by the contractor.
 2. A hospital claim is considered paid on the date indicated on the disbursement check.
 3. A denied hospital claim is considered adjudicated on the date of the claim's denial.
 4. For a claim that is pending for additional supporting documentation specified in A.R.S. § 36-2903.01 or 36-2904, the contractor shall assign a new date of receipt upon receipt of the additional documentation.
 5. For a claim that is pending for documentation other than the minimum required documentation specified in either A.R.S. § 36-2903.01 or 36-2904, the contractor shall not assign a new date of receipt.
 6. A contractor and a hospital may, through a contract approved as specified in R9-22-715, adopt a method for identifying, tracking, and adjudicating a claim that is different from the method described in this subsection.
- D.** Payment for in-state inpatient hospital services. A contractor shall reimburse an in-state provider of inpatient hospital services rendered with an admission date on or after March 1, 1993, at either a rate specified by subcontract or, in absence of the subcontract, the prospective tiered-per-diem amount in

A.R.S. § 36-2903.01 and this Article. Subcontract rates, terms, and conditions are subject to review and approval or disapproval under A.R.S. § 36-2904 and R9-22-715. This subsection does not apply to an urban contractor as specified in R9-22-718 and A.R.S. § 36-2905.01.

E. Payment for in-state outpatient hospital services.

1. A contractor shall reimburse an in-state provider of outpatient hospital services rendered on or after March 1, 1993 through June 30, 2005, at either a rate specified by a subcontract that complies with R9-22-715(A) or, in absence of a subcontract, as described in R9-22-712 or under A.R.S. § 36-2903.01. Subcontract rates, terms, and conditions are subject to review and approval or disapproval under A.R.S. § 36-2904 and R9-22-715.
2. A contractor shall reimburse an in-state provider of outpatient hospital services rendered on or after July 1, 2005, at either a rate specified by a subcontract or, in absence of a subcontract, as provided under R9-22-712.10, A.R.S. § 36-2903.01 and other sections of this Article. The terms of the subcontract are subject to review and approval or disapproval under A.R.S. § 36-2904 and R9-22-715.

F. Inpatient and outpatient out-of-state hospital payments. In the absence of a contract with an out-of-state hospital that specifies payment rates, a contractor shall reimburse out-of-state hospitals for covered inpatient services by multiplying covered charges by the most recent state-wide urban cost-to-charge ratio as determined in R9-22-712.01(6)(b). In the absence of a contract with an out-of-state hospital that specifies payment rates, a contractor shall reimburse out-of-state hospitals for covered outpatient services by applying the methodology described in R9-22-712.10 through R9-22-712.50. If the outpatient procedure is not assigned a fee schedule amount, the contractor shall pay the claim by multiplying the covered charges for the outpatient services by the state-wide outpatient cost-to-charge ratio.

G. Payment for observation days. A contractor shall reimburse a provider and a noncontracting provider for the provision of observation days at either a rate specified by subcontract or, in the absence of a subcontract, as prescribed under R9-22-712, R9-22-712.10, and R9-22-712.45. An "observation day" means a physician-ordered evaluation period of less than 24 hours to determine the need of treatment or the need for admission as an inpatient.

H. Review of claims and coverage for hospital supplies.

1. A contractor may conduct a review of any claims submitted and recoup any payments made in error.
2. A hospital shall obtain prior authorization from the appropriate contractor for nonemergency admissions. When issuing prior authorization, a contractor shall consider the medical necessity of the service, and the availability and cost effectiveness of an alternative treatment. Failure to obtain prior authorization when required is cause for nonpayment or denial of a claim. A contractor shall not require prior authorization for medically necessary services provided during any prior period for which the contractor is responsible. If a contractor and a hospital agree to a subcontract, the parties shall abide by the terms of the subcontract regarding utilization control activities. A hospital shall cooperate with a contractor's reasonable activities necessary to perform concurrent review and shall make the hospital's medical records pertaining to a member enrolled with a contractor available for review.
3. Regardless of prior authorization or concurrent review activities, a contractor may make prepayment or post-payment review of all claims, including but not limited to a hospital claim. A contractor may recoup an erroneously

paid claim. If prior authorization was given for a specific level of care, but medical review of a claim indicates that a different level of care was medically appropriate, a contractor shall adjust the claim to pay for the cost for the appropriate level of care. An adjustment in payment for a different level of care is effective on the date when the different level of care is medically appropriate.

4. A contractor and a hospital may enter into a subcontract that includes hospital claims review criteria and procedures if the subcontract meets the requirements of R9-22-715.

5. Personal care items supplied by a hospital, including but not limited to the following, are not covered services:

- a. Patient care kit,
- b. Toothbrush,
- c. Toothpaste,
- d. Petroleum jelly,
- e. Deodorant,
- f. Septi soap,
- g. Razor,
- h. Shaving cream,
- i. Slippers,
- j. Mouthwash,
- k. Disposable razor,
- l. Shampoo,
- m. Powder,
- n. Lotion,
- o. Comb, and
- p. Patient gown.

6. The following hospital supplies and equipment, if medically necessary and used by the member, are covered services:

- a. Arm board,
- b. Diaper,
- c. Underpad,
- d. Special mattress and special bed,
- e. Gloves,
- f. Wrist restraint,
- g. Limb holder,
- h. Disposable item used instead of a durable item,
- i. Universal precaution,
- j. Stat charge, and
- k. Portable charge.

7. The contractor shall determine in a hospital claims review whether services rendered were:

- a. Covered services as defined in R9-22-102;
- b. Medically necessary;
- c. Provided in the most appropriate, cost-effective, and least restrictive setting; and
- d. For claims with dates of admission on and after March 1, 1993, substantiated by the minimum documentation specified in A.R.S. § 36-2904.

8. If a contractor adjudicates a claim or recoups payment for a claim, a person may file a claim dispute challenging the adjudication or recoupment as described under 9 A.A.C. 34.

I. Non-hospital claims. A contractor shall pay claims for non-hospital services in accordance with contract, or in the absence of a contract, at a rate not less than the Administration's capped fee-for-service schedule or at a lower rate if negotiated between the two parties.

J. Payments to hospitals. A contractor shall pay for inpatient hospital admissions and outpatient hospital services rendered on or after March 1, 1993, as follows and as described in A.R.S. § 36-2904:

1. If the hospital bill is paid within 30 days from the date of receipt, the claim is paid at 99 percent of the rate.
2. If the hospital bill is paid between 30 and 60 days from the date of receipt, the claim is paid at 100 percent of the rate.
3. If the hospital bill is paid after 60 days from the date of receipt, the claim is paid at 100 percent of the rate plus a 1 percent penalty of the rate for each month or portion of the month following the 60th day of receipt of the bill until date of payment.

- K.** Interest payment. In addition to the requirements in subsection (J), a contractor shall pay interest for late claims as defined by contract.
- L.** For services subject to limitations or exclusions such as the number of hours, days, or visits covered as described in Article 2 of this Chapter, once the limit is reached the Administration will not reimburse the services.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-705 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Amended as a permanent rule effective May 16, 1983; text of the amended rule identical to emergency (Supp. 83-3). Former Section R9-22-705 repealed, new Section R9-22-705 adopted effective October 1, 1983 (Supp. 83-5).

Amended as an emergency effective October 25, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-5). Emergency expired. Permanent amendment adopted effective February 1, 1985 (Supp. 85-1).

Amended effective October 1, 1985 (Supp. 85-5).

Amended subsection (C) effective October 1, 1986 (Supp. 86-5). Amended subsection (C) effective October 1, 1987; amended subsection (C) effective December 22, 1987 (Supp. 87-4). Amended subsections (A) and (C) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 5 A.A.R. 867, effective March 4, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by final rulemaking at 11 A.A.R. 3222, effective October 1, 2005 (Supp. 05-3). Amended by final rulemaking at 13 A.A.R. 662, effective April 7, 2007 (Supp. 07-1). Amended by final rulemaking at 14 A.A.R. 1439, effective May 31, 2008 (Supp. 08-2). Amended by exempt rulemaking at 17 A.A.R. 1707, effective October 1, 2011 (Supp. 11-3).

R9-22-706. Repealed

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-706 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-706 repealed, new Section R9-22-706 adopted effective October 1, 1983 (Supp. 83-5). Adopted as an emergency

effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Amended as an emergency effective October 25, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-5).

Emergency expired. Permanent amendment adopted effective February 1, 1985 (Supp. 85-1). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended subsections (A), (D), (E), (F), and (G) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (F) effective December 22, 1987 (Supp. 87-4). Amended subsections (A) and (F) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective September 22, 1997 (Supp. 97-3). Section repealed by final rulemaking at 10 A.A.R. 4656, effective January 1, 2005 (Supp. 04-4).

R9-22-707. Repealed

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-707 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Repealed as a permanent action effective May 16, 1983 (Supp. 83-3).

New Section R9-22-707 adopted effective October 1, 1983 (Supp. 83-5). Adopted as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Adopted as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Former Section R9-22-707 repealed, new Section R9-22-707 adopted effective October 1, 1985 (Supp. 85-5). Former Section R9-22-707 repealed, new Section R9-22-707 adopted effective October 1, 1986 (Supp. 86-5). Amended subsection (A) effective October 1, 1987 (Supp. 87-4). Amended effective September 29, 1992 (Supp. 92-3). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Section repealed by final rulemaking at 13 A.A.R. 856, effective May 5, 2007 (Supp. 07-1).

R9-22-708. Payments for Services Provided to Eligible Native Americans

- A.** For purposes of this Article “IHS enrolled” or “enrolled with IHS” means a Native American who has elected to receive covered services through IHS instead of a contractor.
- B.** For a Native American who is enrolled with IHS, AHCCCS shall pay IHS the most recent all-inclusive inpatient, outpatient or ambulatory surgery rates published by Health and Human Services (HHS) in the *Federal Register*, or a separately contracted rate with IHS, for AHCCCS-covered services provided in an IHS facility. AHCCCS shall reimburse providers for the Medicare coinsurance and deductible amounts required to be paid by the Administration or contractor in Chapter 29, Article 3 of this Title.
- C.** When IHS refers a Native American enrolled with IHS to a provider other than an IHS or tribal facility, the provider to whom the referral is made shall obtain prior authorization from AHCCCS for services as required under Articles 2, 7 or 12 of this Chapter.

- D. For a Native American enrolled with a contractor, AHCCCS shall pay the contractor a monthly capitation payment.
- E. Once a Native American enrolls with a contractor, AHCCCS shall not reimburse any provider other than IHS or a Tribal facility.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-708 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-708 repealed, new Section R9-22-708 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-708 renumbered and amended as Section R9-22-709, new Section R9-22-708 adopted effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended by final rulemaking at 10 A.A.R. 4656, effective January 1, 2005 (Supp. 04-4).

R9-22-709. Contractor's Liability to Hospitals for the Provision of Emergency and Post-stabilization Care

A contractor is liable for emergency hospitalization and post-stabilization care as described in R9-22-210 and R9-22-210.01.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-709 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-709 repealed, new Section R9-22-709 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-709 renumbered and amended as Section R9-22-713, former Section R9-22-708 renumbered and amended as Section R9-22-709 effective October 1, 1985 (Supp. 85-5). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 13 A.A.R. 856, effective May 5, 2007 (Supp. 07-1).

Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General did not certify this rule. This Section was subsequently amended through the regular rulemaking process.

R9-22-710. Payments for Non-hospital Services

- A. Capped fee-for-service. The Administration shall provide notice of changes in methods and standards for setting payment rates for services in accordance with 42 CFR 447.205, December 19, 1983, incorporated by reference and on file with the Administration and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
 - 1. Non-contracted services. In the absence of a contract that specifies otherwise, a contractor shall reimburse a provider or noncontracting provider for non-hospital services according to the Administration's capped-fee-for-service schedule.

- 2. Procedure codes. The Administration shall maintain a current copy of the National Standard Code Sets mandated under 45 CFR 160 (October 1, 2004) and 45 CFR 162 (October 1, 2004), incorporated by reference and on file with the Administration and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
 - a. A person shall submit an electronic claim consistent with 45 CFR 160 (October 1, 2004) and 45 CFR 162 (October 1, 2004).
 - b. A person shall submit a paper claim using the National Standard Code Sets as described under 45 CFR 160 (October 1, 2004) and 45 CFR 162 (October 1, 2004).
 - c. The Administration may deny a claim for failure to comply with subsection (A)(2)(a) or (b).
- 3. Fee schedule. The Administration shall pay providers, including noncontracting providers, at the lesser of billed charges or the capped fee-for-service rates specified in subsections (A)(3)(a) through (d) unless a different fee is specified in a contract between the Administration and the provider, or is otherwise required by law.
 - a. Physician services. Fee schedules for payment for physician services are on file at the central office of the Administration for reference use during customary business hours.
 - b. Dental services. Fee schedules for payment for dental services are on file at the central office of the Administration for reference use during customary business hours.
 - c. Transportation services. Fee schedules for payment for transportation services are on file at the central office of the Administration for reference use during customary business hours. For dates of service beginning October 1, 2012, through September 30, 2013, the Administration and its contractors shall reimburse ambulance services at 68.59 percent of the ADHS rates that are in effect as of August 2, 2012.
 - d. Medical supplies and durable medical equipment (DME). Fee schedules for payment for medical supplies and DME are on file at the central office of the Administration for reference use during customary business hours. The Administration shall reimburse a provider once for purchase of DME during any two-year period, unless the Administration determines that DME replacement within that period is medically necessary for the member. Unless prior authorized by the Administration, no more than one repair and adjustment of DME shall be reimbursed during any two-year period.
- B. Pharmacy services. The Administration shall not reimburse pharmacy services unless the services are provided by a pharmacy having a subcontract with a Pharmacy Benefit Manager (PBM) contracted with AHCCCS. Except as specified in subsection (C), the Administration shall reimburse pharmacy services according to the terms of the contract.
- C. FQHC Pharmacy reimbursement.
 - 1. For purposes of this Section the following terms are defined:
 - a. "340B Drug Pricing Program" means the discount drug purchasing program described in 42 U.S.C. 256b.

- b. “340B Ceiling Price” means the maximum price that drug manufacturers can charge covered entities participating in the 340B Drug Pricing Program as reported by the drug manufacturer to HRSA.
 - c. “340B entity” means a covered entity, eligible to participate in the 340B Drug Pricing Program, as defined by the Health Resources and Human Services Administration.
 - d. “Actual Acquisition Cost (AAC)” means the purchase price of a drug paid by a pharmacy net of discounts, rebates, chargebacks and other adjustments to the price of the drug. The AAC excludes dispensing fees.
 - e. “Contracted Pharmacy” means an arrangement through which a 340B entity may contract with an outside pharmacy to provide comprehensive pharmacy services utilizing medications subject to 340B pricing.
 - f. “Dispensing Fee” means the amount paid for the professional services provided by the pharmacist for dispensing a prescription. The Dispensing Fee does not include any payment for the drugs being dispensed.
 - g. “Federally Qualified Health Center” means a public or private non-profit health care organization that has been identified by HRSA and certified by CMS as meeting the criteria under sections 1861(aa)(4) and 1905(l)(2)(B) of the Social Security Act and receives funds under section 330 of the Public Health Service Act.
 - h. “Federally Qualified Health Center Look-Alike” means a public or private non-profit health care organization that has been identified by HRSA and certified by CMS as meeting the definition of “health center” under section 330 of the Public Health Service Act, but does not receive grant funding under section 330.
 - i. “FQHC or FQHC Look-Alike pharmacy” means a pharmacy that dispenses drugs to FQHC or FQHC-LA patients and that is owned and/or operated by an FQHC/FQHC-LA or by an entity that reports the costs of an FQHC/FQHC-LA on its Medicare Cost Report, whether or not collocated with an FQHC or an FQHC Look-Alike.
2. Effective the later of February 1, 2012, or CMS approval of a State Plan Amendment, an FQHC or FQHC Look-Alike shall:
 - a. Notify the AHCCCS provider registration unit of its status as a 340B covered entity no later than:
 - i. 30 days after the effective date of this Section,
 - ii. 30 days after registration with the Health Resources and Services Administration (HRSA) for participation in the 340B program, or
 - iii. The time of application to become an AHCCCS provider.
 - b. Provide the 340B pricing file to the AHCCCS Administration upon request. The 340B pricing file shall be provided in the file format as defined by AHCCCS.
 - c. Identify 340B drug claims submitted to the AHCCCS FFS PBM or the Managed Care Contractors’ PBMs for reimbursement. The 340B drug claim identification and claims processing for a drug claim submission shall be consistent with claim instructions issued and required by AHCCCS to identify such claims.
 3. The FQHC and the FQHC Look-Alike pharmacies shall submit claims for AHCCCS members for drugs that are identified in the 340B pricing file, whether or not purchased under the 340B pricing file, with the lesser of:
 - a. The actual acquisition cost, or
 - b. The 340B ceiling price.
 4. The AHCCCS Fee-for-Service and Managed Care Contractors’ PBMs shall reimburse claims for drugs which are identified in the 340B pricing file dispensed by FQHC and FQHC Look-Alike pharmacies, whether or not purchased under the 340B pricing file, at the amount submitted under subsection (C)(3) plus a dispensing fee listed in the AHCCCS Capped Fee-For-Service Schedule unless a contract between the 340B entity and a Managed Care Contractor’s PBM specifies a different dispensing fee.
 5. Contracted pharmacies shall not submit claims for drugs dispensed under an agreement with the 340B entity as part of the 340B drug pricing program, and the AHCCCS Administration and Managed Care Contractors shall not reimburse such claims.
 6. The AHCCCS Administration and Managed Care Contractors shall reimburse contracted pharmacies for drugs not dispensed under an agreement with the 340B entity as part of the 340B program at the price and dispensing fee set forth in the contract between the contracted pharmacy and the AHCCCS or its Managed Care Contractors’ PBMs. Neither the Administration nor its Managed Care Contractors will reimburse a contracted pharmacy that does not have a contract with the Administration or MCO’s PBM.
 7. The AHCCCS Administration and its Managed Care Contractors shall reimburse FQHC and FQHC Look-Alike pharmacies for drugs that are not eligible under the 340B Drug Pricing Program at the price and dispensing fee set forth in their contract with the AHCCCS or its Managed Care Contractors’ PBMs.
 8. AHCCCS may periodically conduct audits to ensure compliance with this Section.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-710 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Amended as a permanent rule effective May 16, 1983; text of amended rule identical to emergency (Supp. 83-3). Former Section R9-22-710 repealed, new Section R9-22-710 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985. The capped fee-for-service schedules, deleted from Section R9-22-710, are now on file at the central office of the Administration (Supp. 85-5). Amended subsections (B) through (D) effective October 1, 1986 (Supp. 86-5). Amended subsection (B) effective July 1, 1988 (Supp. 88-3). Amended subsection (B) effective April 27, 1989 (Supp. 89-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective December 13, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 11 A.A.R. 3830, effective November 12, 2005 (Supp. 05-3). Amended by

exempt rulemaking at 18 A.A.R. 212, effective February 1, 2012 (Supp. 12-1). Amended by exempt rulemaking at 18 A.A.R. 1971, effective August 1, 2012 (Supp. 12-3). Amended by exempt rulemaking at 18 A.A.R. 2630, effective October 1, 2012 (Supp. 12-4).

R9-22-711. Copayments

A. For purposes of this Article:

1. A copayment is a monetary amount that a member pays directly to a provider at the time a covered service is rendered.
2. An eligible individual is assigned to a hierarchy established in subsections (B) through (F), for the purposes of establishing a copayment amount.
3. No refunds shall be made for a retroactive period if there is a change in an individual's status that alters the amount of a copayment.

B. The following services are exempt from AHCCCS copayments:

1. Family planning services and supplies are exempt from copayments for all members.
2. Services related to a pregnancy or any other medical condition that may complicate the pregnancy, including tobacco cessation treatment for a pregnant woman, are exempt from copayments for all members.
3. Emergency services as described in 42 CFR 447.53(b)(4) are exempt from copayments for all members.
4. All services paid on a fee-for-service basis are exempt from copayments for all members.

C. The following individuals are exempt from AHCCCS copayments:

1. An individual under age 19, including individuals eligible for the KidsCare Program in A.R.S. § 36-2982;
2. An individual determined to be Seriously Mentally Ill (SMI) by the Arizona Department of Health Services;
3. An individual eligible for the Arizona Long-term Care Program in A.R.S. § 36-2931;
4. An individual eligible for Medicare Cost Sharing in 9 A.A.C. 29;
5. An individual eligible for the Children's Rehabilitative Services program under A.R.S. § 36-2906(E);
6. An institutionalized person under R9-22-216; and
7. An individual receiving hospice care as defined in 42 U.S.C. 1396d(o).
8. An American Indian individual enrolled in a health plan and who has received services through an IHS facility, tribal 638 facility or urban Indian health program.

D. Copayments for non-Transitional Medical Assistance (TMA) individuals covered under the State Plan. Unless otherwise listed in subsection (B) or (C), individuals under subsections (D)(1) through (8) are subject to the copayments listed in this subsection. A provider shall not deny a service when a member states to the provider an inability to pay a copayment.

1. A family eligible under Section 1931 of the Act;
2. An individual eligible for Young Adult Transitional Insurance (YATI) in A.R.S. § 36-2901(6)(iii);
3. An individual eligible for State Adoption Assistance in R9-22-1433;
4. An individual eligible for Supplemental Security Income (SSI);
5. An individual eligible for SSI Medical Assistance Only (SSI/MAO) in R9-22-1500;
6. An individual eligible for the Freedom to Work program in A.R.S. § 36-2901(6)(g); and
7. An individual eligible for the Breast and Cervical Cancer Treatment program in A.R.S. § 36-2901.05.
8. An individual with respect to whom child welfare services are made available under Part B of Title IV of the

Social Security Act on the basis of being a child in foster care, without regard to age or an individual with respect to whom adoption or foster care assistance is made available under Part E of Title IV of the Social Security Act, without regard to age.

9. Copayment amount per service:

- a. \$2.30 per prescription drug.
- b. \$3.40 per outpatient visit, excluding an emergency room visit, if any of the services rendered during the visit are coded as evaluation and management services or non-emergent surgical procedures according to the National Standard Code Sets. An outpatient visit includes any setting where these services are performed such as a physician's office, an Ambulatory Surgical Center (ASC), or a clinic.
- c. \$2.30 per visit, if a copayment is not being imposed under subsection (D)(9)(b) and any of the services rendered during the visit are coded as physical, occupational or speech therapy services according to the National Standard Code Sets.

E. Copayments for individuals eligible for Transitional Medical Assistance.

1. Unless otherwise listed in subsection (C)(1), (2), (5), (6), (7) or (D)(1) through (8), an individual eligible for Transitional Medical Assistance (TMA) in A.R.S. § 36-2924 is required to pay the following copayments:
 - a. \$2.30 per prescription drug.
 - b. \$4.00 per outpatient visit, excluding an emergency room visit, if any of the services rendered during the visit are coded as evaluation and management services according to the National Standard Code Sets. An outpatient visit includes any setting where these services are performed, such as a physician's office, an Ambulatory Surgical Center (ASC), or a clinic.
 - c. If a copayment is not being imposed under subsection (E)(1)(b), \$3.00 per visit if any of the services rendered during the visit are coded as physical, occupational or speech therapy services according to the National Standard Code Sets.
 - d. If a copayment is not being imposed under subsection (E)(1)(b) or (c), \$3.00 per visit, if any of the services rendered during the visit are coded as non-emergent surgical procedures according to the National Standard Code Sets when provided in a physician's office, an (ASC), or any other outpatient setting, excluding an emergency room, where these services are performed.
2. The provider may deny a service if the member does not pay the copayment required by subsection (E)(1), however, a provider may choose to reduce or waive copayments under this subsection on a case-by-case basis.

F. Copayments for individuals covered under Section 1115 Waiver. Unless otherwise listed in subsection (C), (D), or (E) the individuals whose income is equal to or under 100% of the Federal Poverty Level in A.R.S. § 36-2901.01 are required to pay the copayments listed in this subsection. The provider may deny a service if the member does not pay the required copayment. However, a provider may choose to reduce or waive copayments under this subsection on a case-by-case basis.

Covered Services	Copayment
Generic prescriptions or brand name prescriptions if generic is not available	\$4.00 per prescription drug

Brand name prescriptions when generic is available	\$10.00 per prescription drug
Nonemergency use of the emergency room.	\$30.00 per visit
Physician office visit	\$5.00 per office visit
Taxi transportation (Maricopa and Pima county residents only)	\$2.00 per one-way trip

- G.** A provider is responsible for collecting any copayment imposed under this Section.
- H.** The total aggregate amount of copayments under subsections (D) or (E) may not exceed 5% of the family's income as applied on a quarterly basis. The member may establish that the aggregate limit has been met on a quarterly basis by providing the Administration with records of copayments incurred during the quarter. In addition, the Administration shall also use claims and encounters information available to the Administration to establish when a member's copayment obligation has reached 5% of the family's income.
- I.** Reduction in payments to providers. The Administration shall reduce the payment it makes to any provider by the amount of a member's copayment obligation under subsections (E) and (F), regardless of whether the provider successfully collects the copayments described in this Section.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Sections R9-22-711 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-711 repealed, new Section R9-22-711 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Amended by exempt rulemaking at 9 A.A.R. 4557, effective October 1, 2003 (Supp. 03-4). Amended by exempt rulemaking at 10 A.A.R. 2194, effective May 3, 2004 (Supp. 04-2). Amended by exempt rulemaking at 10 A.A.R. 4266, effective October 1, 2004 (Supp. 04-3). Amended by final rulemaking at 16 A.A.R. 1449, effective October 1, 2010 (Supp. 10-3). Section amended by exempt rulemaking at 18 A.A.R. 461, effective April 1, 2012 (Supp. 12-1).

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

R9-22-712. Reimbursement: General

- A.** Inpatient and outpatient discounts and penalties. If a claim is pending for additional documentation required under A.R.S. § 36-2903.01(H)(4), the period during which the claim is pending is not used in the calculation of the quick-pay discounts and slow-pay penalties under A.R.S. § 36-2903.01(H)(5).
- B.** Inpatient and outpatient out-of-state hospital payments. In the absence of a contract with an out-of-state hospital that specifies payment rates, AHCCCS shall reimburse out-of-state hospitals for covered inpatient services by multiplying covered charges by the most recent state-wide urban cost-to-charge ratio as determined in R9-22-712.01(6)(d). In the absence of a contract with an out-of-state hospital that specifies payment rates, AHCCCS shall reimburse an out-of-state hospital for covered outpatient services by applying the methodology described in R9-22-712.10 through R9-22-712.50. If the outpatient procedure is not assigned a fee schedule amount, the Administration shall pay the claim by multiplying the covered charges for the outpatient services by the state-wide outpatient cost-to-charge ratio.
- C.** Access to records. Subcontracting and noncontracting providers of outpatient or inpatient hospital services shall allow the Administration access to medical records regarding eligible persons and shall in all other ways fully cooperate with the Administration or the Administration's designated representative in performance of the Administration's utilization control activities. The Administration shall deny a claim for failure to cooperate.
- D.** Prior authorization. The Administration or contractor may deny a claim if a provider fails to obtain prior authorization as required under R9-22-210.
- E.** Review of claims. Regardless of prior authorization or concurrent review activities, the Administration may subject all hospital claims, including outliers, to prepayment medical review or post-payment review, or both. The Administration shall conduct post-payment reviews consistent with A.R.S. § 36-2903.01 and may recoup erroneously paid claims. If prior authorization was given for a specific level of care but medical review of the claim indicates that a different level of care was appropriate, the Administration may adjust the claim to reflect the more appropriate level of care, effective on the date when the different level of care was medically appropriate.
- F.** Claim receipt.
1. The Administration's date of receipt of inpatient or outpatient hospital claims is the date the claim is received by the Administration as indicated by the date stamp on the claim and the system-generated claim reference number or system-generated date-specific number.
 2. Hospital claims are considered paid on the date indicated on disbursement checks.
 3. A denied claim is considered adjudicated on the date the claim is denied.
 4. Claims that are denied and are resubmitted are assigned new receipt dates.
 5. For a claim that is pending for additional supporting documentation specified in A.R.S. § 36-2903.01 or 36-2904, the Administration shall assign a new date of receipt upon receipt of the additional documentation.
 6. For a claim that is pending for documentation other than the minimum required documentation specified in either A.R.S. § 36-2903.01 or 36-2904, the Administration shall not assign a new date of receipt.
- G.** Outpatient hospital reimbursement. The Administration shall pay for covered outpatient hospital services provided to eligible persons with dates of service from March 1, 1993 through

June 30, 2005, at the AHCCCS outpatient hospital cost-to-charge ratio, multiplied by the amount of the covered charges.

1. Computation of outpatient hospital reimbursement. The Administration shall compute the cost-to-charge ratio on a hospital-specific basis by determining the covered charges and costs associated with treating eligible persons in an outpatient setting at each hospital. Outpatient operating and capital costs are included in the computation but outpatient medical education costs that are included in the inpatient medical education component are excluded. To calculate the outpatient hospital cost-to-charge ratio annually for each hospital, the Administration shall use each hospital's Medicare Cost Reports and a database consisting of outpatient hospital claims paid and encounters processed by the Administration for each hospital, subjecting both to the data requirements specified in R9-22-712.01. The Administration shall use the following methodology to establish the outpatient hospital cost-to-charge ratios:
 - a. Cost-to-charge ratios. The Administration shall calculate the costs of the claims and encounters for outpatient hospital services by multiplying the ancillary line item cost-to-charge ratios by the covered charges for corresponding revenue codes on the claims and encounters. Each hospital shall provide the Administration with information on how the revenue codes used by the hospital to categorize charges on claims and encounters correspond to the ancillary line items on the hospital's Medicare Cost Report. The Administration shall then compute the overall outpatient hospital cost-to-charge ratio for each hospital by taking the average of the ancillary line items cost-to-charge ratios for each revenue code weighted by the covered charges.
 - b. Cost-to-charge limit. To comply with 42 CFR 447.325, the Administration may limit cost-to-charge ratios to 1.00 for each ancillary line item from the Medicare Cost Report. The Administration shall remove ancillary line items that are non-covered or not applicable to outpatient hospital services from the Medicare Cost Report data for purposes of computing the overall outpatient hospital cost-to-charge ratio.
2. New hospitals. The Administration shall reimburse new hospitals at the weighted statewide average outpatient hospital cost-to-charge ratio multiplied by covered charges. The Administration shall continue to use the statewide average outpatient hospital cost-to-charge ratio for a new hospital until the Administration rebases the outpatient hospital cost-to-charge ratios and the new hospital has a Medicare Cost Report for the fiscal year being used in the rebasing.
3. Specialty outpatient services. The Administration may negotiate, at any time, reimbursement rates for outpatient hospital services in a specialty facility.
4. Reimbursement requirements. To receive payment from the Administration, a hospital shall submit claims that are legible, accurate, error free, and have a covered charge greater than zero. The Administration shall not reimburse hospitals for emergency room treatment, observation hours or days, or other outpatient hospital services performed on an outpatient basis, if the eligible person is admitted as an inpatient to the same hospital directly from the emergency room, observation area, or other outpatient department. Services provided in the emergency room, observation area, and other outpatient hospital services

provided before the hospital admission are included in the tiered per diem payment.

5. Rebasing. The Administration shall rebase the outpatient hospital cost-to-charge ratios at least every four years but no more than once a year using updated Medicare Cost Reports and claim and encounter data.
6. If a hospital files an increase in its charge master for an existing outpatient service provided on or after July 1, 2004, and on or before June 30, 2005, which represents an aggregate increase in charges of more than 4.7%, the Administration shall adjust the hospital-specific cost-to-charge ratio as calculated under subsection (G)(1) through (5) by applying the following formula:

$$CCR * [1.047 / (1 + \% \text{ increase})]$$

Where "CCR" means the hospital-specific cost-to-charge ratio as calculated under subsection (G)(1) through (5) and "% increase" means the aggregate percentage increase in charges for outpatient services shown on the hospital charge master.

"Charge master" means the schedule of rates and charges as described under A.R.S. § 36-436 and the rules that relate to those rates and charges that are filed with the Director of the Arizona Department of Health Services.

Historical Note

Adopted as an emergency effective February 23, 1983 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Adopted as a permanent rule effective May 16, 1983; text of adopted rule identical to emergency (Supp. 83-3). Former Section R9-22-712 repealed, new Section R9-22-712 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-712 renumbered and amended as Section R9-22-1001 effective October 1, 1985 (Supp. 85-5). New Section R9-22-712 adopted under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended effective January 14, 1997 (Supp. 97-1). Amended by exempt rulemaking at 10 A.A.R. 3831, effective August 25, 2004 (Supp. 04-3). Amended by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2). Amended by final rulemaking at 11 A.A.R. 3231, effective October 1, 2005 (Supp. 05-3). Amended by final rulemaking at 14 A.A.R. 1439, effective May 31, 2008 (Supp. 08-2). Amended by exempt rulemaking at 17 A.A.R. 1337, effective October 1, 2011 (Supp. 11-3). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3).

R9-22-712.01. Inpatient Hospital Reimbursement

Inpatient hospital reimbursement. The Administration shall pay for covered inpatient acute care hospital services provided to eligible persons with admissions on and after October 1, 1998, on a prospective reimbursement basis. The prospective rates represent payment in full, excluding quick-pay discounts, slow-pay penalties, and third-party payments for both accommodation and ancillary department services. The rates include reimbursement for operating and capital costs. The Administration shall make reimbursement for direct graduate medical education as described in A.R.S. § 36-2903.01. For payment purposes, the Administration shall classify each AHCCCS inpatient hospital day of care into one of several tiers appropriate to the services rendered. The rate for a tier is referred to as the tiered per diem rate of reimbursement. The number of tiers is seven and the maximum number of tiers payable per continuous stay is two. Payment of outlier claims, transplant

claims, or payment to out-of-state hospitals, freestanding psychiatric hospitals, and other specialty facilities may differ from the inpatient hospital tiered per diem rates of reimbursement described in this Section.

1. Tier rate data. The Administration shall base tiered per diem rates effective on and after October 1, 1998 on Medicare Cost Reports for Arizona hospitals for fiscal years ending in 1996 and a database consisting of inpatient hospital claims and encounters for dates of service matching each hospital's 1996 fiscal year end.
 - a. Medicare Cost Report data. Because Medicare Cost Report years are not standard among hospitals and were not audited at the time of the rate calculation, the Administration shall inflate all the costs to a common point in time as described in subsection (2) for each component of the tiered per diem rates. The Administration shall not make any changes to the tiered per diem rates if the Medicare Cost Report data are subsequently updated or adjusted. If a single Medicare Cost Report is filed for more than one hospital, the Administration shall allocate the costs to each of the respective hospitals. A hospital shall submit information to assist the Administration in this allocation.
 - b. Claim and encounter data. For the database, the Administration shall use only those inpatient hospital claims paid by the Administration and encounters that were accepted and processed by the Administration at the time the database was developed for rates effective on and after October 1, 1998. The Administration shall subject the claim and encounter data to a series of data quality, reasonableness, and integrity edits and shall exclude from the database or adjust claims and encounters that fail these edits. The Administration shall also exclude from the database the following claims and encounters:
 - i. Those missing information necessary for the rate calculation,
 - ii. Medicare crossovers,
 - iii. Those submitted by freestanding psychiatric hospitals, and
 - iv. Those for transplant services or any other hospital service that the Administration would pay on a basis other than the tiered per diem rate.
2. Tier rate components. The Administration shall establish inpatient hospital prospective tiered per diem rates based on the sum of the operating and capital components. The rate for the operating component is a statewide rate for each tier except for the NICU and Routine tiers, which are based on peer groups. The rate for the capital component is a blend of statewide and hospital-specific values, as described in A.R.S. § 36-2903.01. The Administration shall use the following methodologies to establish the rates for each of these components.
 - a. Operating component. Using the Medicare Cost Reports and the claim and encounter database, the Administration shall compute the rate for the operating component as follows:
 - i. Data preparation. The Administration shall identify and group into department categories, the Medicare Cost Report data that provide ancillary department cost-to-charge ratios and accommodation costs per day. To comply with 42 CFR 447.271, the Administration shall limit cost-to-charge ratios to 1.00 for each ancillary department.
 - ii. Operating cost calculation. To calculate the rate for the operating component, the Administration shall derive the operating costs from claims and encounters by combining the Medicare Cost Report data and the claim and encounter database for all hospitals. In performing this calculation, the Administration shall match the revenue codes on the claims and encounters to the departments in which the line items on the Medicare Cost Reports are grouped. The ancillary department cost-to-charge ratios for a particular hospital are multiplied by the covered ancillary department charges on each of the hospital's claims and encounters. The AHCCCS inpatient days of care on the particular hospital's claims and encounters are multiplied by the corresponding accommodation costs per day from the hospital's Medicare Cost Report. The ancillary cost-to-charge ratios and accommodation costs per day do not include medical education and capital costs. The Administration shall inflate the resulting operating costs for the claims and encounters of each hospital to a common point in time, December 31, 1996, using the DRI inflation factor and shall reduce the operating costs for the hospital by an audit adjustment factor based on available national data and Arizona historical experience in adjustments to Medicare reimbursable costs. The Administration shall further inflate operating costs to the midpoint of the rate year (March 31, 1999).
 - iii. Operating cost tier assignment. After calculating the operating costs, the Administration shall assign the claims and encounters used in the calculation to tiers based on diagnosis, procedure, or revenue codes, or NICU classification level, or a combination of these. For the NICU tier, the Administration shall further assign claims and encounters to NICU Level II or NICU Level III peer groups, based on the hospital's certification by the Arizona Perinatal Trust. For the Routine tier, the Administration shall further assign claims and encounters to the general acute care hospital or rehabilitation hospital peer groups, based on state licensure by the Department of Health Services. For claims and encounters assigned to more than one tier, the Administration shall allocate ancillary department costs to the tiers in the same proportion as the accommodation costs. Before calculating the rate for the operating component, the Administration shall identify and exclude any claims and encounters that are outliers as defined in subsection (6).
 - iv. Operating rate calculation. The Administration shall set the rate for the operating component for each tier by dividing total statewide or peer group hospital costs identified in this subsection within the tier by the total number of AHCCCS inpatient hospital days of care reflected in the claim and encounter database for that tier.
- b. Capital component. For rates effective October 1, 1999 the capital component is calculated as described in A.R.S. § 36-2903.01.

- c. Statewide inpatient hospital cost-to-charge ratio. For dates of service prior to October 1, 2007, the statewide inpatient hospital cost-to-charge ratio is used for payment of outliers, as described in subsections (4), (5), and (6), and out-of-state hospitals, as described in R9-22-712(B). The Administration shall calculate the AHCCCS statewide inpatient hospital cost-to-charge ratio by using the Medicare Cost Report data and claim and encounter database described in subsection (1) and used to determine the tiered per diem rates. For each hospital, the covered inpatient days of care on the claims and encounters are multiplied by the corresponding accommodation costs per day from the Medicare Cost Report. Similarly, the covered ancillary department charges on the claims and encounters are multiplied by the ancillary department cost-to-charge ratios. The accommodation costs per day and the ancillary department cost-to-charge ratios for each hospital are determined in the same way described in subsection (2)(a) but include costs for operating and capital. The Administration shall then calculate the statewide inpatient hospital cost-to-charge ratio by summing the covered accommodation costs and ancillary department costs from the claims and encounters for all hospitals and dividing by the sum of the total covered charges for these services for all hospitals.
- d. Unassigned tiered per diem rates. If a hospital has an insufficient number of claims to set a tiered per diem rate, the Administration shall pay that hospital the statewide average rate for that tier.
3. Tier assignment. The Administration shall assign AHCCCS inpatient hospital days of care to tiers based on information submitted on the inpatient hospital claim or encounter including diagnosis, procedure, or revenue codes, peer group, NICU classification level, or a combination of these.
 - a. Tier hierarchy. In assigning claims for AHCCCS inpatient hospital days of care to a tier, the Administration shall follow the Hierarchy for Tier Assignment in R9-22-712.09. The Administration shall not pay a claim for inpatient hospital services unless the claim meets medical review criteria and the definition of a clean claim. The Administration shall not pay for a hospital stay on the basis of more than two tiers, regardless of the number of interim claims that are submitted by the hospital.
 - b. Tier exclusions. The Administration shall not assign to a tier or pay AHCCCS inpatient hospital days of care that do not occur during a period when the person is eligible. Except in the case of death, the Administration shall pay claims in which the day of admission and the day of discharge are the same, termed a same day admit and discharge, including same day transfers, as an outpatient hospital claim. The Administration shall pay same day admit and discharge claims that qualify for either the maternity or nursery tiers based on the lesser of the rate for the maternity or nursery tier, or the outpatient hospital fee schedule.
 - c. Seven tiers. The seven tiers are:
 - i. Maternity. The Administration shall identify the Maternity Tier by a primary diagnosis code. If a claim has an appropriate primary diagnosis, the Administration shall pay the AHCCCS inpatient hospital days of care on the claim at the maternity tiered per diem rate.
 - ii. NICU. The Administration shall identify the NICU Tier by a revenue code. A hospital does not qualify for the NICU tiered per diem rate unless the hospital is classified as either a NICU Level II or NICU Level III perinatal center by the Arizona Perinatal Trust. The Administration shall pay AHCCCS inpatient hospital days of care on the claim that meet the medical review criteria for the NICU tier and have a NICU revenue code at the NICU tiered per diem rate. The Administration shall pay any remaining AHCCCS inpatient hospital day on the claim that does not meet NICU Level II or NICU Level III medical review criteria at the nursery tiered per diem rate.
 - iii. ICU. The Administration shall identify the ICU Tier by a revenue code. The Administration shall pay AHCCCS inpatient hospital days of care on the claim that meets the medical review criteria for the ICU tier and has an ICU revenue code at the ICU tiered per diem rate. The Administration may classify any AHCCCS inpatient hospital days on the claim without an ICU revenue code, as surgery, psychiatric, or routine tiers.
 - iv. Surgery. The Administration shall identify the Surgery Tier by a revenue code and a valid surgical procedure code that is not on the AHCCCS excluded surgical procedure list. The excluded surgical procedure list identifies minor procedures such as sutures that do not require the same hospital resources as other procedures. The Administration shall only split a surgery tier with an ICU tier. AHCCCS shall pay at the surgery tier rate only when the surgery occurs on a date during which the member is eligible.
 - v. Psychiatric. The Administration shall identify the Psychiatric Tier by either a psychiatric revenue code and a psychiatric diagnosis or any routine revenue code if all diagnosis codes on the claim are psychiatric. The Administration shall not split a claim with AHCCCS inpatient hospital days of care in the psychiatric tier with any tier other than the ICU tier.
 - vi. Nursery. The Administration shall identify the Nursery Tier by a revenue code. The Administration shall not split a claim with AHCCCS inpatient hospital days of care in the nursery tier with any tier other than the NICU tier.
 - vii. Routine. The Administration shall identify the Routine Tier by revenue codes. The routine tier includes AHCCCS inpatient hospital days of care that are not classified in another tier or paid under any other provision of this Section. The Administration shall not split the routine tier with any tier other than the ICU tier.
4. Annual update. The Administration shall annually update the inpatient hospital tiered per diem rates through September 30, 2011.
5. New hospitals. For rates effective on and after October 1, 1998, the Administration shall pay new hospitals the statewide average rate for each tier, as appropriate. The

Administration shall update new hospital tiered per diem rates through September 30, 2011.

6. Outliers. The Administration shall reimburse hospitals for AHCCCS inpatient hospital days of care identified as outliers under this Section by multiplying the covered charges on a claim by the Medicare Urban or Rural Cost-to-Charge Ratio. The Urban cost-to-charge ratio will be used for hospitals located in a county of 500,000 residents or more. The Rural cost-to-charge ratio will be used for hospitals located in a county of fewer than 500,000 residents.
 - a. Outlier criteria. For rates effective on and after October 1, 1998, the Administration set the statewide outlier cost threshold for each tier at the greater of three standard deviations from the statewide mean operating cost per day within the tier, or two standard deviations from the statewide mean operating cost per day across all the tiers. If the covered costs per day on a claim exceed the urban or rural cost threshold for a tier, the claim is considered an outlier. Outliers will be paid by multiplying the covered charges by the applicable Medicare Urban or Rural CCR. The resulting amount will be the outlier payment. If there are two tiers on a claim, the Administration shall determine whether the claim is an outlier by using a weighted threshold for the two tiers. The weighted threshold is calculated by multiplying each tier rate by the number of AHCCCS inpatient hospital days of care for that tier and dividing the product by the total tier days for that hospital. Routine maternity stays shall be excluded from outlier reimbursement. A routine maternity is any one-day stay with a delivery of one or two babies. A routine maternity stay will be paid at tier.
 - b. Update. The CCR is updated annually by the Administration for dates of service beginning October 1, using the most current Medicare cost-to-charge ratios published or placed on display by CMS by August 31 of that year. The Administration shall update the outlier cost thresholds for each hospital through September 30, 2011 as described under A.R.S. § 36-2903.01. For inpatient hospital admissions with begin dates of service on and after October 1, 2011, AHCCCS will increase the outlier cost thresholds by 5% of the thresholds that were effective on September 30, 2011.
 - c. Medicare Cost-to-Charge Ratio Phase-In. AHCCCS shall phase in the use of the Medicare Urban or Rural Cost-to-Charge Ratios for outlier determination, calculation and payment. The three-year phase-in does not apply to out-of-state or new hospitals.
 - i. Medicare Cost-to-Charge Ratio Phase-In outlier determination and threshold calculation. For outlier claims with dates of service on or after October 1, 2007 through September 30, 2008, AHCCCS shall adjust each hospital specific inpatient cost-to-charge ratio in effect on September 30, 2007 by subtracting one-third of the difference between the hospital specific inpatient cost-to-charge ratio and the effective Medicare Urban or Rural Cost-to-Charge Ratio. For outlier claims with dates of service on or after October 1, 2008 through September 30, 2009, AHCCCS shall adjust each hospital specific inpatient cost-to-charge ratio in effect on September 30, 2007 by subtracting two-thirds of the difference between the hospital specific inpatient cost-to-charge ratio and the effective Medicare Urban or Rural Cost-to-Charge Ratio. The adjusted hospital specific inpatient cost-to-charge ratios shall be used for all calculations using the Medicare Urban or Rural Cost-to-Charge Ratios, including outlier determination, and threshold calculation.
 - ii. Medicare Cost-to-Charge Ratio Phase-In calculation for payment. For payment of outlier claims with dates of service on or after October 1, 2007 through September 30, 2008, AHCCCS shall adjust the statewide inpatient hospital cost-to-charge ratio in effect on September 30, 2007 by subtracting one-third of the difference between the statewide inpatient hospital cost-to-charge ratio and the effective Medicare urban or rural cost-to-charge ratio. For payment of outlier claims with dates of service on or after October 1, 2008 through September 30, 2009, AHCCCS shall adjust the statewide inpatient hospital cost-to-charge ratio in effect on September 30, 2007 by subtracting two-thirds of the difference between the statewide inpatient hospital cost-to-charge ratio and the effective Medicare urban or rural cost-to-charge ratio.
 - iii. Medicare Cost-to-Charge Ratio for outlier determination, threshold calculation, and payment. For outlier claims with dates of service on or after October 1, 2009, the full Medicare Urban or Rural Cost-to-Charge Ratios shall be utilized for all outlier calculations.
 - d. Cost-to-Charge Ratio used for qualification and payment of outlier claims.
 - i. For qualification and payment of outlier claims with begin dates of service on or after April 1, 2011 through September 30, 2011, the CCR will be equal to 95% of the ratios in effect on October 1, 2010.
 - ii. For qualification and payment of outlier claims with begin dates of service on or after October 1, 2011, the CCR will be equal to 90.25% of the most recent published Urban or Rural Medicare CCR as described in subsection (6)(b).
 - iii. For qualification and payment of outlier claims with begin dates of service on or after October 1, 2011 through September 30, 2012, AHCCCS will reduce the cost-to-charge ratio determined under subsection (6)(d)(ii) for a hospital that filed a charge master with ADHS on or after April 1, 2011 by an additional percentage equal to the total percent increase reported on the charge master.
 - iv. Subject to approval by CMS, for qualification and payment of outlier claims with begin dates of service on or after October 1, 2012, AHCCCS will reduce the cost-to-charge ratio determined under subsection (6)(d)(ii) for a hospital that filed a charge master with ADHS on or after June 1, 2012 by an additional percentage equal to the total percent increase reported on the charge master.
7. Transplants. The Administration shall reimburse hospitals for an AHCCCS inpatient stay in which a covered transplant as described in R9-22-206 is performed

through the terms of the relevant contract. As described in R9-22-716, if the Administration and a hospital that performs transplant surgery on an eligible person do not have a contract for the transplant surgery, the Administration shall not reimburse the hospital more than what would have been paid to the contracted hospital for that same surgery.

8. Ownership change. The Administration shall not change any of the components of a hospital's tiered per diem rates upon an ownership change.
9. Psychiatric hospitals. The Administration shall pay free-standing psychiatric hospitals an all-inclusive per diem rate based on the contracted rates used by the Department of Health Services.
10. Specialty facilities. The Administration may negotiate, at any time, reimbursement rates for inpatient specialty facilities or inpatient hospital services not otherwise addressed in this Section as provided by A.R.S. § 36-2903.01. For purposes of this subsection, "specialty facility" means a facility where the service provided is limited to a specific population, such as rehabilitative services for children.
11. Outliers for new hospitals. Outliers for new hospitals will be calculated using the Medicare Urban or Rural Cost-to-Charge Ratio times covered charges. If the resulting cost is equal to or above the cost threshold, the claim will be paid at the Medicare Urban or Rural Cost-to-Charge ratio.
12. Reductions to tiered per diem payment for inpatient hospital services. Inpatient hospital admissions with begin dates of service on or after October 1, 2011, shall be reimbursed at 95 percent of the tiered per diem rates in effect on September 30, 2011.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 3231, effective October 1, 2005 (Supp. 05-3). Amended by exempt rulemaking at 13 A.A.R. 3190, effective October 1, 2007 (Supp. 07-3). Amended by exempt rulemaking at 17 A.A.R. 1337, effective October 1, 2011 (Supp. 11-3). Amended by exempt rulemaking at 18 A.A.R. 1914, effective July 18, 2012 (Supp. 12-3).

R9-22-712.02. Reserved

R9-22-712.03. Reserved

R9-22-712.04. Reserved

R9-22-712.05. Graduate Medical Education Fund Allocation

- A. Graduate medical education (GME) reimbursement as of September 30, 1997. Subject to legislative appropriation, the Administration shall make a distribution based on direct graduate medical education costs as described in A.R.S. § 36-2903.01(H)(9)(a).
- B. Subject to available funds and approval by CMS, the Administration shall annually distribute monies appropriated for the expansions of GME programs approved by the Administration to hospitals for direct program costs eligible for funding under A.R.S. § 36-2903.01(H)(9)(b). A GME program is deemed to be established as of the date of its original accreditation. All determinations that are necessary to make distributions described by this subsection shall be made using information possessed by the Administration as of the date of reporting under subsection (B)(3).
 1. Eligible health care facilities. A health care facility is eligible for distributions under subsection (B) if all of the following apply:
 - a. It is a hospital in Arizona that is the sponsoring institution of, or a participating institution in, one or more of the GME programs in Arizona;
 - b. It incurs direct costs for the training of residents in the GME programs, which costs are or will be reported on the hospital's Medicare Cost Report;
 - c. It is not administered by or does not receive its primary funding from an agency of the federal government.

2. Eligible resident positions. For purposes of determining program allocation amounts under subsection (B)(4) the following resident positions are eligible for consideration to the extent that the resident training takes place in Arizona and not at a health care facility made ineligible under subsection (B)(1)(c):
 - a. Filled resident positions in approved programs established as of October 1, 1999 at hospitals that receive funding as described in A.R.S. § 36-2903.01(H)(9)(a) that are additional to the number of resident positions that were filled as of October 1, 1999; and
 - b. All filled resident positions in approved programs other than GME programs described in A.R.S. § 36-2903.01(H)(9)(a) that were established before July 1, 2006.
3. Annual reporting. By April 1st of each year, each GME program and each hospital seeking a distribution under subsection (B) shall provide the applicable information listed in this subsection to the Administration:
 - a. A GME program shall provide all of the following:
 - i. The program name and number assigned by the accrediting organization;
 - ii. The original date of accreditation;
 - iii. The names of the sponsoring institution and all participating institutions current as of the date of reporting;
 - iv. The number of approved resident positions and the number of filled resident positions current as of the date of reporting;
 - v. For programs established as of October 1, 1999, the number of resident positions that were filled as of October 1, 1999, if the program has not already provided this information to the Administration;
 - b. A hospital seeking a distribution under subsection (B) shall provide all of the following that apply:
 - i. If the hospital uses the Intern and Resident Information System (IRIS) for tracking and reporting its resident activity to the fiscal intermediary, copies of the IRIS master and assignment files for the hospital's two most recently completed Medicare cost reporting years as filed with the fiscal intermediary;
 - ii. If the hospital does not use the IRIS or has less than two cost reporting years available in the form of the IRIS master and assignment files, the information normally contained in the IRIS master and assignment files in an alternative format for the hospital's two most recently completed Medicare cost reporting years;
 - iii. At the request of the Administration, a copy of the hospital's Medicare Cost Report or any part of the report for the most recently completed cost reporting year.

4. Allocation of expansion funds. Annually the Administration shall allocate available funds to each approved GME program in the following manner:
 - a. Information provided by hospitals under subsection (B)(3)(b) shall be used to determine the program in which each eligible resident is enrolled and the number of days that each eligible resident worked in any area of the hospital complex or in a non-hospital setting under agreement with the reporting hospital during the period of assignment to that hospital. For this purpose, the Administration shall use data relating to the most recent 12-month period that is common to all information provided under subsections (B)(3)(b)(i) and (ii).
 - b. The number of eligible residents allocated to each participating institution within each approved GME program shall be determined as follows:
 - i. Total the number of days determined for each participating institution under subsection (B)(4)(a) and divide each total by 365.
 - ii. Proportionally adjust the result of subsection (B)(4)(b)(i) for each participating institution within each program according to the number of residents determined to be eligible under subsection (B)(2).
 - c. The number of allocated eligible residents determined under subsection (B)(4)(b)(ii) shall be adjusted for Arizona Medicaid utilization using the most recent Medicare Cost Report information on file with the Administration as of the date of reporting under subsection (B)(3) and the Administration's inpatient hospital claims and encounter data for the time period corresponding to the Medicare Cost Report information for each hospital. The Administration shall use only those inpatient hospital claims paid by the Administration and encounters that were adjudicated by the Administration as of the date of reporting under subsection (B)(3). The Medicaid-adjusted eligible residents shall be determined as follows:
 - i. For each hospital, the total AHCCCS inpatient hospital days of care shall be divided by the total Medicare Cost Report inpatient hospital days, multiplied by 100 and rounded up to the nearest multiple of 5 percent.
 - ii. The number of allocated eligible residents determined for each participating hospital under subsection (B)(4)(b)(ii) shall be multiplied by the percentage derived under subsection (B)(4)(c)(i) for that hospital. The number of allocated eligible residents determined under subsection (B)(4)(b)(ii) for a participating institution that is not a hospital and not a health care facility made ineligible under subsection (B)(1)(c) shall be multiplied by the percentage derived under subsection (B)(4)(c)(i) for the program's sponsoring institution or, if the sponsoring institution is not a hospital, the sponsoring institution's affiliated hospital. The number of allocated eligible residents determined under subsection (B)(4)(b)(ii) for a participating institution that is made ineligible under subsection (B)(1)(c) shall be multiplied by zero percent.
 - d. The total allocation for each approved program shall be determined by multiplying the Medicaid-adjusted eligible residents determined under subsection (B)(4)(c)(ii) by the per resident conversion factor determined below and totaling the resulting dollar amounts for all participating institutions in the program. The per resident conversion factor shall be determined as follows:
 - i. Calculate the total direct GME costs from the most recent Medicare Cost Reports on file with the Administration for all hospitals that have reported such costs.
 - ii. Calculate the total allocated residents determined under subsection (B)(4)(b)(i) for those hospitals described under subsection (B)(4)(d)(i).
 - iii. Divide the total GME costs calculated under subsection (B)(4)(d)(i) by the total allocated residents calculated under subsection (B)(4)(d)(ii).
5. Distribution of expansion funds. On an annual basis subject to available funds, the Administration shall distribute the allocated amounts determined under subsection (B)(4) in the following manner:
 - a. The allocated amounts shall be distributed in the following order of priority:
 - i. To eligible hospitals that do not receive funding in accordance with A.R.S. § 36-2903.01(H)(9)(a) for the direct costs of programs established before July 1, 2006;
 - ii. To eligible hospitals that receive funding in accordance with A.R.S. § 36-2903.01(H)(9)(a) for the direct costs of programs established before July 1, 2006;
 - b. The allocated amounts shall be distributed to the eligible hospitals in each approved program in proportion to the number of Medicaid-adjusted eligible residents allocated to each hospital within that program under subsection (B)(4)(c)(ii).
 - c. If funds are insufficient to cover all distributions within any priority group described under subsection (B)(5)(a), the Administration shall adjust the distributions proportionally within that priority group.
- C. Subject to available funds and approval by CMS, the Administration shall annually distribute monies appropriated for the expansions of GME programs approved by the Administration to hospitals for direct program costs eligible for funding under A.R.S. § 36-2903.01(H)(9)(c)(i). A GME program is deemed to be established as of the date of its original accreditation. All determinations that are necessary to make distributions described by this subsection shall be made using information possessed by the Administration as of the date of reporting under subsection (C)(3).
 1. Eligible health care facilities. A health care facility is eligible for distributions under subsection (C) if it meets all the conditions of subsections (B)(1)(a) through (c).
 2. Eligible resident positions. For purposes of determining program allocation amounts under subsection (C)(4), the following resident positions are eligible for consideration to the extent that the resident training takes place in Arizona and not at a health care facility made ineligible under subsection (B)(1)(c):
 - a. All filled resident positions in approved programs established on or after July 1, 2006; and
 - b. For approved programs established on or after July 1, 2006 that have been established for less than one year as of the date of reporting under subsection (C)(3) and have not yet filled their first-year resident positions, all prospective residents reasonably

- expected by the program to be enrolled as a result of the most recently completed annual resident match.
3. Annual reporting. By April 1st of each year, each GME program and each hospital seeking a distribution under subsection (C) shall provide to the Administration:
 - a. A GME program shall provide all of the following:
 - i. The requirements of subsections (B)(3)(a)(i) through (iv);
 - ii. The academic year rotation schedule on file with the program current as of the date of reporting; and
 - iii. For programs described under subsection (C)(2)(b), the number of residents expected to be enrolled as a result of the most recently completed annual resident match.
 - b. A hospital seeking a distribution under subsection (C) shall provide the requirements of subsection (B)(3)(b).
 4. Allocation of expansion funds. Annually the Administration shall allocate available funds to approved GME programs in the following manner:
 - a. Information provided by hospitals in accordance with subsection (B)(3)(b) shall be used to determine the program in which each eligible resident is enrolled and the number of days that each eligible resident worked in any area of the hospital complex or in a non-hospital setting under agreement with the reporting hospital during the period of assignment to that hospital. For this purpose, the Administration shall use data relating to the most recent 12-month period that is common to all information provided in accordance with subsections (B)(3)(b)(i) and (ii).
 - b. For approved programs whose resident activity is not represented in the information provided in accordance with subsection (B)(3)(b), information provided by GME programs under subsection (C)(3)(a) shall be used to determine the number of days that each eligible resident is expected to work at each participating institution.
 - c. The number of eligible residents allocated to each participating institution for each approved GME program shall be determined by totaling the number of days determined under subsections (C)(4)(a) and (b) and dividing the totals by 365.
 - d. The number of allocated residents determined under subsection (C)(4)(c) shall be adjusted for Arizona Medicaid utilization in accordance with subsection (B)(4)(c).
 - e. The total allocation for each approved program shall be determined in accordance with subsection (B)(4)(d).
 5. Distribution of expansion funds. On an annual basis subject to available funds, the Administration shall distribute the allocated amounts determined under subsection (C)(4) to the eligible hospitals in each approved program in proportion to the number of Medicaid-adjusted eligible residents allocated to each within that program under subsection (C)(4)(d).
- D.** Subject to available funds and approval by CMS, the Administration shall annually distribute monies appropriated for GME programs approved by the Administration to hospitals for indirect program costs eligible for funding under A.R.S. § 36-2903.01(H)(9)(c)(ii). A GME program is deemed to be established as of the date of its original accreditation. All determinations that are necessary to make distributions described by this subsection shall be made using information possessed by the Administration as of the date of reporting under subsection (D)(3).
1. Eligible health care facilities. A health care facility is eligible for distributions under subsection (D) if all of the following apply:
 - a. It is a hospital in Arizona that is the sponsoring institution of one or more of the GME programs in Arizona or the base hospital for one or more of the GME programs in Arizona whose sponsoring institutions are not hospitals;
 - b. It incurs indirect program costs for the training of residents in the GME programs;
 - c. It is not administered by or does not receive its primary funding from an agency of the federal government.
 2. Eligible resident positions. For purposes of determining program allocation amounts under subsection (D)(4) the following resident positions are eligible for consideration to the extent that the resident training takes place in Arizona and not at a health care facility made ineligible under subsection (D)(1)(c):
 - a. Any filled resident position in an approved program that includes a rotation of at least one month per year in a county other than Maricopa or Pima whose population was less than 500,000 persons at the time the residency rotation was added to the academic year rotation schedule;
 - b. For approved programs that have been established for less than one year as of the date of reporting under subsection (D)(3) and have not yet filled their first-year resident positions, all prospective residents reasonably expected by the program to be enrolled as a result of the most recently completed annual resident match who will perform rotations of at least one month per year in a county other than Maricopa or Pima whose population was less than 500,000 persons at the time the residency rotation was added to the academic year rotation schedule.
 3. Annual reporting. By April 1st of each year, each GME program and each hospital seeking a distribution under subsection (D) shall provide to the Administration:
 - a. A GME program shall provide all of the following:
 - i. The requirements of subsections (B)(3)(a)(i) through (iv);
 - ii. The academic year rotation schedule on file with the program current as of the date of reporting;
 - iii. For programs described under subsection (D)(2)(c), the number of residents expected to be enrolled as a result of the most recently completed annual resident match.
 - b. A hospital seeking a distribution under subsection (D) shall provide the requirements of subsection (B)(3)(b)(iii).
 4. Allocation of funds for indirect program costs. Annually the Administration shall allocate available funds to approved GME programs in the following manner:
 - a. Using the information provided by programs under subsection (D)(3), the Administration shall determine for each program the number of residents in the program who are eligible under subsection (D)(2) and the number of months per year that each eligible resident will perform rotations in counties described by subsection (D)(2), multiply the number of eligible residents by the number of months and multiply the result by the per resident per month

conversion factor determined under subsection (D)(4)(b).

- b. Using the most recent Medicare Cost Reports on file with the Administration for all hospitals that have calculated a Medicare indirect medical education payment, the Administration shall determine a per resident per month conversion factor as follows:

- i. Calculate each hospital's Medicaid share by dividing the AHCCCS inpatient hospital days of care by the total inpatient hospital days from the Medicare Cost Report. For this purpose, the Administration shall use the information described by subsection (B)(4)(c) for adjusting allocated residents for Arizona Medicaid utilization.
- ii. Calculate each hospital's Medicare share by dividing the Medicare inpatient days on the Medicare Cost Report by the total inpatient hospital days on the Medicare Cost Report.
- iii. Divide the Medicaid share by the Medicare share and multiply the resulting ratio by the indirect medical education payment calculated on the Medicare Cost Report.
- iv. Total the results for all hospitals, divide the result by the total allocated residents determined under subsection (B)(4)(b)(i) for these hospitals, and divide that result by 12.

5. Distribution of funds for indirect program costs. On an annual basis subject to available funds, the Administration shall distribute the allocated amounts determined under subsection (D)(4) to the program's sponsoring hospital or the program's base hospital if the sponsoring institution is not a hospital, up to but not exceeding:

- a. The amount calculated for the hospital at subsection (D)(4)(b)(iii), or
- b. The median of all amounts calculated at subsection (D)(4)(b)(iii) if no amount was calculated for the hospital.

- E. Reallocation of funds. If funds appropriated for subsection (B) are not allocated by the Administration and funds appropriated for subsections (C) and (D) are insufficient to cover all distributions under subsections (C)(5) and (D)(5), the funds not allocated under subsection (B) shall be allocated under subsections (C) and (D) to the extent of the calculated distributions. If funds are insufficient to cover all distributions under subsections (C)(5) and (D)(5), the Administration shall adjust the distributions proportionally. If funds appropriated for subsections (C) and (D) are not allocated by the Administration and funds appropriated for subsection (B) are insufficient to cover all distributions under subsection (B)(5), the funds not allocated under subsections (C) and (D) shall be allocated under subsection (B) to the extent of the calculated distributions.

- F. The Administration may enter into intergovernmental agreements with local, county, and tribal governments wherein local, county and tribal governments may transfer funds or certify public expenditures to the Administration. Such funds or certification, subject to approval by CMS, will be used to qualify for additional federal funds. Those funds will be used for the purposes of reimbursing hospitals specified by the local, county, or tribal government for indirect program costs other than those reimbursed under subsection (D). Funds transferred and available under this subsection shall be distributed in accordance with subsection (D) except that reimbursement with such funds is not limited to resident positions or rotations in counties with populations of less than 500,000 persons.

Historical Note

New Section made by final rulemaking at 13 A.A.R. 1782, effective June 30, 2007 (Supp. 07-2). Amended by exempt rulemaking at 13 A.A.R. 4032, effective November 1, 2007 (Supp. 07-4).

R9-22-712.06. Reserved

R9-22-712.07. Rural Hospital Inpatient Fund Allocation

- A. For purposes of this Section, the following words and phrases have the following meanings unless the context specifically requires another meaning:

1. "Calculated inpatient costs" means the sum of inpatient covered charges multiplied by the Milliman study's implied cost-to-charge ratio of .8959.
2. "Claims paid amount" means the sum of all claims paid by the Administration and contractors, as reported by the contractor to the Administration, to a rural hospital for covered inpatient services rendered during the previous state fiscal year.
3. "Fund" means any state funds appropriated by the Legislature for the purposes set forth in A.R.S. § 36-2905.02 and any federal funds that are available for matching the state funds.
4. "Inpatient covered charges" means the sum of all covered charges billed by a hospital to the Administration or contractors, as reported by the contractors to the Administration, for inpatient services rendered during the previous state fiscal year.
5. "Milliman study" means the report issued by Milliman USA on March 11, 2004, to the Arizona Hospital and Healthcare Association that updated a portion of a cost study entitled "Evaluation of the AHCCCS Inpatient Hospital Reimbursement System" prepared by Milliman USA for AHCCCS on November 15, 2002. A copy of each report is on file with the Administration.
6. "Rural hospital" means a health care institution that is licensed as a hospital by the Arizona Department of Health Services for the previous state fiscal year and is not a hospital operated by IHS or a special hospital that limits the care provided to rehabilitation service and:
 - a. Has 100 or fewer beds and is located in a county with a population of less than 500,000 persons, or
 - b. Is designated as a critical access hospital for the majority of the previous state fiscal year.
7. "Total inpatient payments" means the sum of:
 - a. The claims paid amount,
 - b. Any disproportionate share hospital payments for the previous fiscal year, and
 - c. The inpatient component of any Critical Access Hospital payments made to the hospital for the previous state fiscal year.

- B. Each February, the Administration shall allocate the Fund to the following three pools for the fiscal year:

1. Rural hospitals with fewer than 26 PPS beds and all Critical Access Hospitals, regardless of the number of beds in the Critical Access Hospital;
2. Rural hospitals other than Critical Access Hospitals with 26 to 75 PPS beds; and
3. Rural hospitals other than Critical Access Hospitals with 76 to 100 PPS beds.

- C. The Administration shall allocate the Fund to each pool according to the ratio of total inpatient payments to all hospitals assigned to the pool to total inpatient payments to all rural hospitals.

- D. The Administration shall determine each hospital's claims paid amount and allocate the funds in each pool to each hospi-

tal in the pool based on the ratio of each hospital's claims paid amount to the sum of the claims paid amount for all hospitals assigned to the pool.

- E.** The Administration shall not make a Fund payment to a hospital that will result in the hospital's total inpatient payments plus that hospital's Fund payment being greater than that hospital's calculated inpatient costs.
1. If a hospital's total inpatient payments plus the hospital's Fund payment would be greater than the hospital's calculated inpatient costs, the Administration shall make a Fund payment to the hospital equal to the difference between the hospital's calculated inpatient costs and the hospital's total inpatient payments.
 2. The Administration shall reallocate any portion of a hospital's Fund allocation that is not paid to the hospital due to the reason in subsection (E)(1) to the other eligible hospitals in the pool based upon the ratio of the claims

paid amount for each hospital remaining in the pool to the sum of the claims paid amount for each hospital remaining in the pool.

- F.** If funds remain in a pool after allocations to each hospital in the pool under subsections (D) and (E), the Administration shall reallocate the remaining funds to the other pools based upon the ratio of each pool's original allocation of the Fund as determined under subsection (C) to the sum of the remaining pools' original Fund allocations under subsection (C). The Administration shall allocate remaining funds to the hospitals in the remaining pools under subsection (D) and (E). See Exhibit 1 for an example.
- G.** Subject to CMS approval of the method and distribution of the Fund, the administration or its contractors will distribute the Fund as a lump sum allocation to the rural hospitals in either one or two installments by the end of each state fiscal year.

Exhibit 1. Pool Example

Pool A receives \$2,000,000. Pool B receives \$7,000,000. Pool C receives \$3,000,000.

If all of the funds in Pool B are paid to eligible hospitals and there is \$1,000,000 remaining, the remaining funds would be allocated to Pool A and Pool C based on the ratio of each pool's original allocation (original allocations of \$2,000,000 and \$3,000,000) to the total of their original allocation (\$2,000,000 + \$3,000,000 = \$5,000,000).

Pool A would receive 2/5 of the remaining funds (\$400,000) and Pool C would receive 3/5 of the remaining funds (\$600,000).

Historical Note

New Section made by final rulemaking at 12 A.A.R. 2188, effective June 6, 2006 (Supp. 06-2).

R9-22-712.08. Reserved

R9-22-712.09. Hierarchy for Tier Assignment

TIER	IDENTIFICATION CRITERIA	ALLOWED SPLITS
MATERNITY	A primary diagnosis defined as maternity 640.xx - 643.xx, 644.2x - 676.xx, v22.xx - v24.xx or v27.xx.	None
NICU	Revenue Code of 174 and the provider has a Level II or Level III NICU.	Nursery
ICU	Revenue Codes of 200-204, 207-212, or 219.	Surgery Psychiatric Routine
SURGERY	Surgery is identified by a revenue code of 36x. To qualify in this tier, there must be a valid surgical procedure code that is not on the excluded procedure list.	ICU
PSYCHIATRIC	Psychiatric Revenue Codes of 114, 124, 134, 144, or 154 AND primary Psychiatric Diagnosis = 290.xx - 316.xx. If a routine revenue code is present and all diagnoses codes on the claim are equal to 290.xx - 316.xx, classify as a psychiatric claim.	ICU
NURSERY	Revenue Code of 17x, not equal to 174.	NICU
ROUTINE	Revenue Codes of 100 - 101, 110-113, 116 - 123, 126 - 133, 136 - 143, 146 - 153, 156 - 159, 16x, 206, 213, or 214.	ICU

Historical Note

New Section made by final rulemaking at 11 A.A.R. 3231, effective October 1, 2005 (Supp. 05-3). Amended by exempt rulemaking at 17 A.A.R. 1707, effective October 1, 2011 (Supp. 11-3).

R9-22-712.10. Outpatient Hospital Reimbursement: General

- A.** Effective rule. The outpatient hospital reimbursement rules apply to dates of service beginning July 1, 2005, subject to Laws 2004, Ch. 279, § 19.
- B.** Basis For Payment. Except as provided under R9-22-712.30, AHCCCS shall pay for designated outpatient procedures provided to AHCCCS members according to the AHCCCS Outpatient Capped Fee-For-Service Schedule as defined in R9-22-712.20.
- C.** Data. AHCCCS shall use Medicare Cost Report and adjudicated claim and encounter data from non-IHS acute care hospitals located in the state of Arizona to develop fees for the AHCCCS Outpatient Capped Fee-For-Service Schedule.
- D.** Hospital Services Subject To Fees. AHCCCS shall reimburse services, in the following outpatient hospital categories under the AHCCCS Outpatient Capped Fee-For-Service Schedule:
1. Surgery,
 2. Emergency Department,
 3. Laboratory,
 4. Radiology,
 5. Clinic, and
 6. Other services.
- E.** Reimbursement. AHCCCS shall reimburse outpatient hospital services by procedure codes, in proper combination with revenue codes, as prescribed by AHCCCS.

Historical Note

New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2).

R9-22-712.11. Reserved**R9-22-712.12. Reserved****R9-22-712.13. Reserved****R9-22-712.14. Reserved****R9-22-712.15. Outpatient Hospital Reimbursement: Affected Hospitals**

Except as provided in R9-22-712(G), the AHCCCS Outpatient Capped Fee-For-Service Schedule shall apply to AHCCCS payments for outpatient services in all non-IHS acute hospitals.

Historical Note

New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2).

R9-22-712.16. Reserved**R9-22-712.17. Reserved****R9-22-712.18. Reserved****R9-22-712.19. Reserved****R9-22-712.20. Outpatient Hospital Reimbursement: Methodology for the AHCCCS Outpatient Capped Fee-For-Service Schedule**

A. To establish the AHCCCS Outpatient Capped Fee-for-service Schedule for all claims with a begin date of service on or before September 30, 2011, AHCCCS shall:

1. Define the dataset of claims and encounters that shall be used to establish the AHCCCS Outpatient Capped Fee-for-service Schedule.
2. Identify all the claims and encounters from non-IHS acute hospitals located in Arizona for services to be paid under the AHCCCS Outpatient Capped Fee-for-service Schedule.
3. Match the revenue code on each detail of each claim and encounter to the ancillary line item CCR as reported on hospital-specific mapping documents and hospital-specific Medicare Cost Report for those hospitals that have submitted Medicare Cost Reports FYE 2002.
4. Multiply the line item CCR from subsection (A)(3) by the covered billed charge for that revenue code to establish the cost for the service.
5. Inflate the cost for the service from subsection (A)(4) using Global Insight Health-care Cost Review inflation factors from date of service month to the midpoint of the rate year in which the fees are initially effective.
6. Include associated costs under R9-22-712.25 to calculate the rates for emergency room and surgery services.
7. Combine data from all Arizona hospitals identified in subsection (A)(3) for each procedure code to establish the statewide median cost for each procedure.
8. Group procedure codes according to the Ambulatory Payment Classification (APC) System groups as listed in 69 FR 65682, November 15, 2004, and establish a statewide median cost for each APC. Multiply each statewide median APC cost by 116 percent to establish the AHCCCS-based fee for each procedure in that specific APC group. AHCCCS shall assign each procedure in the group the same fee.
9. For those procedure codes that are not grouped into any APC, establish a procedure-specific fee using either:
 - a. The AHCCCS Non-hospital Capped Fee-for-service Fee Schedule,
 - b. 116 percent of the procedure-specific median cost AHCCCS-based fee, or

c. The Medicare Clinical Laboratory Fee Schedule for laboratory services.

10. Compare the AHCCCS-based fee established in subsections (A)(8) and (9) against the comparable Medicare fee established for the Medicare APC group as listed in the 69 FR 65682, November 15, 2004. The fee for each procedure shall be the greater of the AHCCCS-based fee or the Medicare fee but no more than 150 percent of the AHCCCS-based fee; however, for those laboratory services for which a limit is established in the Medicare Clinical Laboratory Fee Schedule, the fee shall not exceed that limit.
 11. Assign the 2005 Medicare fee in the AHCCCS Outpatient Capped Fee-for-service Schedule for those procedures for which there are fewer than 20 occurrences of the procedure code in the dataset, either independently, or, if applicable, for all procedure codes within an APC Group.
- B. For all claims with a begin date of service on or after October 1, 2011, the AHCCCS Outpatient Capped Fee-for-service Schedule shall be derived from the CMS Medicare Outpatient Prospective Payment System (OPPS) fee schedule modified by an Arizona conversion factor determined annually.
1. When clinic services are billed using 51X revenue codes, the reimbursement to the hospital is the difference between the facility and non-facility rates payable to the practitioner for the procedures listed in the Administration's Capped Fee-for-service Schedule under R9-22-710.
 2. Observation services, when not billed in conjunction with a service for which a single payment is made under R9-22-712.25, are reimbursed at an hourly rate published in the Outpatient Capped Fee-for-service Schedule. This hourly rate includes reimbursement for associated services.
- C. The AHCCCS Outpatient Capped Fee-for-service Schedule including the effective date of any changes to the listing are on file and posted on AHCCCS' web site.

Historical Note

New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2). Amended by final rulemaking at 17 A.A.R. 1460, effective October 1, 2011 (Supp. 11-3). Amended by exempt rulemaking at 18 A.A.R. 1914, effective July 18, 2012 (Supp. 12-3).

R9-22-712.21. Reserved**R9-22-712.22. Reserved****R9-22-712.23. Reserved****R9-22-712.24. Reserved****R9-22-712.25. Outpatient Hospital Fee Schedule Calculations: Associated Service Costs**

- A. AHCCCS shall include the costs of associated services, as defined by revenue codes and procedure codes, when determining the specific fees for the outpatient hospital procedures for emergency department and surgery services.
- B. Payment made under subsection (A) or R9-22-712.20(B)(2) is inclusive of all services on the claim regardless of whether the services are provided on one or more days.
- C. A complete listing of the revenue codes and procedure codes for associated costs included in the payment for emergency and surgery services including the effective date of any changes to the listing are on file and posted on AHCCCS' web site.

Historical Note

New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2). Amended by final rulemaking at 17 A.A.R. 1460, effective October 1, 2011 (Supp. 11-3).

R9-22-712.26. Reserved**R9-22-712.27. Reserved****R9-22-712.28. Reserved****R9-22-712.29. Reserved****R9-22-712.30. Outpatient Hospital Reimbursement: Payment for a Service Not Listed in the AHCCCS Outpatient Capped Fee-for-service Schedule**

- A. AHCCCS shall calculate a statewide CCR for a service where a specific fee cannot be determined under R9-22-712.20.
- B. For claims with a begin date of service on or before September 30, 2011, the statewide CCR shall be calculated based on the costs and covered charges associated with a service under subsection (A) for all Arizona hospitals, using the method specified in R9-22-712.20(A)(3).
- C. For all claims with a begin date of service on or after October 1, 2011, the statewide CCR calculation shall equal either the CMS Medicare Outpatient Urban Cost-to-charge Ratio or the CMS Medicare Outpatient Rural Cost-to-charge Ratio published by CMS for the state of Arizona. AHCCCS shall use the urban cost-to-charge ratio for hospitals located in a county of 500,000 residents or more and for out-of-state hospitals. AHCCCS shall use the rural cost-to-charge ratio for hospitals located in a county of fewer than 500,000 residents. On October 1st of each year, AHCCCS shall adjust urban and rural CCRs to the CCRs as published by CMS in the *Federal Register* on or before August 1st of that year.
- D. To determine the payment amount for procedures where a specific fee is not determined under R9-22-712.20, the statewide CCR is multiplied by the covered charges.
- E. Reductions to payments for outpatient hospital services not listed in the AHCCCS Outpatient Capped Fee-For-Service Schedule. Outpatient hospital services not listed in the AHCCCS Outpatient Capped Fee-For-Service Schedule with dates of service on or after October 1, 2011, shall be reimbursed at 95 percent of the rate published by CMS pursuant to subsection (C) of this Section.

Historical Note

New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2). Amended by final rulemaking at 17 A.A.R. 1460, effective October 1, 2011 (Supp. 11-3). Amended by exempt rulemaking at 18 A.A.R. 1914, effective July 18, 2012 (Supp. 12-3).

R9-22-712.31. Reserved**R9-22-712.32. Reserved****R9-22-712.33. Reserved****R9-22-712.34. Reserved****R9-22-712.35. Outpatient Hospital Reimbursement: Adjustments to Fees**

- A. For all claims with a begin date of service on or before September 30, 2011, AHCCCS shall increase the Outpatient Capped Fee-for-service Schedule established under R9-22-712.20 (except for laboratory services and out-of-state hospital services) for the following hospitals submitting any claims:
 1. By 48 percent for public hospitals on July 1, 2005, and hospitals that were public anytime during the calendar year 2004;

2. By 45 percent for hospitals in counties other than Maricopa and Pima with more than 100 Medicare PPS beds during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective;
 3. By 50 percent for hospitals in counties other than Maricopa and Pima with 100 or less Medicare PPS beds during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective;
 4. By 115 percent for hospitals designated as Critical Access Hospitals or hospitals that have not been designated as Critical Access Hospitals but meet the criteria during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective;
 5. By 113 percent for a Freestanding Children's Hospital with at least 110 pediatric beds during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective; or
 6. By 14 percent for a University Affiliated Hospital which is a hospital that has a majority of the members of its board of directors appointed by the Board of Regents during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective.
- B. For all claims with a begin date of service on or after October 1, 2011, AHCCCS shall increase the Outpatient Capped Fee-for-service Schedule (except for laboratory services, and out-of-state hospital services) for the following hospitals. A hospital shall receive an increase from only one of the following categories:
 1. By 73 percent for public hospitals;
 2. By 31 percent for hospitals in counties other than Maricopa and Pima with more than 100 licensed beds as of October 1 of that contract year;
 3. By 37 percent for hospitals in counties other than Maricopa and Pima with 100 or fewer licensed beds as of October 1 of that contract year;
 4. By 100 percent for hospitals designated as Critical Access Hospitals or hospitals that have not been designated as Critical Access Hospitals but meet the critical access criteria;
 5. By 78 percent for a Freestanding Children's Hospital with at least 110 pediatric beds as of October 1 of that contract year; or
 6. By 41 percent for a University Affiliated Hospital, which is a hospital that has a majority of the members of its board of directors appointed by the Arizona Board of Regents.
 - C. In addition to subsections (A) and (B), an Arizona Level 1 trauma center as defined by R9-22-2101 shall receive a 50 percent increase to the Outpatient Capped Fee-for-service Schedule (except for laboratory services and out-of-state hospital services) for Level 2 and 3 emergency department procedures.
 - D. Hospitals with greater than 100 pediatric beds not receiving an increase under subsection (B) shall receive an 18 percent increase to the Outpatient Capped Fee-for-service Schedule (except for laboratory services, and out-of-state hospital services).
 - E. Fee adjustments made under subsection (A), (B), (C) and (D) are on file with AHCCCS and current adjustments are posted on AHCCCS' web site.

Historical Note

New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2). Amended by final rulemaking at 13 A.A.R. 3584, effective October 1, 2007 (Supp. 07-4). Amended by final rulemaking at 14 A.A.R. 1439, effective May 31, 2008 (Supp. 08-2).

Amended by final rulemaking at 17 A.A.R. 1460, effective October 1, 2011 (Supp. 11-3).

R9-22-712.36. Reserved

R9-22-712.37. Reserved

R9-22-712.38. Reserved

R9-22-712.39. Reserved

R9-22-712.40. Outpatient Hospital Reimbursement: Annual and Periodic Update

- A. Procedure codes. When procedure codes are issued by CMS and added to the Current Procedural Terminology published by the American Medical Association, AHCCCS shall add to the Outpatient Capped Fee-for-service Schedule the new procedure codes for covered outpatient services and shall either assign the default CCR under R9-22-712.40(F)(2), the Medicare rate, or calculate an appropriate fee.
- B. APC changes. AHCCCS may reassign procedure codes to new or different APC groups when APC groups are revised by CMS. AHCCCS may reassign procedure codes to a different APC group than Medicare. If AHCCCS determines that utilization of a procedure code within the Medicare program is substantially different from utilization of the procedure code in the AHCCCS program, AHCCCS may choose not to assign the procedure code to any APC group. For procedure codes not grouped into an APC by Medicare, AHCCCS may assign the code to an APC group when AHCCCS determines that the cost and resources associated with the non-assigned code are substantially similar to those in the APC group.
- C. Annual update for Outpatient Hospital Fee Schedule. Beginning October 1, 2006, through September 30, 2011, AHCCCS shall adjust outpatient fee schedule rates:
 1. Annually by multiplying the rates effective during the prior year by the Global Insight Prospective Hospital Market Basket Inflation Index; or
 2. In a particular year the director may substitute the increases in subsection (C)(1) by calculating the dollar value associated with the inflation index in subsection (C)(1), and applying the dollar value to adjust rates at varying levels.
- D. Reductions to the Outpatient Capped Fee-For-Service Schedule. Claims paid using the Outpatient Capped Fee-For-Service Schedule with dates of service on or after October 1, 2011, shall be reimbursed at 95 percent of the rates in effect September 30, 2011, subject to the annual adjustments to procedure codes and APCs under this Section.
- E. Rebase. AHCCCS shall rebase the outpatient fees every five years.
- F. Statewide CCR:
 1. For begin dates of service on or before September 30, 2011, the statewide CCR calculated in R9-22-712.30 shall be recalculated at the time of rebasing. When rebasing, AHCCCS may recalculate the statewide CCR based on the costs and charges for services excluded from the outpatient hospital fee schedule.
 2. For begin dates of service on or after October 1, 2011, the statewide CCR shall be set under R9-22-712.30(C).

Historical Note

New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2). Amended by final rulemaking at 13 A.A.R. 3584, effective October 1, 2007 (Supp. 07-4). Amended by final rulemaking at 14 A.A.R. 1439, effective May 31, 2008 (Supp. 08-2). Amended by final rulemaking at 17 A.A.R. 1460, effective

October 1, 2011 (Supp. 11-3). Amended by exempt rulemaking at 18 A.A.R. 1914, effective July 18, 2012 (Supp. 12-3).

R9-22-712.41. Reserved

R9-22-712.42. Reserved

R9-22-712.43. Reserved

R9-22-712.44. Reserved

R9-22-712.45. Outpatient Hospital Reimbursement: Outpatient Payment Restrictions

- A. AHCCCS shall not reimburse hospitals for emergency room treatment, observation hours, or other outpatient hospital services performed on an outpatient basis if the member is admitted as an inpatient to the same hospital directly from the emergency room, observation, or other outpatient department.
- B. AHCCCS shall include payment for the emergency room, observation, and other outpatient hospital services provided to the member before the hospital admission in the AHCCCS Inpatient Tiered Per Diem Capped Fee-For-Service Schedule under Article 7 of this Chapter.
- C. Same day admit and discharge claims that qualify for either the maternity or nursery tiers shall be paid based on the lesser of the rate for the maternity or nursery tier, or the outpatient hospital fee schedule.

Historical Note

New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2).

R9-22-712.46. Reserved

R9-22-712.47. Reserved

R9-22-712.48. Reserved

R9-22-712.49. Reserved

R9-22-712.50. Outpatient Hospital Reimbursement: Billing

To receive appropriate reimbursement, hospitals shall:

1. Bill outpatient hospital services on the CMS approved Uniform Billing Form or in electronic format using the appropriate HIPAA transaction.
2. Follow the UB Manual Guidelines, as published by the National Uniform Billing Committee, and use the appropriate revenue code and procedure code combination as prescribed by AHCCCS and on file and online with AHCCCS.

Historical Note

New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2).

R9-22-713. Overpayment and Recovery of Indebtedness

- A. If a contractor or a subcontracting provider receives an overpayment from the Administration or otherwise becomes indebted to the Administration, the contractor or subcontracting provider shall immediately remit the amount of the indebtedness or overpayment to the Administration for deposit in the AHCCCS fund.
- B. If the funds described in subsection (A) are not remitted, the Administration may recover the funds paid by the Administration to a contractor or subcontracting provider through:
 1. A repayment agreement executed with the Administration;
 2. Withholding or offsetting against current or future payments to be paid to the contractor or subcontracting provider; or

3. Enforcement of, or collection against, the performance bond, financial reserve, or other financial security under A.R.S. § 36-2903.

Historical Note

Adopted as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Adopted as a permanent rule effective May 16, 1983; text of adopted rule identical to the emergency (Supp. 83-3). Former Section R9-22-713 repealed, new Section R9-22-713 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-713 renumbered and amended as Section R9-22-714, former Section R9-22-709 renumbered and amended as Section R9-22-713 effective October 1, 1985 (Supp. 85-5). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Amended by final rulemaking at 13 A.A.R. 856, effective May 5, 2007 (Supp. 07-1).

R9-22-714. Payments to Providers

- A. Provider agreement. The Administration or a contractor shall not reimburse a covered service provided to a member unless the provider has signed a provider agreement with the Administration that establishes the terms and conditions of participation and payment under A.R.S. § 36-2904.
- B. Provider reimbursement. The Administration or a contractor shall reimburse a provider for a service furnished to a member only if:
 1. The provider personally furnishes the service to a specific member. For purposes of this Section, services personally furnished by a provider include:
 - a. Services provided by medical residents or dental students in a teaching environment; or
 - b. Services provided by a licensed or certified assistant under the general supervision of a licensed practitioner in accordance with 4 A.A.C. 24, 9 A.A.C. 16, 4 A.A.C. 43, or 4 A.A.C. 45;
 2. The provider verifies that individuals who have provided services described in subsection (B)(1) have not been placed on the List of Excluded Individuals/Entities (LEIE) maintained by the United States Department of Health and Human Services Office of the Inspector General (OIG), located at OIG's web site;
 3. The service contributes directly to the diagnosis or treatment of the member; and
 4. The service ordinarily requires performance by the type of provider seeking reimbursement.
- C. The Administration or a contractor may make a payment for covered services only:
 1. To the provider;
 2. To anyone specified in a reassignment from the provider to a government agency or reassignment by a court order;
 3. To a business agent, if the agent's compensation for the service is:
 - a. Related to the cost of processing the billing;
 - b. Not related on a percentage or other basis to the amount that is billed or collected; and
 - c. Not dependent upon collection of the payment;
 4. To the employer of the provider, if the provider is required as a condition of employment to turn over the provider's fees to the employer;
 5. To the inpatient facility in which the service is provided, if the provider has a contract under which the inpatient facility submits the claim; or
 6. To a foundation, plan, or similar organization operating an organized health care delivery system, if the provider

has a contract under which the foundation, plan or similar organization submits the claim.

- D. The Administration or a contractor shall not make a payment to or through a factor, either directly or by power of attorney, for a covered service furnished to a member by a provider.
- E. Reimbursement for a pathology service. Unless otherwise specified in a contract, the Administration or a contractor shall reimburse a pathologist for a pathology service furnished to a member only if the other requirements in this Section are met and the service is:
 1. A surgical pathology service;
 2. A specific cytopathology, hematology, or blood banking pathology service that requires performance by a physician and is listed in the capped fee-for-service schedule;
 3. A clinical consultation service that:
 - a. Is requested by the member's attending physician or primary care physician,
 - b. Is related to a test result that is outside the clinically significant normal or expected range in view of the condition of the member,
 - c. Results in a written narrative report included in the member's medical record,
 - d. Requires the exercise of medical judgment by the consultant pathologist, and
 - e. Is listed in the capped fee-for-service schedule; or
 4. A clinical laboratory interpretative service that:
 - a. Is requested by the member's attending physician or primary care physician,
 - b. Results in a written narrative report included in the member's medical record,
 - c. Requires the exercise of medical judgment by the consultant pathologist, and
 - d. Is listed in the capped fee-for-service schedule.

Historical Note

Adopted as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Adopted as a permanent rule effective May 16, 1983; text of adopted rule is similar to the emergency (Supp. 83-3). Repealed effective October 1, 1983 (Supp. 83-5). Former Section R9-22-713 renumbered and amended as Section R9-22-714 effective October 1, 1985 (Supp. 85-5). Section repealed; new Section made by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 9 A.A.R. 3800, effective October 4, 2003 (Supp. 03-3). Amended by final rulemaking at 13 A.A.R. 662, effective April 7, 2007 (Supp. 07-1).

Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General did not certify this rule. This Section was subsequently amended through the regular rulemaking process.

R9-22-715. Hospital Rate Negotiations

- A. A contractor that negotiates with hospitals for inpatient or outpatient services shall reimburse hospitals for services rendered on or after March 1, 1993, as described in A.R.S. § 36-2903.01 and this Article, or at the negotiated rate that, in the aggregate, does not exceed reimbursement levels that would have been paid under A.R.S. § 36-2903.01, and this Article. This subsection does not apply to urban hospitals described under R9-22-718.

1. Contractors may engage in rate negotiations with a hospital at any time during the contract period.
 2. Within seven days before the effective date of a contract, a contractor shall submit copies of the contractor's negotiated rate agreements with hospitals, including all rates, terms, and conditions, to the Administration for approval.
- B.** The Administration may negotiate or contract with a hospital on behalf of a contractor for discounted hospital rates and may require that the negotiated discounted rates be included in a subcontract between the contractor and hospital.

Historical Note

Adopted as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Adopted as a permanent rule effective May 16, 1983; text of adopted rule identical to the emergency (Supp. 83-3). Repealed effective October 1, 1983 (Supp. 83-5). New Section R9-22-715 adopted effective October 1, 1985 (Supp. 85-5). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective January 14, 1997 (Supp. 97-1). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 11 A.A.R. 3222, effective October 1, 2005 (Supp. 05-3).

Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General did not certify this rule. This Section was subsequently amended through the regular rulemaking process.

R9-22-716. Repealed

Historical Note

Adopted effective October 1, 1985 (Supp. 85-5). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective January 14, 1997 (Supp. 97-1). Amended by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Section repealed by final rulemaking at 13 A.A.R. 662, effective April 7, 2007 (Supp. 07-1).

R9-22-717. Repealed

Historical Note

Adopted effective July 30, 1993 (Supp. 93-3). Amended effective September 22, 1997 (Supp. 97-3). Section repealed by final rulemaking at 11 A.A.R. 3222, effective October 1, 2005 (Supp. 05-3).

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

R9-22-718. Urban Hospital Inpatient Reimbursement Program

- A.** Definitions. The following definitions apply to this Section:
1. "Noncontracted Hospital" means an urban hospital which does not have a contract under this Section with an urban contractor in the same county.

2. "Rural Contractor" means a contractor or program contractor as defined in A.R.S. Title 36, Chapter 29 that does not provide services to members residing in either Maricopa or Pima County.
 3. "Urban Contractor" means a contractor or program contractor as defined in A.R.S. Title 36, Chapter 29, that provides services to members residing in Maricopa or Pima County and may also provide services to members who reside in other counties. An urban contractor does not include BHS, CRS, CMDP, HCG or a Tribal government.
 4. "Rural Hospital" means a hospital, as defined in Article 1, that is physically located in Arizona but in a county other than Maricopa and Pima County.
 5. "Urban Hospital" means a hospital, as defined in Article 1, that is physically located in Maricopa or Pima County.
- B.** General Provisions.
1. This Section applies to an urban hospital who receives payment for inpatient hospital services under A.R.S. §§ 36-2903.01 and 36-2904.
 2. AHCCCS shall operate an inpatient hospital reimbursement program under A.R.S. § 36-2905.01 and this Section.
 3. Residency of the member receiving inpatient AHCCCS covered services is not a factor in determining which hospitals are required to contract with which contractors.
 4. An urban contractor shall enter into a contract for reimbursement for inpatient AHCCCS covered services with one or more urban hospitals located in the same county as the urban contractor.
 5. A noncontracted urban hospital shall be reimbursed for inpatient services by an urban contractor at 95% of the amount calculated as defined in A.R.S. § 36-2903.01 and this Article, unless otherwise negotiated by both parties.
- C.** Contract Begin Date. A contract under this Article shall cover inpatient acute care hospital services for members with hospital admissions on and after October 1, 2003.
- D.** Outpatient urban hospital services. Outpatient urban hospital services, including observation days and emergency room treatments that do not result in an admission, shall be reimbursed either through an urban hospital contract negotiated between a contractor and an urban hospital, or the reimbursement rates set forth in A.R.S. § 36-2903.01. Outpatient services in an urban hospital that result in an admission shall be paid as inpatient services in accordance with this Section.
- E.** Urban Hospital Contract.
1. Provisions of an urban hospital contracts. The urban hospital contract shall contain but is not limited to the following provisions:
 - a. Required provisions as described in the Request for Proposals (RFP);
 - b. Dispute settlement procedures. If the AHCCCS Grievance System prescribed in A.R.S. § 36-2903.01(B) and rule is not used, then arbitration shall be used;
 - c. Arbitration procedure. If arbitration is used, the urban hospital contract shall identify:
 - i. The parties' agreement on arbitrating claims arising from the contract,
 - ii. Whether arbitration is nonbinding or binding,
 - iii. Timeliness of arbitration,
 - iv. What contract provisions may be appealed,
 - v. What rules will govern arbitrations,
 - vi. The number of arbitrators that shall be used,
 - vii. How arbitrators shall be selected, and
 - viii. How arbitrators shall be compensated.
 - d. Timeliness of claims submission and payment;

- e. Prior authorization;
 - f. Concurrent review;
 - g. Electronic submission of claims;
 - h. Claims review criteria;
 - i. Payment of discounts or penalties such as quick-pay and slow-pay provisions;
 - j. Payment of outliers;
 - k. Claim documentation specifications under A.R.S. § 36-2904.
 - l. Treatment and payment of emergency room services; and
 - m. Provisions for rate changes and adjustments.
2. AHCCCS review and approval of urban hospital contracts:
- a. AHCCCS may review, approve, or disapprove the hospital contract rates, terms, conditions, and amendments to the contract;
 - b. An urban contractor shall submit urban hospital contracts and amendments as specified in the RFPs for the contract year beginning October 1, 2003, or as specified in the RFP for a new urban hospital contract negotiated after October 1, 2003;
 - c. The AHCCCS evaluation of each urban hospital contract shall include but not be limited to the following areas:
 - i. Availability and accessibility of services to members,
 - ii. Related party interests,
 - iii. Inclusion of required terms pursuant to this Section, and
 - iv. Reasonableness of the rates.
3. Evaluation of urban contractor's use of a noncontracted hospital. AHCCCS shall evaluate the contractor's use of a contracted versus noncontracted hospital.
- F. Quick-Pay/Slow-Pay.** A payment made by urban contractor to a noncontracted hospital shall be subject to quick-pay discounts and slow-pay penalties under A.R.S. § 36-2904.

Historical Note

Adopted under an exemption from the provisions of the Administrative Procedure Act, effective January 29, 1997; pursuant to Laws 1996, Ch. 288, § 24 (Supp. 97-1). Amended by exempt rulemaking at 10 A.A.R. 500, effective February 1, 2004 (Supp. 04-1). Amended by exempt rulemaking at 13 A.A.R. 3190, effective October 1, 2007 (Supp. 07-3).

R9-22-719. Contractor Performance Measure Outcomes

The Administration may retain a specified percentage of capitation reimbursement to distribute to contractors based on their performance measure outcomes under A.R.S. § 36-2904. The Administration shall notify contractors 60 days prior to a new contract year if this methodology is implemented. The Administration shall specify the details of the reimbursement methodology in contract.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1).

R9-22-720. Reinsurance

- A.** Reinsurance is a stop-loss program provided by the Administration to a contractor for partial reimbursement of the cost of covered services for a member with an acute medical condition when the cost of covered services exceeds a pre-determined deductible level amount within a contract year. The Administration self-insures the reinsurance program through a reduction to capitation rates. The reinsurance program also

includes a catastrophic reinsurance program for members diagnosed with specific medical conditions.

- B.** The Administration shall specify in contract guidelines for claims submission, processing, payment, and the types of care and services that are provided to a member whose care is covered by reinsurance.
- C.** When the Administration determines that a contractor does not follow the specified guidelines for care or services and the care or services could have been provided at a lower cost according to the guidelines, the Administration shall reimburse the contractor as if the care or services had been provided as specified in the guidelines.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Amended by final rulemaking at 13 A.A.R. 856, effective May 5, 2007 (Supp. 07-1).

ARTICLE 8. REPEALED

Article 8, consisting of Sections R9-22-801 through R9-22-804 and Exhibit A, repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004. The subject matter of Article 8 is now in 9 A.A.C. 34 (Supp. 04-1).

R9-22-801. Repealed

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-801 adopted as an emergency adoption now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-801 repealed, new Section R9-22-801 adopted effective October 29, 1985 (Supp. 85-5). Amended subsections (C), (F), (H), (I), and (K) effective October 1, 1986 (Supp. 86-5). Change of heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (H) effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Section heading amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Amended effective December 13, 1993 (Supp. 93-4). Former Section R9-22-801 repealed, new Section R9-22-801 adopted January 14, 1997 (Supp. 97-1). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

R9-22-802. Repealed

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-802 adopted as an emergency adoption now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 29, 1985 (Supp. 85-5). Amended subsections (A), (B), (C) and (D) effective October 14, 1988 (Supp. 88-4). Amended effective September 29, 1992 (Supp. 92-3). Amended effective December 13, 1993 (Supp. 93-4). Former Section R9-22-802 repealed, new Section R9-22-802 adopted effective January 14, 1997 (Supp. 97-1). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3).

- 3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

R9-22-803. Repealed**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-803 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-803 repealed, new Section R9-22-803 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-803 renumbered and amended as Section R9-22-804. Adopted effective January 31, 1986 (Supp. 86-1). Amended effective September 29, 1992 (Supp. 92-3). Former Section R9-22-803 repealed, new Section R9-22-803 adopted January 14, 1997 (Supp. 97-1). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

R9-22-804. Repealed**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-804 adopted as an emergency adoption now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1983 (Supp. 83-5). Former Section R9-22-804 repealed, former Section R9-22-803 renumbered and amended as Section R9-22-804 effective October 29, 1985 (Supp. 85-5). Amended effective October 14, 1988 (Supp. 88-4). Amended subsections (B) and (C) effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective December 13, 1993 (Supp. 93-4). Former Section R9-22-804 repealed, new Section R9-22-804 adopted effective January 14, 1997 (Supp. 97-1). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

Exhibit A. Repealed**Historical Note**

New Exhibit adopted by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Exhibit repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

R9-22-805. Repealed**Historical Note**

Former Section R9-22-805 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective January 31, 1986 (Supp. 86-1).

ARTICLE 9. REPEALED**R9-22-901. Repealed****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-901 adopted as an emergency adoption now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective

October 1, 1983 (Supp. 83-5). Adopted effective August 29, 1985 (Supp. 85-4). Amended effective October 1, 1986 (Supp. 86-5). Amended effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

R9-22-902. Repealed**Historical Note**

Adopted effective August 29, 1985 (Supp. 85-4). Former Section R9-22-902 renumbered and amended as Section R9-22-904, former Section R9-22-903 renumbered and amended as Section R9-22-902 effective October 1, 1986 (Supp. 86-5). Former Section R9-22-902 repealed, new Section R9-22-902 adopted effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

R9-22-903. Repealed**Historical Note**

Adopted effective August 29, 1985 (Supp. 85-4). Former Section R9-22-903 renumbered and amended as Section R9-22-902, former Section R9-22-904 renumbered and amended as Section R9-22-903 effective October 1, 1986 (Supp. 86-5). Former Section R9-22-903 repealed, new Section R9-22-903 adopted effective May 30, 1989 (Supp. 89-2). Section repealed by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). New Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

R9-22-904. Repealed**Historical Note**

Adopted effective August 29, 1985 (Supp. 85-4). Former Section R9-22-904 renumbered and amended as Section R9-22-903, former Section R9-22-902 renumbered and amended as Section R9-22-904 effective October 1, 1986 (Supp. 86-5). Amended effective May 30, 1989 (Supp. 89-2). Section repealed by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). New Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

R9-22-905. Repealed**Historical Note**

Adopted effective August 29, 1985 (Supp. 85-4). Former Section R9-22-905 renumbered without change as Section R9-22-908, former Section R9-22-907 renumbered and amended as Section R9-22-905 effective October 1, 1986 (Supp. 86-5). Amended effective May 30, 1989 (Supp. 89-2). Section repealed by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). New Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

R9-22-906. Repealed**Historical Note**

Adopted effective August 29, 1985 (Supp. 85-4). Amended effective October 1, 1986 (Supp. 86-5). Amended effective October 1, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective September 22, 1997 (Supp. 97-3). Section repealed by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). New Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

R9-22-907. Repealed**Historical Note**

Adopted effective August 29, 1985 (Supp. 85-4). Former Section R9-22-907 renumbered and amended as Section R9-22-905, former Section R9-22-908 renumbered and amended as Section R9-22-907 effective October 1, 1986 (Supp. 86-5). Amended effective May 30, 1989 (Supp. 89-2). Section repealed by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). New Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

R9-22-908. Repealed**Historical Note**

Adopted effective August 29, 1985 (Supp. 85-4). Former Section R9-22-908 renumbered and amended as Section R9-22-907, former Section R9-22-905 renumbered without change as Section R9-22-908 effective October 1, 1986 (Supp. 86-5). Former R9-22-908 repealed effective May 30, 1989 (Supp. 89-2). New Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

R9-22-909. Repealed**Historical Note**

New Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

ARTICLE 10. FIRST- AND THIRD-PARTY LIABILITY AND RECOVERIES**R9-22-1001. Definitions**

In addition to the definitions in A.R.S. §§ 36-2901, 36-2923 and 9 A.A.C. 22, Article 1, the following definitions apply to this Article:

“Cost avoid” means to deny a claim and return the claim to the provider for a determination of the amount of first- or third-party liability.

“First-party liability” means the obligation of any insurance plan or other coverage obtained directly or indirectly by a member that provides benefits directly to the member to pay all or part of the expenses for medical services incurred by AHCCCS or a member.

“Third-party” means a person, entity, or program that is, or may be, liable to pay all or part of the medical cost of injury, disease, or disability of an applicant or member.

“Third-party liability” means any individual, entity, or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished to a member under a state plan.

Historical Note

Former Section R9-22-712 renumbered and amended as Section R9-22-1001 effective October 1, 1985 (Supp. 85-5). Amended subsections (E) through (H) effective October 1, 1986 (Supp. 86-5). Amended subsections (B), (C), (E), and (F) effective December 22, 1987 (Supp. 87-4). Section repealed; new Section adopted effective November 7, 1997 (Supp. 97-4). Section repealed; new Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 15 A.A.R. 179, effective March 7, 2009 (Supp. 09-1).

R9-22-1002. General Provisions

AHCCCS is the payor of last resort unless specifically prohibited by applicable state or federal law. Entities that pay before AHCCCS include but are not limited to:

1. Indian Health Services (IHS/638),
2. Title IV-E,
3. Arizona Early Intervention Program (AZEIP), and
4. Contract health.

Historical Note

Section R9-22-529 adopted effective October 1, 1985, then renumbered as Section R9-22-1002 effective October 1, 1985 (Supp. 85-5). Amended subsections (C) and (D) effective October 1, 1986 (Supp. 86-5). Amended effective December 22, 1987 (Supp. 87-4). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed; new Section adopted effective November 7, 1997 (Supp. 97-4). Section repealed; new Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 15 A.A.R. 179, effective March 7, 2009 (Supp. 09-1).

R9-22-1003. Cost Avoidance

A. The Administration’s reimbursement responsibility.

1. The Administration shall pay no more than the difference between the Capped Fee-For-Service schedule and the amount of the third-party liability, unless Medicare is the third-party.
2. If Medicare is the third-party that is liable, the Administration shall pay the Medicare copayment and deductible regardless of the Capped Fee-For-Service Schedule.

B. The Contractor’s reimbursement responsibility.

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1. If the contract between the contractor and the provider does not state otherwise, a contractor shall pay no more than the difference between the contracted rate and the amount of the third-party liability.
 2. If the provider does not have a contract with the contractor, a contractor shall pay no more than the difference between the Capped Fee-For-Service rate and the amount of the third-party liability.
- C.** The requirement to cost avoid applies to all AHCCCS-covered services under Article 2 of this Chapter, unless otherwise specified in this Section. The following parties shall take reasonable measures to identify potentially legally liable first- or third-party sources:
1. AHCCCS, the Administration, or a contractor;
 2. A provider;
 3. A noncontracting provider; and
 4. A member.
- D.** When the Administration or a contractor determines that a third party may be liable for services provided, the Administration or contractor shall pay the full amount of the claim according to the Capped-Fee-For-Service Schedule and then seek reimbursement, when:
1. The claim is for labor and delivery and postpartum care; or
 2. The liability is from an absent parent, and the claim is for prenatal care or EPSDT services.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 10 A.A.R. 3012, effective September 11, 2004 (Supp. 04-3). Amended by final rulemaking at 15 A.A.R. 179, effective March 7, 2009 (Supp. 09-1).

R9-22-1004. Member Participation

A member shall cooperate in identifying potentially legally liable first- or third-parties and timely assist the Administration and a contractor, provider, or noncontracting provider in pursuing any first- or third-party who may be liable to pay for covered services.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 15 A.A.R. 179, effective March 7, 2009 (Supp. 09-1).

R9-22-1005. Collections

- A.** Parties that notify AHCCCS. A provider or noncontracting provider shall cooperate with AHCCCS by identifying all potential sources of first- or third-party liability and notify AHCCCS of these sources.
- B.** Parties that pursue collection or reimbursement. AHCCCS, a provider, or noncontracting provider shall pursue collection or reimbursement from all potential sources of first- or third-party liability.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1).

R9-22-1006. AHCCCS Monitoring Responsibilities

AHCCCS shall monitor first- or third-party liability payments to a provider or noncontracting provider, which include but are not limited to payments by or for:

1. Private health insurance;
2. Employment-related disability and health insurance;
3. Long-term care insurance;
4. Other federal programs not excluded by statute from recovery;

5. Court ordered or non-court ordered medical support from an absent parent;
6. State worker's compensation;
7. Automobile insurance, including underinsured and uninsured motorists insurance;
8. Court judgment or settlement from a liability insurer including settlement proceeds placed in a trust;
9. First-party probate estate recovery;
10. Adoption-related payment; or
11. A tortfeasor.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1).

R9-22-1007. Notification for Perfection, Recording, and Assignment of AHCCCS Liens

- A.** Hospital requirements. A hospital providing medical services to a member for an injury or condition resulting from circumstances reflecting the probable liability of a first- or third-party shall within 30 days after a member's discharge:
1. Notify AHCCCS via facsimile or mail under R9-22-1008, or
 2. Mail AHCCCS a copy of the lien the hospital proposes to record or has recorded under A.R.S. § 33-932.
- B.** Provider and noncontracting provider requirements. A provider or noncontracting provider, other than a hospital, rendering medical services to a member for an injury or condition resulting from circumstances reflecting the probable liability of a first- or third-party shall notify AHCCCS via facsimile or mail under R9-22-1008 within 30 days after providing the service.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 15 A.A.R. 179, effective March 7, 2009 (Supp. 09-1).

R9-22-1008. Notification Information for Liens

- A.** Except as provided in subsection (B), a hospital, provider, and noncontracting provider identified in R9-22-1007 shall provide the following information to AHCCCS in writing:
1. Name of the hospital, provider or noncontracting provider;
 2. Address of the hospital, provider or noncontracting provider;
 3. Name of member;
 4. Member's Social Security Number or AHCCCS identification number;
 5. Address of member;
 6. Date of member's admission or date service is provided;
 7. Amount estimated to be due for care of member;
 8. Date of discharge, if member has been discharged;
 9. Name of county in which injuries were sustained; and
 10. Name and address of all persons, firms, and corporations and their insurance carriers identified by the member or legal representative as being liable for damages.
- B.** If the date of discharge is not known at the time the information in subsection (A) is provided, a party identified in subsection (A) shall notify AHCCCS of the date of discharge within 30 days after the member has been discharged.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 15 A.A.R. 179, effective March 7, 2009 (Supp. 09-1).

R9-22-1009. Notification of Health Insurance Information

A provider or noncontracting provider shall notify AHCCCS, in writing, of the following health insurance information within 10 days of receipt of the health insurance information:

1. Name of member,
2. Member's Social Security Number or AHCCCS identification number,
3. Insurance carrier name,
4. Insurance carrier address,
5. Policy number or insurance holder's Social Security Number,
6. Policy begin and end dates, and
7. Insurance holder's name.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1).

ARTICLE 11. CIVIL MONETARY PENALTIES AND ASSESSMENTS**R9-22-1101. Basis for Civil Monetary Penalties and Assessments for Fraudulent Claims; Definitions**

- A. Scope. This Article applies to prohibited acts as described under A.R.S. § 36-2918(A), and submissions of encounters to the Administration. The Administration considers a person who aids and abets a prohibited act affecting any of the AHCCCS programs or Health Care Group to be engaging in a prohibited act under A.R.S. § 36-2918(A).
- B. Purpose. This Article describes the circumstances AHCCCS considers and the process that AHCCCS uses to determine the amount of a penalty, assessment, or penalty and assessment as required under A.R.S. § 36-2918. This Article includes the process and time-frames used by a person to request a State Fair Hearing.
- C. Definitions. The following definitions apply to this Article:
 1. "Assessment" means a monetary amount that does not exceed twice the dollar amount claimed by the person for each service.
 2. "Claim" means a request for payment submitted by a person for payment for a service or line item of service, including a submission of an encounter.
 3. "Day" means calendar day unless otherwise specified.
 4. "File" means the date that AHCCCS receives a written acceptance, request for compromise, request for a counter proposal, or a request for a State Fair Hearing as established by a date stamp on the written document or other record of receipt.
 5. "Penalty" means a monetary amount, based on the number of items of service claimed or reported, that does not exceed \$2,000 times the number of line items of service.
 6. "Person" means an individual or entity as described under A.R.S. § 1-215.
 7. "Reason to know" or "had reason to know" means that a person, acts in deliberate ignorance of the truth or falsity of, or with reckless disregard of the truth or falsity of information. No proof of specific intent to defraud is required.

Historical Note

Adopted effective October 1, 1986 (Supp. 86-5).
 Amended subsection A. effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective June 9, 1998 (Supp. 98-2).
 Amended by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3). Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

R9-22-1102. Determining the Amount of a Penalty and an Assessment

- A. AHCCCS shall determine the amount of a penalty and assessment according to A.R.S. § 36-2918(B) and (C), R9-22-1104, and R9-22-1105.
- B. AHCCCS shall include in the amount of the penalty and assessment the cost incurred by AHCCCS for conducting the following:
 1. An investigation,
 2. Audit, or
 3. Inquiry.

Historical Note

Adopted effective October 1, 1986 (Supp. 86-5).
 Amended effective December 13, 1993 (Supp. 93-4).
 Amended effective June 9, 1998 (Supp. 98-2). Section repealed; new Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3).
 Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

R9-22-1103. Repealed**Historical Note**

Adopted effective October 1, 1986 (Supp. 86-5).
 Amended effective December 13, 1993 (Supp. 93-4).
 Amended effective June 9, 1998 (Supp. 98-2). Section repealed; new Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3).
 Section repealed by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

R9-22-1104. Mitigating Circumstances

AHCCCS shall consider any of the following to be mitigating circumstances when determining the amount of a penalty, assessment, or penalty and assessment.

1. Nature and circumstances of a claim. The following are mitigating circumstances:
 - a. All the services are of the same type,
 - b. All the dates of services occurred within six months or less,
 - c. The number of claims submitted is less than 25,
 - d. The nature and circumstances do not indicate a pattern of inappropriate claims for the services, and
 - e. The total amount claimed for the services is less than \$1,000.
2. Degree of culpability. The degree of culpability of a person who presents or causes to present a claim is a mitigating circumstance if:
 - a. Each service is the result of an unintentional and unrecognized error in the process that the person followed in presenting or in causing to present the service,
 - b. Corrective steps were taken promptly by the person after the error was discovered, and
 - c. The person had a fraud and abuse control plan that was operating effectively at the time each claim was presented or caused to be presented.
3. Financial condition. The financial condition of a person who presents or causes to present a claim is a mitigating circumstance if the imposition of a penalty, assessment, or penalty and assessment without reduction will render the provider incapable to continue providing services. AHCCCS shall consider the resources available to the person when determining the amount of the penalty, assessment, or penalty and assessment.
4. Other matters as justice may require. AHCCCS shall take into account other circumstances of a mitigating nature, if

in the interest of justice, the circumstances require a reduction of the penalty, assessment, or penalty and assessment.

Historical Note

Adopted effective October 1, 1986 (Supp. 86-5).
Amended effective June 9, 1998 (Supp. 98-2). Section repealed; new Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3).
Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

R9-22-1105. Aggravating Circumstances

AHCCCS shall consider any of the following to be aggravating circumstances when determining the amount of a penalty, assessment, or penalty and assessment.

1. Nature and circumstances of each claim. The nature and circumstances of each claim and the circumstances under which the claim is presented or caused to be presented are aggravating circumstances if:
 - a. A person has forged, altered, recreated, or destroyed records;
 - b. The person refuses to provide pertinent documentation to AHCCCS for a claim or refuses to cooperate with investigators;
 - c. The services are of several types;
 - d. All the dates of services did not occur within six months or less;
 - e. The number of claims submitted is greater than 25;
 - f. The nature and circumstances indicate a pattern of inappropriate claims for the services; and
 - g. The total amount claimed for the services is \$5,000 or greater.
2. Degree of culpability. The degree of culpability of a person who presents or causes to present each claim is an aggravating circumstance if:
 - a. The person knows or had reason to know that each service was not provided as claimed,
 - b. The person knows or had reason to know that no payment could be made because the person had been excluded from reimbursement by AHCCCS, or
 - c. The person knows or had reason to know that the payment would violate the terms of an agreement between the person and AHCCCS system.
3. Prior offenses. The prior offenses of a person who presents or causes to present each claim are an aggravating circumstance if:
 - a. At any time before the submittal of the claim the person was held criminally or civilly liable for any act, or
 - b. The person had received an administrative sanction in connection with:
 - i. A Medicaid program,
 - ii. A Medicare program, or
 - iii. Any other public or private program of reimbursement for medical services.
4. Effect on patient care. The adverse effect on patient care that resulted, or could have resulted, from the failure to provide medically necessary care by a person in connection with a claim.
5. Other matters as justice may require. AHCCCS shall take into account other circumstances of an aggravating nature, if in the interest of justice, the circumstances require an increase of the penalty, assessment, or penalty and assessment.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3).
Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

R9-22-1106. Notice of Intent

If AHCCCS imposes a penalty, assessment, or a penalty and assessment, AHCCCS shall hand deliver or send by certified mail return receipt requested or Federal Express to the person, a written Notice of Intent to impose a penalty, assessment, or a penalty and assessment. The Notice of Intent shall include:

1. The statutory basis for the penalty, assessment, or the penalty and assessment;
2. Identification of the state or federal regulation and state or federal law that AHCCCS alleges has been violated;
3. The factual basis for AHCCCS' determination that the penalty, assessment, or the penalty and assessment should be imposed;
4. The amount of the penalty, assessment, or penalty and assessment;
5. The process for the person to accept or request a compromise of the penalty, assessment, or penalty and assessment; and
6. The process for requesting a State Fair Hearing.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3).
Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

R9-22-1107. Reserved

R9-22-1108. Request for a Compromise

- A. To request a compromise, the person shall file a written request with AHCCCS within 30 days from the date of receipt of the Notice of Intent. The written request for compromise shall contain the person's reasons for the reduction or modification of the penalty, assessment, or penalty and assessment.
- B. Within 30 days from the date of receipt of the request for compromise from the person, AHCCCS shall send a Notice of Compromise Decision that accepts, denies, or offers a counter proposal to the person's request for compromise. If AHCCCS offers a counter proposal the amount of the counter proposal shall represent the penalty, assessment, or penalty and assessment.
 1. If AHCCCS does not withdraw the Notice of Intent under R9-22-1112 or denies the request for compromise the original penalty, assessment, or penalty and assessment is upheld.
 2. To dispute the Compromise Decision, the person shall file a request for a State Fair Hearing under R9-22-1110 within 30 days from the date of receipt of the Notice of Compromise Decision.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3).
Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

R9-22-1109. Failure to Respond to the Notice of Intent

If a person fails to respond timely to the Notice of Intent, AHCCCS shall uphold the original penalty, assessment, or penalty and assessment.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3).
Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

R9-22-1110. Request for State Fair Hearing

- A. To request a State Fair Hearing regarding a dispute concerning a penalty, assessment, or penalty and assessment, the person shall file a written request for a State Fair Hearing with AHCCCS within 60 days from the date of the receipt of the Notice of Intent under R9-22-1106 or within 30 days from the date of receipt of the Notice of Compromise Decision under R9-22-1108, if applicable.
- B. AHCCCS shall mail a Notice of Hearing under A.R.S. § 41-1092.05 if AHCCCS receives a timely request for a State Fair Hearing from the person.
- C. AHCCCS shall mail a Director's Decision to the person no later than 30 days after the date the Administrative Law Judge sends the decision of the Office of Administrative Hearings (OAH) to AHCCCS.
- D. AHCCCS shall accept a written request for withdrawal of a hearing request if the written request for withdrawal is received from the person before AHCCCS mails a Notice of Hearing under A.R.S. § 41-1092 et seq. If AHCCCS mailed a Notice of Hearing under A.R.S. § 41-1092 et seq., a person may withdraw the hearing request only by sending a written request for withdrawal to OAH.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3).
Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

R9-22-1111. Issues and Burden of Proof

- A. Preponderance of evidence. In any State Fair Hearing conducted under R9-22-1110, AHCCCS shall prove by a preponderance of the evidence that a person presented or caused to be presented each claim in violation of this Article and any aggravating circumstances under R9-22-1105. A person shall bear the burden of producing and proving by a preponderance of the evidence any circumstance that would justify reducing the amount of the penalty, assessment, or penalty and assessment.
- B. Statistical sampling.
 1. In meeting the burden of proof described in subsection (A), AHCCCS may introduce the results of a statistical sampling study as evidence of the number and amount of claims that were presented or caused to be presented by the person. A statistical sampling study constitutes prima facie evidence of the number and amount of claims if computed by valid statistical methods.
 2. The burden of proof shall shift to the person to produce evidence reasonably calculated to rebut the findings of the statistical sampling study once AHCCCS has made a prima facie case as described in subsection (B)(1). AHCCCS shall be given the opportunity to rebut this evidence.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3).
Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

R9-22-1112. Withdrawal and Continuances

AHCCCS may withdraw the Notice of Intent at any time. Prior to referring a matter to the Office of Administrative Hearings the parties may mutually agree to a continuance.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3).

ARTICLE 12. BEHAVIORAL HEALTH SERVICES**R9-22-1201. General Requirements**

General requirements. The following general requirements apply to behavioral health services provided under this Article, subject to all exclusions and limitations specified in this Article.

1. Administration. The program shall be administered as specified in A.R.S. § 36-2903.
2. Provision of services. Behavioral health services shall be provided as specified in A.R.S. § 36-2907 and this Chapter.
3. Definitions. The following definitions apply to this Article:
 - a. "Agency" for the purposes of this Article means the same as in A.A.C. R9-20-101.
 - b. "Behavior management services" means services that assist the member in carrying out daily living tasks and other activities essential for living in the community, including personal care services.
 - c. "Behavioral health adult therapeutic home" means a licensed behavioral health service agency that is the licensee's residence where behavioral health adult therapeutic home care services are provided to at least one, but no more than three individuals, who reside at the residence, have been diagnosed with behavioral health issues, and are provided with food and are integrated into the licensee's family.
 - d. "Behavioral health therapeutic home care services" means interactions that teach the client living, social, and communication skills to maximize the client's ability to live and participate in the community and to function independently, including assistance in the self-administration of medication and any ancillary services indicated by the client's treatment plan, as appropriate.
 - e. "Behavioral health evaluation" means the assessment of a member's medical, psychological, psychiatric, or social condition to determine if a behavioral health disorder exists and, if so, to establish a treatment plan for all medically necessary services.
 - f. "Behavioral health medical practitioner" means a health care practitioner with at least one year of full-time behavioral health work experience.
 - g. "Behavioral health professional" means the same as in A.A.C. R9-20-101.
 - h. "Behavioral health service" means a service provided for the evaluation and diagnosis of a mental health or substance abuse condition and the planned care, treatment, and rehabilitation of the member.
 - i. "Behavioral health technician" means the same as in A.A.C. R9-20-101.
 - j. "Case management" for the purposes of this Article, means services and activities that enhance treatment, compliance, and effectiveness of treatment.
 - k. "Certified psychiatric nurse practitioner" means a registered nurse practitioner who meets the psychiatric specialty area requirements under A.A.C. R4-19-505(C).
 - l. "Client" for the purposes of this rule means the same as in A.A.C. R9-22-101.
 - m. "Cost avoid" means to avoid payment of a third-party liability claim when the probable existence of

- third-party liability has been established under 42 CFR 433.139(b).
- n. “Health care practitioner” means a:
 - Physician;
 - Physician assistant;
 - Nurse practitioner; or
 - Other individual licensed and authorized by law to use and prescribe medication and devices, as defined in A.R.S. § 32-1901.
 - o. “Licensee” means the same as in A.A.C. R9-20-101.
 - p. “OBHL” means the same as in A.A.C. R9-20-101.
 - q. “Partial care” means a day program of services provided to individual members or groups that is designed to improve the ability of a person to function in a community, and includes basic, therapeutic, and medical day programs.
 - r. “Physician assistant” means the same as in A.R.S. § 32-2501 except that when providing a behavioral health service, the physician assistant shall be supervised by an AHCCCS-registered psychiatrist.
 - s. “Psychiatrist” means a physician who meets the licensing requirements under A.R.S. § 32-1401 or a doctor of osteopathy who meets the licensing requirements under A.R.S. § 32-1800, and meets the additional requirements of a psychiatrist under A.R.S. § 36-501.
 - t. “Psychologist” means a person who meets the licensing requirements under A.R.S. §§ 32-2061 and 36-501.
 - u. “Qualified behavioral health service provider” means a behavioral health service provider that meets the requirements of R9-22-1206.
 - v. “Respite” means a period of care and supervision of a member to provide rest or relief to a family member or other person caring for the member. Respite provides activities and services to meet the social, emotional, and physical needs of the member during respite.
 - w. “TRBHA” or “Tribal Regional Behavioral Health Authority” means a Native American tribe under contract with ADHS/DBHS to coordinate the delivery of behavioral health services to eligible and enrolled members of the federally-recognized tribal nation.
1. Be responsible for providing all inpatient emergency behavioral health services for a non-FES member with a psychiatric or substance abuse diagnosis who is enrolled with a contractor in accordance with R9-22-210.01(A)(3);
 2. Be responsible for providing all inpatient emergency behavioral health services for a FFS member with a psychiatric or substance abuse diagnosis who is not enrolled with a contractor in accordance with R9-22-210.01(A)(3);
 3. Be responsible for providing all non-inpatient emergency behavioral health services for a non-FES member in accordance with R9-22-210.01;
 4. Be responsible for providing all non-emergency behavioral health services for a non-FES member;
 5. Contract with a RBHA for the provision of behavioral health services in R9-22-1205 for all Title XIX members under A.R.S. § 36-2907. ADHS/DBHS shall ensure that a RBHA provides behavioral health services to members directly, or through subcontracts, with qualified service providers who meet the qualifications specified in R9-22-1206. If behavioral health services are unavailable within a RBHA’s GSA, ADHS/DBHS shall ensure that a RBHA provides behavioral health services to a Title XIX member outside the RBHA’s GSA;
 6. Ensure that a member’s behavioral health service is provided in collaboration with a member’s primary care provider; and
 7. Coordinate the transition of care and medical records, under A.R.S. §§ 36-2903, 36-509, R9-22-512, and in contract, when a member transitions from:
 - a. A behavioral health provider to another behavioral health provider,
 - b. A RBHA to another RBHA,
 - c. A RBHA to a contractor,
 - d. A contractor to a RBHA, or
 - e. A contractor to another contractor.
- B.** ADHS/DBHS may contract with a TRBHA for the provision of behavioral health services for Native American members. Native American members may receive covered behavioral health services:
1. From an IHS facility,
 2. From a TRBHA, or
 3. From a RBHA.
- C.** Contractor responsibilities. A contractor shall:
1. Refer a member to an RBHA under the contract terms;
 2. Provide EPSDT developmental and behavioral health screening as specified in R9-22-213;
 3. Provide inpatient emergency behavioral health services as specified in R9-22-1205 and R9-22-210.01 for a member not yet enrolled with a RBHA or TRBHA and all behavioral health services as specified in contract;
 4. Provide psychotropic medication services for a member, in consultation with the member’s RBHA as needed, for behavioral health conditions specified in contract and within the primary care provider’s scope of practice; and
 5. Coordinate a member’s transition of care and medical records under subsection (A)(7).

Historical Note

Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1).

R9-22-1202. ADHS and Contractor Responsibilities

- A.** ADHS responsibilities. Except as provided in subsection (B), behavioral health services shall be provided by a RBHA through a contract with ADHS/DBHS. ADHS/DBHS shall:

Historical Note

Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993

(Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended to correct typographical errors, filed in the Office of the Secretary of State October 30, 2001 (Supp. 01-4). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1).

R9-22-1203. Eligibility for Covered Services

- A.** Title XIX members. A member determined eligible under A.R.S. § 36-2901(6)(a), shall receive medically necessary covered services under R9-22-1205 and R9-22-201.
- B.** FES members. A person who would be eligible under A.R.S. § 36-2901(6)(a)(i), A.R.S. § 36-2901(6)(a)(ii), or A.R.S. § 36-2901(6)(a)(iii) except for the failure to meet the U.S. citizenship or qualified alien status requirements under A.R.S. § 36-2903.03(A) and A.R.S. § 36-2903.03(B) is eligible for emergency services only.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1).

R9-22-1204. General Service Requirements

- A.** Services. Behavioral health services include both mental health and substance abuse services.
- B.** Medical necessity. A service shall be medically necessary as provide under R9-22-201.
- C.** Prior authorization. A service shall be provided to a member under Title 36, Chapter 29, Article 1, by a contractor, subcontractor, or provider consistent with the prior authorization requirements in contract and the following:
 - 1. Emergency behavioral health services. A provider is not required to obtain prior authorization for emergency behavioral health services.
 - 2. Non-emergency behavioral health services. When a member's behavioral health condition is determined by the provider not to require emergency behavioral health services, the provider shall follow the prior authorization requirements of ADHS/DBHS or the RBHA/TRBHA.
- D.** EPSDT. For Title XIX members under age 21, EPSDT services include all medically necessary covered behavioral health services.
- E.** Experimental services. Experimental services and services that are provided primarily for the purpose of research are not covered.
- F.** Gratuities. A service or an item, if furnished gratuitously to a member, is not covered and payment to a provider shall be denied.

- G.** GSA. Behavioral health services rendered to a member shall be provided within the RBHA's GSA except when:
 - 1. A contractor's primary care provider refers a member to another area for medical specialty care,
 - 2. A member's medically necessary covered service is not available within the GSA, or
 - 3. A net savings in behavioral health service delivery costs is documented by the RBHA for a member. Undue travel time or hardship for a member or a member's family is considered for a member or a member's family in determining whether there is a net savings.
- H.** Travel. If a member travels or temporarily resides outside of a behavioral health service area, covered services are restricted to emergency behavioral health care, unless otherwise authorized by the member's RBHA or TRBHA.
- I.** Non-covered services. If a member requests a behavioral health service that is not covered or is not authorized by a RBHA or TRBHA, an AHCCCS-registered behavioral health service provider may provide the service according to R9-22-702.
- J.** Referral. If a member is referred outside of a RBHA's or TRBHA's service area to receive authorized, medically necessary behavioral health services, the TRBHA or RBHA is responsible for reimbursement if the claim is otherwise payable under this Chapter.
- K.** Restrictions and limitations.
 - 1. The restrictions, limitations, and exclusions in this Article do not apply to a contractor, ADHS/DBHS, or a RBHA when electing to provide a noncovered service.
 - 2. Room and board is not a covered service unless provided in an inpatient, Level 1 sub-acute, or residential facility under R9-22-1205.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective January 1, 1996; filed with the Secretary of State December 22, 1995 (Supp. 95-4). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1).

R9-22-1205. Scope and Coverage of Behavioral Health Services

- A.** Inpatient behavioral health services. The following inpatient services are covered subject to the limitations and exclusions in this Article.
 - 1. Covered inpatient behavioral health services include all behavioral health services, medical detoxification, accommodations and staffing, supplies, and equipment, if the service is provided under the direction of a physician in a Medicare-certified:
 - a. General acute care hospital, or
 - b. Inpatient psychiatric hospital.
 - 2. Inpatient service limitations:

- a. Inpatient services, other than emergency services specified in this Section, are not covered unless prior authorized.
 - b. Inpatient services and room and board are reimbursed on a per diem basis. The per diem rate includes all services, except the following licensed or certified providers may bill independently for services:
 - i. A licensed psychiatrist,
 - ii. A certified psychiatric nurse practitioner,
 - iii. A licensed physician assistant,
 - iv. A licensed psychologist,
 - v. A licensed clinical social worker,
 - vi. A licensed marriage and family therapist,
 - vii. A licensed professional counselor,
 - viii. A licensed independent substance abuse counselor, and
 - ix. A behavioral health medical practitioner.
 - c. A member age 21 through 64 is eligible for behavioral health services provided in a hospital listed in subsection (A)(1)(b) that meets the criteria for an IMD up to 30 days per admission and no more than 60 days per benefit year as allowed under the Administration's Section 1115 Waiver with CMS.
- B. Level 1 residential treatment center services.** Services provided in a Level 1 residential treatment center as defined in A.A.C. R9-20-101 are covered subject to the limitations and exclusions under this Article.
1. Level 1 residential treatment center services are not covered unless provided under the direction of a licensed physician in a licensed Level 1 residential treatment center accredited by an AHCCCS-approved accrediting body as specified in contract.
 2. Covered residential treatment center services include room and board and treatment services for behavioral health and substance abuse conditions.
 3. Residential treatment center service limitations.
 - a. Services are not covered unless prior authorized, except for emergency services as specified in this Section.
 - b. Services are reimbursed on a per diem basis. The per diem rate includes all services, except the following licensed or certified providers may bill independently for services:
 - i. A licensed psychiatrist,
 - ii. A certified psychiatric nurse practitioner,
 - iii. A licensed physician assistant,
 - iv. A licensed psychologist,
 - v. A licensed clinical social worker,
 - vi. A licensed marriage and family therapist,
 - vii. A licensed professional counselor,
 - viii. A licensed independent substance abuse counselor, and
 - ix. A behavioral health medical practitioner.
 4. The following may be billed independently if prescribed by a provider as specified in this Section who is operating within the scope of practice:
 - a. Laboratory services,
 - b. Radiology services, and
 - c. Psychotropic medication.
- C. Covered Level 1 sub-acute agency services.** Services provided in a Level 1 sub-acute agency as defined in A.A.C. R9-20-101 are covered subject to the limitations and exclusions under this Article.
1. Level 1 sub-acute agency services are not covered unless provided under the direction of a licensed physician in a licensed Level 1 sub-acute agency that is accredited by an AHCCCS-approved accrediting body as specified in contract.
 2. Covered Level 1 sub-acute agency services include room and board and treatment services for behavioral health and substance abuse conditions.
 3. Services are reimbursed on a per diem basis. The per diem rate includes all services, except the following licensed or certified providers may bill independently for services:
 - a. A licensed psychiatrist,
 - b. A certified psychiatric nurse practitioner,
 - c. A licensed physician assistant,
 - d. A licensed psychologist,
 - e. A licensed clinical social worker,
 - f. A licensed marriage and family therapist,
 - g. A licensed professional counselor,
 - h. A licensed independent substance abuse counselor, and
 - i. A behavioral health medical practitioner.
 4. The following may be billed independently if prescribed by a provider specified in this Section who is operating within the scope of practice:
 - a. Laboratory services,
 - b. Radiology services, and
 - c. Psychotropic medication.
 5. A member age 21 through 64 is eligible for behavioral health services provided in a Level 1 sub-acute agency that meets the criteria for an IMD for up to 30 days per admission and no more than 60 days per benefit year as allowed under the Administration's Section 1115 Waiver with CMS. These limitations do not apply to a member under age 21 or age 65 or over.
- D. Level 2 behavioral health residential agency services.** Services provided in a Level 2 behavioral health residential agency are covered subject to the limitations and exclusions in this Article.
1. Level 2 behavioral health residential agency services are not covered unless provided by a licensed Level 2 behavioral health residential agency as defined in A.A.C. R9-20-101.
 2. Covered services include all services except room and board.
 3. The following licensed or certified providers may bill independently for services:
 - a. A licensed psychiatrist,
 - b. A certified psychiatric nurse practitioner,
 - c. A licensed physician assistant,
 - d. A licensed psychologist,
 - e. A licensed clinical social worker,
 - f. A licensed marriage and family therapist,
 - g. A licensed professional counselor,
 - h. A licensed independent substance abuse counselor, and
 - i. A behavioral health medical practitioner.
- E. Level 3 behavioral health residential agency services.** Services provided in a licensed Level 3 behavioral health residential agency as defined in A.A.C. R9-20-101 are covered subject to the limitations and exclusions under this Article.
1. Level 3 behavioral health residential agency services are not covered unless provided by a licensed Level 3 behavioral health residential agency.
 2. Covered services include all non-prescription drugs as defined in A.R.S. § 32-1901, non-customized medical supplies, and clinical supervision of the Level 3 behavior

- ioral health residential agency staff. Room and board are not covered services.
3. The following licensed and certified providers may bill independently for services:
 - a. A licensed psychiatrist,
 - b. A certified psychiatric nurse practitioner,
 - c. A licensed physician assistant,
 - d. A licensed psychologist,
 - e. A licensed clinical social worker,
 - f. A licensed marriage and family therapist,
 - g. A licensed professional counselor,
 - h. A licensed independent substance abuse counselor, and
 - i. A behavioral health medical practitioner.
- F.** Partial care. Partial care services are covered subject to the limitations and exclusions in this Article.
1. Partial care services are not covered unless provided by a licensed and AHCCCS-registered behavioral health agency that provides a regularly scheduled day program of individual member, group, or family activities that are designed to improve the ability of the member to function in the community. Partial care services include basic, therapeutic, and medical day programs.
 2. Partial care services. Educational services that are therapeutic and are included in the member's behavioral health treatment plan are included in per diem reimbursement for partial care services.
- G.** Outpatient services. Outpatient services are covered subject to the limitations and exclusions in this Article.
1. Outpatient services include the following:
 - a. Screening provided by a behavioral health professional or a behavioral health technician as defined in R9-22-1201;
 - b. A behavioral health evaluation provided by a behavioral health professional or a behavioral health technician;
 - c. Counseling including individual therapy, group, and family therapy provided by a behavioral health professional or a behavioral health technician;
 - d. Behavior management services as defined in R9-22-1201; and
 - e. Psychosocial rehabilitation services as defined in R9-22-102.
 2. Outpatient service limitations.
 - a. The following licensed or certified providers may bill independently for outpatient services:
 - i. A licensed psychiatrist;
 - ii. A certified psychiatric nurse practitioner;
 - iii. A licensed physician assistant as defined in R9-22-1201;
 - iv. A licensed psychologist;
 - v. A licensed clinical social worker;
 - vi. A licensed professional counselor;
 - vii. A licensed marriage and family therapist;
 - viii. A licensed independent substance abuse counselor;
 - ix. A behavioral health medical practitioner; and
 - x. An outpatient clinic or a Level IV transitional agency licensed under 9 A.A.C. 20, Article 1, that is an AHCCCS-registered provider.
 - b. A behavioral health practitioner not specified in subsections (G)(2)(a)(i) through (x), who is contracted with or employed by an AHCCCS-registered behavioral health agency shall not bill independently.
- H.** Emergency behavioral health services are covered subject to the limitations and exclusions under this Article. In order to be covered, behavioral health services shall be provided by qualified service providers under R9-22-1206. ADHS/DBHS shall ensure that emergency behavioral health services are available 24 hours per day, seven days per week in each GSA for an emergency behavioral health condition for a non-FES member as defined in R9-22-102.
- I.** Other covered behavioral health services. Other covered behavioral health services include:
1. Case management as defined in R9-22-1201;
 2. Laboratory and radiology services for behavioral health diagnosis and medication management;
 3. Psychotropic medication and related medication;
 4. Monitoring, administration, and adjustment for psychotropic medication and related medications;
 5. Respite care as described within subsection (K);
 6. Behavioral health therapeutic home care services provided by a RBHA in a professional foster home defined in 6 A.A.C. 5, Article 58 or in a behavioral health adult therapeutic home as defined in 9 A.A.C. 20, Article 1;
 7. Personal care services, including assistance with daily living skills and tasks, homemaking, bathing, dressing, food preparation, oral hygiene, self-administration of medications, and monitoring of the behavioral health recipient's condition and functioning level provided by a licensed and AHCCCS-registered behavioral health agency or a behavioral health professional, behavioral health technician, or behavioral health paraprofessional as defined in 9 A.A.C. 20, Article 1; and
 8. Other support services to maintain or increase the member's self-sufficiency and ability to live outside an institution.
- J.** Transportation services. Transportation services are covered under R9-22-211.
- K.** Limited Behavioral Health services. Respite services are limited to no more than 600 hours per benefit year.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed, new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 5480, effective December 6, 2005 (Supp. 05-4). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1). Amended by exempt rulemaking at 17 A.A.R. 1870, effective October 1, 2011 (Supp. 11-3).

R9-22-1206. General Provisions and Standards for Service Providers

- A.** Qualified service provider. A qualified behavioral health service provider shall:
1. Have all applicable state licenses or certifications, or comply with alternative requirements established by the Administration;
 2. Register with the Administration as a service provider;
 3. Comply with all requirements under Article 5 and this Article.

4. Register with ADHS/DBHS as a behavioral health service provider, and
5. Contract with the appropriate RBHA/TRBHA.

B. Quality and utilization management.

1. Service providers shall cooperate with the quality and utilization management programs of a RBHA, a TRBHA, a contractor, ADHS/DBHS, and the Administration as specified in this Chapter and in contract.
2. Service providers shall comply with applicable procedures under 42 CFR 456, as of October 1, 2006, incorporated by reference, on file with the Administration and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol St., NW, Washington, DC 20401. This incorporation contains no future editions or amendments.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed, new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1).

R9-22-1207. General Provisions for Payment

- A.** Payment to ADHS/DBHS. The Administration shall make a monthly capitation payment to ADHS/DBHS based on the number of acute members at the beginning of each month. The Administration shall incorporate ADHS/DBHS' administrative costs into the capitation payment.
- B.** Claims submissions.
 1. ADHS/DBHS shall require all service providers to submit clean claims no later than the time-frame specified in ADHS/DBHS' contract with the Administration.
 2. A provider of behavioral health services shall submit a claim for non-emergency behavioral health services provided to a member enrolled in a RBHA to the appropriate RBHA, and if not enrolled in a RBHA, to ADHS/DBHS.
 3. A provider of behavioral health services shall submit a claim for non-inpatient emergency behavioral health services provided to a member enrolled in a RBHA to the appropriate RBHA, and if not enrolled in a RBHA, to ADHS/DBHS.
 4. A provider of behavioral health services shall submit a claim for non-inpatient emergency behavioral health services provided to a member enrolled in a TRBHA to the Administration.
 5. A provider of behavioral health services shall submit a claim for non-emergency behavioral health services provided to a member enrolled in a TRBHA to the Administration.
 6. A provider of emergency behavioral health services, that are the responsibility of ADHS/DBHS or a contractor, shall submit a claim to the entity responsible for emergency behavioral health services under R9-22-210.01(A).

7. A provider shall comply with the time-frames and other payment procedures in Article 7 of this Chapter, if applicable, and A.R.S. § 36-2904.
 8. ADHS/DBHS or a contractor, whichever entity is responsible for covering behavioral health services, shall cost avoid any behavioral health service claims if it establishes the existence or probable existence of first-party liability or third-party liability.
- C.** Prior authorization. Payment to a provider for behavioral health services or items requiring prior authorization may be denied if a provider does not obtain prior authorization from a RBHA, ADHS/DBHS, a TRBHA, or a contractor.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1).

R9-22-1208. Repealed

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 11 A.A.R. 5480, effective December 6, 2005 (Supp. 05-4).

ARTICLE 13. CHILDREN'S REHABILITATIVE SERVICES (CRS)

Article 13, consisting of Sections R9-22-1301 through R9-22-1306, made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3).

Article 13, consisting of Sections R9-22-1301 through R9-22-1309, repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004. The subject matter of Article 13 is now in 9 A.A.C. 34 (Supp. 04-1).

R9-22-1301. Children's Rehabilitative Services (CRS) related Definitions

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

"Active treatment" means there is a current need for treatment or evaluation for continuing treatment of the CRS qualifying condition or it is anticipated that treatment or evaluation for continuing treatment of the CRS qualifying condition will be needed within the next 18 months.

"CRS application" means a submitted form with any additional documentation required by the Administration to determine whether an individual is medically eligible for CRS.

"Chronic" means expected to persist over an extended period of time.

"CRS condition" means any of the covered medical conditions in R9-22-1303.

"CRS provider" means a person who is authorized by employment or written agreement with the Administration to provide

covered CRS medical services to a member or covered support services to a member or a member's family.

"Functionally limiting" means a restriction having a significant effect on an individual's ability to perform an activity of daily living as determined by a CRS provider.

"Medically eligible" means meeting the medical eligibility requirements of R9-22-1303.

"Redetermination" means a decision made by the Administration regarding whether a member continues to meet the requirements in R9-22-1302.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).
Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1). Section made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3).

R9-22-1302. Children's Rehabilitative Services (CRS) Eligibility Requirements

Beginning October 1, 2013, an AHCCCS eligible individual who needs active treatment for one or more of the qualifying medical conditions in R9-22-1303 shall be enrolled with the CRS contractor, unless enrolled with an ALTCS EPD contractor. Initial enrollment with the CRS contractor is limited to individuals under the age of 21. The CRS contractor shall provide covered services necessary to treat the CRS condition and other services described within the CRS contract. The effective date of enrollment in CRS shall be as specified in contract.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).
Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1). Section made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3).

R9-22-1303. Medical Eligibility

The following lists identify those medical conditions that do qualify for the CRS program as well as those that do not qualify for the CRS program. The covered conditions list is all inclusive. The list of conditions not covered by CRS is not an all-inclusive list:

1. Cardiovascular System:
 - a. CRS conditions:
 - i. Congenital heart defect,
 - ii. Cardiomyopathy,
 - iii. Valvular disorder,
 - iv. Arrhythmia,
 - v. Conduction defect,
 - vi. Rheumatic heart disease,
 - vii. Renal vascular hypertension,
 - viii. Arteriovenous fistula, and
 - ix. Kawasaki disease with coronary artery aneurysm.
 - b. Conditions not medically eligible for CRS:
 - i. Essential hypertension;
 - ii. Premature atrial, nodal or ventricular contractions that are of no hemodynamic significance;
 - iii. Arteriovenous fistula that is not expected to cause cardiac failure or threaten loss of function; and
 - iv. Benign heart murmur.
2. Endocrine system:
 - a. CRS conditions:
 - i. Hypothyroidism,
 - ii. Hyperthyroidism,
 - iii. Adrenogenital syndrome,
 - iv. Addison's disease,
 - v. Hypoparathyroidism,
 - vi. Hyperparathyroidism,
 - vii. Diabetes insipidus,
 - viii. Cystic fibrosis, and
 - ix. Panhypopituitarism.
 - b. Conditions not medically eligible for CRS:
 - i. Diabetes mellitus,
 - ii. Isolated growth hormone deficiency,
 - iii. Hypopituitarism encountered in the acute treatment of a malignancy, and
 - iv. Precocious puberty.
3. Genitourinary system medical conditions:
 - a. CRS conditions:
 - i. Vesicoureteral reflux, with at least mild or moderate dilatation and tortuosity of the ureter and mild or moderate dilatation of renal pelvis;
 - ii. Ectopic ureter;
 - iii. Ambiguous genitalia;
 - iv. Ureteral stricture;
 - v. Complex hypospadias;
 - vi. Hydronephrosis;
 - vii. Deformity and dysfunction of the genitourinary system secondary to trauma after the acute phase of the trauma has passed;
 - viii. Pyelonephritis when treatment with drugs or biologicals has failed to cure or ameliorate and surgical intervention is required;
 - ix. Multicystic dysplastic kidneys;
 - x. Nephritis associated with lupus erythematosus; and
 - xi. Hydrocele associated with a ventriculo-peritoneal shunt.
 - b. Conditions not medically eligible for CRS:
 - i. Nephritis, infectious or noninfectious;
 - ii. Nephrosis;
 - iii. Undescended testicle;
 - iv. Phimosis;
 - v. Hydrocele not associated with a ventriculo-peritoneal shunt;
 - vi. Enuresis;
 - vii. Meatal stenosis; and
 - viii. Hypospadias involving isolated glandular or coronal aberrant location of the urethralmeatus without curvature of the penis.
4. Ear, nose, or throat medical conditions:
 - a. CRS conditions:
 - i. Cholesteatoma;
 - ii. Chronic mastoiditis;
 - iii. Deformity and dysfunction of the ear, nose, or throat secondary to trauma, after the acute phase of the trauma has passed;
 - iv. Neurosensory hearing loss;
 - v. Congenital malformation;
 - vi. Significant conductive hearing loss due to an anomaly in one ear or both ears equal to or greater than a pure tone average of 30 decibels, that despite medical treatment, requires a hearing aid;
 - vii. Craniofacial anomaly that requires treatment by more than one CRS provider; and
 - viii. Microtia that requires multiple surgical interventions.
 - b. Conditions not medically eligible for CRS:

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- i. Tonsillitis,
 - ii. Adenoiditis,
 - iii. Hypertrophic lingual frenum,
 - iv. Nasal polyp,
 - v. Cranial or temporal mandibular joint syndrome,
 - vi. Simple deviated nasal septum,
 - vii. Recurrent otitis media,
 - viii. Obstructive apnea,
 - ix. Acute perforation of the tympanic membrane,
 - x. Sinusitis,
 - xi. Isolated preauricular tag or pit, and
 - xii. Uncontrolled salivation.
5. Musculoskeletal system medical conditions:
- a. CRS conditions:
 - i. Achondroplasia;
 - ii. Hypochondroplasia;
 - iii. Diastrophic dysplasia;
 - iv. Chondrodysplasia;
 - v. Chondroectodermal dysplasia;
 - vi. Spondyloepiphyseal dysplasia;
 - vii. Metaphyseal and epiphyseal dysplasia;
 - viii. Larsen syndrome;
 - ix. Fibrous dysplasia;
 - x. Osteogenesis imperfecta;
 - xi. Rickets;
 - xii. Enchondromatosis;
 - xiii. Juvenile rheumatoid arthritis;
 - xiv. Seronegative spondyloarthropathy;
 - xv. Orthopedic complications of hemophilia;
 - xvi. Myopathy;
 - xvii. Muscular dystrophy;
 - xviii. Myoneural disorder;
 - xix. Arthrogryposis;
 - xx. Spinal muscle atrophy;
 - xxi. Polyneuropathy;
 - xxii. Chronic stage bone infection;
 - xxiii. Chronic stage joint infection;
 - xxiv. Upper limb amputation;
 - xxv. Syndactyly;
 - xxvi. Kyphosis;
 - xxvii. Scoliosis;
 - xxviii. Congenital spinal deformity;
 - xxix. Congenital or developmental cervical spine abnormality;
 - xxx. Hip dysplasia;
 - xxxi. Slipped capital femoral epiphysis;
 - xxxii. Femoral anteversion and tibial torsion;
 - xxxiii. Legg-Calve-Perthes disease;
 - xxxiv. Lower limb amputation, including prosthetic sequelae of cancer;
 - xxxv. Metatarsus adductus;
 - xxxvi. Leg length discrepancy of five centimeters or more;
 - xxxvii. Metatarsus primus varus;
 - xxxviii. Dorsal bunions;
 - xxxix. Collagen vascular disease;
 - xl. Benign bone tumor;
 - xli. Deformity and dysfunction secondary to musculoskeletal trauma;
 - xl. Osgood Schlatter's disease that requires surgical intervention; and
 - xl. Complicated flat foot, such as rigid foot, unstable subtalar joint, or significant calcaneus deformity.
 - b. Conditions not medically eligible for CRS:
- i. Ingrown toenail;
 - ii. Back pain with no structural abnormality;
 - iii. Ganglion cyst;
 - iv. Flat foot other than complicated flat foot;
 - v. Fracture;
 - vi. Popliteal cyst;
 - vii. Simple bunion; and
 - viii. Carpal tunnel syndrome;
 - ix. Deformity and dysfunction secondary to trauma or injury if:
 - (1) Three months have not passed since the trauma or injury, and
 - (2) Leg length discrepancy of less than five centimeters at skeletal maturity.
6. Gastrointestinal system medical conditions:
- a. CRS conditions:
 - i. Tracheoesophageal fistula;
 - ii. Anorectal atresia;
 - iii. Hirschsprung's disease;
 - iv. Diaphragmatic hernia;
 - v. Gastroesophageal reflux that has failed treatment with drugs or biologicals and requires surgery;
 - vi. Deformity and dysfunction of the gastrointestinal system secondary to trauma, after the acute phase of the trauma has passed;
 - vii. Biliary atresia;
 - viii. Congenital atresia, stenosis, fistula, or rotational abnormalities of the gastrointestinal tract;
 - ix. Cleft lip;
 - x. Cleft palate;
 - xi. Omphalocele; and
 - xii. Gastroschisis.
 - b. Conditions not medically eligible for CRS:
 - i. Malabsorption syndrome, also known as short bowel syndrome;
 - ii. Crohn's disease;
 - iii. Hernia other than a diaphragmatic hernia;
 - iv. Ulcer disease;
 - v. Ulcerative colitis;
 - vi. Intestinal polyp;
 - vii. Pyloric stenosis; and
 - viii. Celiac disease.
7. Nervous system medical conditions:
- a. CRS conditions:
 - i. Uncontrolled seizure disorder, in which there have been more than two seizures with documented adequate blood levels of one or more medications;
 - ii. Cerebral palsy;
 - iii. Muscular dystrophy or other myopathy;
 - iv. Myoneural disorder;
 - v. Neuropathy, hereditary or idiopathic;
 - vi. Central nervous system degenerative disease;
 - vii. Central nervous system malformation or structural abnormality;
 - viii. Hydrocephalus;
 - ix. Craniosynostosis of a sagittal suture, a unilateral coronal suture, or multiple sutures in a child less than 18 months of age;
 - x. Myasthenia gravis, congenital or acquired;
 - xi. Benign intracranial tumor;
 - xii. Benign intraspinal tumor;
 - xiii. Tourette's syndrome;

- xiv. Residual dysfunction after resolution of an acute phase of vascular accident, inflammatory condition, or infection of the central nervous system;
 - xv. Myelomeningocele, also known as spina bifida;
 - xvi. Neurofibromatosis;
 - xvii. Deformity and dysfunction secondary to trauma in an individual;
 - xviii. Residual dysfunction after acute phase of near drowning; and
 - xix. Residual dysfunction after acute phase of spinal cord injury.
- b. Conditions not medically eligible for CRS:
- i. Headaches;
 - ii. Central apnea secondary to prematurity;
 - iii. Near sudden infant death syndrome;
 - iv. Febrile seizures;
 - v. Occipital plagiocephaly, either positional or secondary to lambdoidal synostosis;
 - vi. Trigonoccephaly secondary to isolated metopic synostosis;
 - vii. Spina bifida occulta;
 - viii. Near drowning in the acute phase; and
 - ix. Spinal cord injury in the acute phase;
 - x. Chronic vegetative state.
8. Ophthalmology:
- a. CRS conditions:
- i. Cataracts;
 - ii. Glaucoma;
 - iii. Disorder of the optic nerve;
 - iv. Non-malignant enucleation and post-enucleation reconstruction;
 - v. Retinopathy of prematurity; and
 - vi. Disorder of the iris, ciliary bodies, retina, lens, or cornea.
- b. Conditions not medically eligible for CRS:
- i. Simple refraction error,
 - ii. Astigmatism,
 - iii. Strabismus, and
 - iv. Ptosis.
9. Respiratory system medical conditions:
- a. CRS conditions:
- i. Anomaly of the larynx, trachea, or bronchi that requires surgery; and
 - ii. Nonmalignant obstructive lesion of the larynx, trachea, or bronchi.
- b. Conditions not medically eligible for CRS:
- i. Respiratory distress syndrome,
 - ii. Asthma,
 - iii. Allergies,
 - iv. Bronchopulmonary dysplasia,
 - v. Emphysema,
 - vi. Chronic obstructive pulmonary disease, and
 - vii. Acute or chronic respiratory condition requiring venting for the neuromuscularly impaired.
10. Integumentary system medical conditions:
- a. CRS conditions:
- i. A craniofacial anomaly that is functionally limiting,
 - ii. A burn scar that is functionally limiting,
 - iii. A hemangioma that is functionally limiting,
 - iv. Cystic hygroma, and
 - v. Complicated nevi requiring multiple procedures.
- b. Conditions not medically eligible for CRS:
- i. A deformity that is not functionally limiting,
 - ii. A burn other than a burn scar that is functionally limiting,
 - iii. Simple nevi,
 - iv. Skin tag,
 - v. Port wine stain,
 - vi. Sebaceous cyst,
 - vii. Isolated malocclusion that is not functionally limiting,
 - viii. Pilonidal cyst,
 - ix. Ectodermal dysplasia, and
 - x. A craniofacial anomaly that is not functionally limiting.
11. Metabolic CRS conditions:
- a. Amino acid or organic acidopathy,
 - b. Inborn error of metabolism,
 - c. Storage disease,
 - d. Phenylketonuria,
 - e. Homocystinuria,
 - f. Maple syrup urine disease,
 - g. Biotinidase deficiency.
12. Hemoglobinopathies CRS conditions:
- a. Sickle cell anemia,
 - b. Thalassemia.
13. Medical/behavioral conditions which are not medically eligible for CRS:
- a. Allergies;
 - b. Anorexia nervosa or obesity;
 - c. Autism;
 - d. Cancer;
 - e. Depression or other mental illness;
 - f. Developmental delay;
 - g. Dyslexia or other learning disabilities;
 - h. Failure to thrive;
 - i. Hyperactivity;
 - j. Attention deficit disorder; and
 - k. Immunodeficiency, such as AIDS and HIV.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).
Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1). Section made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3).

R9-22-1304. Referral and Disposition of CRS Medical Eligibility Determination

- A.** To refer an individual for a CRS medical eligibility determination a person shall submit to the Administration the following information:
- 1. CRS application;
 - 2. Documentation from a provider who evaluated the individual, stating the individual's diagnosis;
 - 3. Diagnostic test results that support the individual's diagnosis; and
 - 4. Documentation of the individual's need for specialized treatment of the CRS condition through medical, surgical, or therapy modalities.
- B.** The Administration shall notify the CRS applicant, member or authorized representative of the outcome of the determination within 60 days of receipt of information required under subsection (A). The member may appeal the determination under 9 A.A.C. 34.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).
Amended by final rulemaking at 6 A.A.R. 3317, effective

August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1). Section made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3).

R9-22-1305. CRS Redetermination

- A.** Continued eligibility for the CRS program shall be redetermined by verifying active treatment status of the CRS qualifying medical conditions as follows:
 1. The CRS Contractor is responsible for notifying the AHCCCS Administration of the date when a CRS member is no longer in active treatment for the CRS qualifying condition(s).
 2. The Administration may request, at any time, that the CRS contractor submit the medical documentation requested in the CRS medical redetermination form within the specified time-frames in contract.
 3. The Administration shall notify the CRS member or authorized representative of the redetermination process.
- B.** If the Administration determines that a CRS member is no longer medically eligible for CRS, the Administration shall provide the CRS member or authorized representative a written notice that informs the CRS member that the Administration is transitioning the CRS member's enrollment according to R9-22-1306.
- C.** Upon reaching his or her 21st birthday the CRS member will be enrolled with a non-CRS contractor unless the member requests to continue enrollment with the CRS contractor.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1). Section made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3).

R9-22-1306. Transition or Termination

- A.** The Administration shall transition a CRS member from the CRS contractor when the Administration determines the CRS member does not meet the medical eligibility requirements in R9-22-1301.
- B.** The Administration shall terminate a CRS member from the CRS contractor and the AHCCCS program when the Administration determines the CRS member does not meet the AHCCCS eligibility requirements.
- C.** If the Administration transitions a CRS member from the CRS contractor, the Administration shall provide the CRS member, or authorized representative a written notice of transition.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1). Section made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3).

R9-22-1307. Covered Services

The AHCCCS will cover medically necessary services as described within Article 2.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1). Section made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3).

R9-22-1308. Repealed

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

R9-22-1309. Repealed

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

ARTICLE 14. AHCCCS MEDICAL COVERAGE FOR FAMILIES AND INDIVIDUALS

R9-22-1401. General Information

- A.** Scope. This Article contains eligibility criteria to determine whether a family or individual is eligible for AHCCCS medical coverage.
- B.** Definitions. In addition to definitions contained in R9-22-101 and A.R.S. § 36-2901, the words and phrases in this Article and Article 15 have the following meanings unless the context explicitly requires another meaning:

"Baby Arizona" means the public or private partnership program that provides a pregnant woman an opportunity to apply for AHCCCS medical coverage at a Baby Arizona provider's office through a streamlined eligibility process.

"BHS" means the division of Behavioral Health Services within the Arizona Department of Health Services.

"Burial plot" means a space reserved in a cemetery, crypt, vault, or mausoleum for the remains of a deceased person.

"Caretaker relative" means a parent who maintains a family setting for a dependent child and who exercises responsibility for the day-to-day physical care, guidance, and support of that child.

"Cash assistance" means a program administered by the Department that provides assistance to needy families with dependent children under 42 U.S.C. 601 et seq.

"CRS" means the program within ADHS that provides covered medical services and covered support services in accordance with A.R.S. 36-261.

"DCSE" means the Division of Child Support Enforcement, which is the division within the Department that administers the Title IV-D program and includes a contract agent operating a child support enforcement program on behalf of the Department.

"FAA" means the Family Assistance Administration, the administration within the Department's Division of Benefits and Medical Eligibility with responsibility for providing cash and food stamp assistance to a member and for determining eligibility for AHCCCS medical coverage.

"Homebound" means a person who is confined to home because of physical or mental incapacity.

"Income" means combined earned and unearned income.

"Indigent" means an applicant's total income, including sponsor deemed income actually received, is less than or

equal to 100% of the federal poverty level for the size of the income group under R9-22-1425.

“Liquid assets” means those assets in the form of cash or other financial instruments, that are convertible to cash and include:

- Savings accounts;
- Checking accounts;
- Stocks and bonds;
- Mutual fund shares;
- Promissory notes;
- Cash value of insurance policies; and
- Similar assets.

“Medical expense deduction” or “MED” means the cost of the following expenses if incurred in the United States:

A medical service or supply that would be covered if provided to an AHCCCS member of any age under Articles 2 and 12 of this Chapter;

A medical service or supply that would be covered if provided to an Arizona Long-term Care System member under 9 A.A.C. 28, Articles 2 and 11;

Other necessary medical services provided by a licensed practitioner or physician;

Assistance with daily living if the assistance is documented in an individual plan of care by a nurse, social service worker, registered therapist, or dietitian under the supervision of a physician except when provided by the spouse of an applicant or the parent of a minor child;

Medical services provided in a licensed nursing home or in an alternative HCBS setting under R9-28-101;

Purchasing and maintaining an animal guide or service animal for the assistance of a member of the MED family unit under R9-22-1436; and

Health insurance premiums, deductibles, and coinsurance, if the insured is a member of the MED family unit.

“Medical support” means to provide health care coverage in the form of health insurance or court-ordered payment for medical care.

“Nonparent caretaker relative” means a person, other than a parent, who is related by blood, marriage, or lawful adoption to a dependent child and who:

- Maintains a family setting for the dependent child, and
- Exercises responsibility for the day-to-day physical care, guidance, and support of the dependent child.

“Pre-enrollment process” means the process that provides an applicant the opportunity to choose an AHCCCS health plan before the determination of eligibility is completed.

“Resources” means real and personal property, including liquid assets.

“Spendthrift restriction” means a legal restriction on the use of a resource that prevents a payee or beneficiary from alienating the resource.

“Sponsor” means an individual who signs the USCIS I-864 Affidavit of Support agreeing to support a non-citizen as a condition of the non-citizen’s admission for permanent residence in the United States.

“Sponsor deemed income” means the unearned income for an applicant named on the USCIS I-864 Affidavit of Support who is applying for AHCCCS medical coverage.

“SVES” means the State Verification and Exchange System, a system through which the Department exchanges income and benefit information with the Internal Revenue Service, Social Security Administration, and State Wage and Unemployment Insurance Benefit data files.

“Title IV-D” means Title IV-D of the Social Security Act, 42 U.S.C. 651-669, the statutes establishing the child support enforcement and paternity program.

“Title IV-E” means Title IV-E of the Social Security Act 42 U.S.C. 670-679, the statutes establishing the foster care and adoption assistance programs.

“USCIS” means the United States Citizen and Immigration Services.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1402. Ineligible Person

A person is not eligible for AHCCCS medical coverage if the person is:

1. An inmate of a public institution, or
2. Age 21 through age 64 and is residing in an Institution for Mental Disease under 42 CFR 435.1009 except if allowed under the Administration’s Section 1115 waiver.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1403. Agency Responsible for Determining Eligibility

The Department shall determine eligibility under the provisions of this Article. The Department shall not discriminate against an applicant or member because of race, color, creed, religion, ancestry, national origin, age, sex, or physical or mental disability.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1404. Assignment of Rights Under Operation of Law

By operation of law and under A.R.S. § 36-2903, a person determined eligible assigns rights to the system and the county all types of medical benefits to which the person is entitled.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1405. Confidentiality and Safeguarding of Information

The Administration and Department shall maintain the confidentiality of an applicant or member's records and limit the release of safeguarded information under R9-22-512 and 6 A.A.C. 12, Article 1. In the event of a conflict between R9-22-512 and 6 A.A.C. 12, Article 1, R9-22-512 prevails.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1406. Application Process

A. Right to apply. A person may apply for AHCCCS medical coverage by submitting an Administration-approved written application to the Administration, an FAA office, or one of the following outstation locations:

1. A BHS site;
2. A facility contracted with CRS Administration;
3. A Baby Arizona-approved provider's office, if the applicant is a pregnant woman;
4. A Federally Qualified Health Center or disproportionate share hospital under 42 U.S.C. 1396r-4; or
5. Any other site, including a hospital, approved by the Department or the Administration.

B. Written application. To initiate the application process, any person may apply by submitting a written application under 42 CFR 435.907 with the appropriate signatures to one of the sites listed in subsection (A).

1. A written application is one that contains the:
 - a. Applicant's legible name,
 - b. Address or location where the applicant can be reached,
 - c. Signature of the person listed in subsection (D)(2) or (D)(3),
 - d. Date the application was signed.
2. The Administration or Administration's designee shall require that a third party witness the signing and attest by signing the application if the individual signing the application signs with a mark.
3. The Administration or Administration's designee shall accept an application for a person who is incapacitated and whose name and address are unknown.

C. Date of application. The date of application is the date a written application is received by the Administration or its designee at a location listed in subsection (A).

D. Complete application form.

1. The Administration shall consider an application complete when:
 - a. All questions are answered; and
 - b. All necessary verification is provided by an applicant or an applicant's representative.
2. The Administration or Administration's designee shall not approve an application unless the applicant's legal representative, if one exists, signs the declarations on the application relating to the applicant's eligibility, under penalty of perjury.
3. If there is no legal representative, or the legal representative is incapacitated, one of the following shall sign the declarations on the application relating to the applicant's eligibility, under penalty of perjury:
 - a. The applicant, if age 18 or older;

- b. The applicant, if less than 18 years old and married or not living with a parent;
 - c. The applicant's spouse if the applicant and spouse are not legally separated;
 - d. An adult who lives with an applicant, if the applicant is less than 18 years old or age 18 and a student;
 - e. One of the unmarried partners if living together with a child in common, if the child is the applicant;
 - f. Another party, if the applicant is incapacitated and no one listed in subsections (D)(3)(a) through (e) is available to sign the application on the applicant's behalf. The Administration shall require incapacity to be verified by written documentation signed by a licensed physician or by one of the following:
 - i. A physician assistant,
 - ii. A nurse practitioner, or
 - iii. A registered nurse under the direction of a licensed physician; or
 - g. A person authorized verbally in the presence of an employee of the Administration or the Administration's designee or in writing, by a person listed in subsection (D)(2) or (D)(3)(a) through (c), to represent the applicant in the application process. The authorized representative may sign the declaration on the application relating to the applicant's eligibility, under penalty of perjury.
4. Unmarried adults not applying for a child in common shall each sign the application if using the same application form.
 5. The application shall be witnessed and signed by a third party if the individual signing the application signs with a mark.
 6. If the application is incomplete, the Administration or the Administration's designee shall do at least one of the following:
 - a. Contact an applicant or an applicant's representative by telephone or electronic medium to obtain the missing information required for an eligibility determination;
 - b. Mail a request for additional information to an applicant or an applicant's representative, allowing 10 days from the date of the request to provide the required additional information; or
 - c. Meet with the applicant, representative, or household member.

E. Assistance with application. The Administration or Administration's designee shall allow a person of the applicant's choice to accompany, assist, and represent the applicant in the application process.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2).

R9-22-1407. Deceased Applicants

- A.** If an applicant dies while an application is pending, the Administration or Administration's designee shall complete an eligibility determination for all applicants listed on the application, including the deceased applicant.
- B.** The Administration or Administration's designee shall complete an eligibility determination on an application filed on

behalf of a deceased applicant, if the application is filed in the same month as the applicant's death.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1408. Applicant and Member Responsibility

- A. An applicant and a member shall authorize the Department to obtain verification for initial eligibility or continuation of eligibility.
- B. As a condition of eligibility, an applicant or a member shall:
 1. Provide the Department with complete and truthful information. The Department may deny an application or discontinue eligibility if:
 - a. The applicant or member fails to provide information necessary for initial or continuing eligibility;
 - b. The applicant or member fails to provide the Department with written authorization to permit the Department to obtain necessary initial or continuing eligibility verification;
 - c. The applicant or member fails to provide verification under R9-22-1412 after the Department made an effort to obtain the necessary verification but has not obtained the necessary information; or
 - d. The applicant or member does not assist the Department in resolving incomplete, inconsistent, or unclear information that is necessary for initial or continuing eligibility;
 2. Cooperate with the Division of Child Support Enforcement (DCSE) in establishing paternity and enforcing medical support obligations when requested unless good cause exists for not cooperating under 42 CFR 433.147 as of October 1, 2006, which is incorporated by reference, on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol St., NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments. The Department shall not deny AHCCCS eligibility to an applicant who would otherwise be eligible, is a minor child, and whose parent or legal representative does not cooperate with the medical support requirements under subsection (E) or first- and third-party liability requirements under Article 10 of this Chapter; and
 3. Provide the following information concerning third-party coverage for medical care:
 - a. Name of policyholder,
 - b. Policyholder's relationship to the applicant or member,
 - c. SSN of the policy holder,
 - d. Name and address of the insurance company, and
 - e. Policy number.
- C. A member or an applicant shall:
 1. Send to the Department any medical support payments received while the member is eligible that result from a medical support order;
 2. Cooperate with the Administration or Administration's designee regarding any issues arising as a result of Eligibility Quality Control described under A.R.S. § 36-2903.01; and

3. Inform the Department of the following changes within 10 days from the date the applicant or member knows of a change:
 - a. In address;
 - b. In the household's composition;
 - c. In income;
 - d. In resources, when required under R9-22-1438 for the Medical Expense Deduction (MED) program;
 - e. In Arizona state residency;
 - f. In citizenship or immigrant status;
 - g. In first- or third-party liability that may contribute to the payment of all or a portion of the person's medical costs; or
 - h. That may affect the member's or applicant's eligibility, including a change in a woman's pregnancy status.
- D. As a condition of eligibility, an applicant or a member shall apply for other benefits as required under 42 CFR 435.608 as of October 1, 2006, which is incorporated by reference, on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol St., NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
- E. As a condition of eligibility, an applicant or a member shall cooperate with the assignment of rights under R9-22-1404. If the applicant or member receives medical care and services for which a first or third party is or may be liable, the applicant or member shall cooperate with the Department and the Administration in identifying and providing information to assist the Department and the Administration in pursuing any first or third party who is or may be liable to pay for medical care and services.
- F. As a condition of eligibility of a child whose parent, legal representative, or other legally responsible adult applies for AHC-CCS medical coverage on behalf of the child, the individual who applies for the child shall cooperate with the Department to establish paternity and obtain medical support or other payments as provided in A.R.S. § 46-292(C). However, a pregnant woman under A.R.S. § 36-2901(6)(a)(ii) is not required to provide the Department with information regarding paternity or medical support from a father of a child born out of wedlock.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2).

R9-22-1409. Withdrawal of Application

- A. An applicant may withdraw an application at any time before the Department completes an eligibility determination by making an oral or written request for withdrawal to the Department and stating the reason for withdrawal.
- B. If an applicant orally requests withdrawal of the application, the Department shall document the:
 1. Date of the request,
 2. Name of the applicant for whom the withdrawal applies, and
 3. Reason for the withdrawal.
- C. An applicant may withdraw an application in writing by:
 1. Completing a Department-approved voluntary withdrawal form; or

2. Submitting a written, signed, and dated request to withdraw the application.
- D.** The effective date of the withdrawal is the date of the application.
- E.** If an applicant requests to withdraw an application, the Department shall:
 1. Deny the application, and
 2. Notify the applicant of the denial following the notice requirements under R9-22-1413.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1410. Department Responsibilities

- A.** The Department shall provide during the application process to the applicant or member information explaining the requirements to:
 1. Cooperate with DCSE in establishing paternity and enforcing medical support, except in circumstances when good cause under 42 CFR 433.147 exists for not cooperating;
 2. If applicable, establish good cause for not cooperating with DCSE in establishing paternity and enforcing medical support;
 3. Report a change listed in R9-22-1408(C)(3) no later than 10 days from the date the applicant or member knows of the change;
 4. Send to the Department any medical support payments received through a Title IV-D court order; and
 5. Cooperate with the Department's and Administration's assignment of rights and securing payments received from any liable party for a member's medical care.
- B.** At initial application or eligibility review a Department representative shall:
 1. Offer to help the applicant or member to complete the application form and to obtain required verification;
 2. Provide the applicant or member with information explaining:
 - a. The eligibility and verification requirements for AHCCCS medical coverage,
 - b. The requirement that the applicant or member obtain and provide a SSN to the Department,
 - c. How the Department uses the SSN,
 - d. The Department's practice of exchanging eligibility and income information through the State Verification and Exchange System (SVES),
 - e. The applicant and member's right to appeal an adverse action under R9-22-1441,
 - f. The assignment of rights under operation of law as provided in A.R.S. § 36-2903,
 - g. That the Department will use any information provided by the member to complete data matches with potentially liable parties,
 - h. The eligibility review process,
 - i. The program coverage and the types of services available under each program,
 - j. The AHCCCS pre-enrollment process,
 - k. Availability of continued AHCCCS medical coverage under R9-22-1427,

- l. That the Department will use the Systematic Alien Verification for Entitlements (SAVE) process to verify eligible alien status, and
- m. That the Department will help the applicant or member obtain necessary verification if the applicant or member asks for help;
3. Provide information regarding the penalties for perjury and fraud printed on the application;
4. Review any verification items provided by the applicant or member and inform the member of any additional verification items and time-frames within which the applicant or member shall provide information to the Department;
5. Explain to the applicant or member the applicant's and member's responsibilities under R9-22-1408;
6. Provide information regarding all reporting requirements and explain to the applicant or member that the applicant or member may lose the earned income disregards under R9-22-1420 if the applicant or member fails to timely report earned income changes.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Section repealed; new Section made by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2).

R9-22-1411. Withdrawal from AHCCCS Medical Coverage

- A.** A member may withdraw from AHCCCS medical coverage at any time by giving oral or written notice of withdrawal to the Department. The member or the member's legal or authorized representative shall provide the Department with:
 1. The reason for the withdrawal,
 2. The date the notice is effective, and
 3. The name of the member for whom AHCCCS medical coverage is being withdrawn.
- B.** The Department shall discontinue eligibility for AHCCCS medical coverage for all family members if the notice of withdrawal does not identify a specific person.
- C.** The Department shall notify the member of the discontinuance as required by R9-22-1415.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1412. Verification of Eligibility Information

- A.** An applicant or a member has the primary responsibility to provide the Department with information necessary to verify eligibility and complete the determination of eligibility at the time of initial application, when a change in circumstances occurs that may affect eligibility, or at the eligibility review under R9-22-1414. With the exception of subsection (B), the applicant or member shall use the following types of documents, in the following order, to verify information:
 1. First, hard copy verification: written evidence originating from an agency, organization, or an individual with actual knowledge of the information;

2. Second, a written record of a collateral contact: a verbal statement from a representative of an agency or organization, or an individual with actual knowledge of the information; and
3. Third, the applicant's or member's written statement, to be used only if:
 - a. Verification under subsections (A)(1) and (A)(2) is not available, and
 - b. The statement is not inconsistent with other information.
- B.** The Department shall not accept any form of verification other than hard copy verification for:
 1. SSN;
 2. Legal alien status;
 3. Proof of alien sponsor under R9-22-1425, if applicable;
 4. Relationship, when questionable; and
 5. Citizenship, when questionable.
- C.** The Department shall only accept hard copy verification or a collateral contact for verification of pregnancy and amounts billed for the care of a dependent child or incapacitated adult.
- D.** The Department shall provide an applicant or member at least 10 days from the date of a written request for information to provide required verification. The Department may deny the application or discontinue eligibility if an applicant or a member does not provide the required information timely.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by exempt rulemaking at 10 A.A.R. 23, effective December 9, 2003 (Supp. 03-4). Amended by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1413. Time-frames, Approval, Discontinuance, or Denial of an Application

- A.** Application processing time. The Department shall complete an eligibility determination under 42 CFR 435.911 within 45 days after the application date under R9-22-1406 unless:
 1. The applicant is pregnant. The Department shall complete an eligibility determination for a pregnant woman within 20 days after the application date unless additional information is required to determine eligibility; or
 2. The applicant is in a hospital as an inpatient at the time of application. Within seven days of the Department's receipt of a signed application the Department shall complete an eligibility determination if the Department does not need additional information or verification to determine eligibility.
- B.** Approval. If the applicant meets all the eligibility requirements and conditions of eligibility of this Article, the Department shall approve the application and provide the applicant with an approval notice. The approval notice shall contain:
 1. The name of each approved applicant,
 2. The effective date of eligibility as defined in R9-22-1416 for each approved applicant,
 3. The reason and the legal citations if a member is approved for only emergency medical services, and
 4. The applicant's right to appeal the decision under R9-22-1441(A).
- C.** Denial. If an applicant fails to meet the eligibility requirements or conditions of eligibility of this Article, the Department shall

deny the application and provide the applicant with a denial notice. The denial notice shall contain:

1. The name of each ineligible applicant,
 2. The specific reason why the applicant is ineligible,
 3. The income and resource calculations for the applicant compared to the income or resource standards for eligibility when the reason for the denial is due to the applicant's income or resources exceeding the applicable standard,
 4. The legal citations supporting the reason for the ineligibility,
 5. The location where the applicant can review the legal citations,
 6. The date of the application being denied; and
 7. The applicant's right to appeal the decision and request a hearing.
- D.** The Department shall reopen an application or reinstate eligibility of a member when any of the following conditions are met:
1. The denial or discontinuance of eligibility was due to an administrative error,
 2. The discontinuance of eligibility was due to noncompliance with a condition of eligibility and the applicant or member complies prior to the effective date of the discontinuance,
 3. The member informs the Department of a change of circumstances prior to the effective date of the discontinuance, that would allow for continued eligibility, or
 4. Following a discontinuance the member requests and is eligible for continuation of medical coverage pending an appeal under R9-22-1441.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2).

R9-22-1414. Review of Eligibility

- A.** Except as provided in subsection (B), the Department shall complete a review of each member's continued eligibility for AHCCCS medical coverage at least once every 12 months.
- B.** The Department shall complete a review of eligibility for a:
 1. Pregnant woman determined eligible under R9-22-1428(2) following the termination of her pregnancy,
 2. Non-pregnant member approved only for Federal Emergency Services at least once in a six-month period,
 3. Member approved for the MED program under R9-22-1435 through R9-22-1440 before the end of the six-month eligibility period,
 4. Any time there is a change in a member's circumstance that may affect eligibility.
- C.** If a member continues to meet all eligibility requirements and conditions of eligibility, the Department shall authorize continued eligibility and notify the member of continued eligibility. If the member continues to be eligible for Federal Emergency Services, the notice shall state that the continued eligibility is for Federal Emergency Services only.
- D.** The Department shall discontinue eligibility and notify the member of the discontinuance under R9-22-1415 if the member:
 1. Fails to comply with the review of eligibility,
 2. Fails to comply with the requirements and conditions of eligibility under this Article without good cause under 42 CFR 433.148, or

3. Does not meet the eligibility requirements.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1415. Notice of Adverse Action

- A. Notice requirement. If a member fails to meet an eligibility requirement or condition of eligibility under this Chapter, the Department shall provide the member a Notice of Adverse Action no later than 10 days before the effective date of the suspension, reduction, or discontinuance.
- B. The Department shall mail a Notice of Adverse Action to a member to discontinue eligibility no later than the effective date of action if the Department:
 1. Receives a request to withdraw under R9-22-1411,
 2. Receives verification that the member is ineligible under R9-22-1402,
 3. Has documented information confirming the death of a member,
 4. Receives returned mail with no forwarding address from the post office and the member's whereabouts are unknown, or
 5. Verifies that the member has been approved for Medicaid by another state.
- C. The Department shall ensure that the Notice of Adverse Action contains:
 1. The name of each ineligible member,
 2. The specific reason why the member is ineligible,
 3. The income and resource calculations compared to the income or resource standards when the reason for the discontinuance is due to the member's income or resources exceeding the applicable standard,
 4. The legal citations supporting the reason for ineligibility,
 5. The location where the member can review the legal citations,
 6. The date the discontinuance is effective, and
 7. The member's appeal rights and right to continued medical coverage pending appeal under R9-22-1441.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1416. Effective Date of Eligibility

- A. Except as provided in subsections (B) and (C), the effective date of eligibility is the first day of the month that the applicant files an application if the applicant is eligible that month, or the first day of the first eligible month following the application month except for:
 1. The MED program under R9-22-1439, and
 2. Eligibility for a newborn under R9-22-1429.
- B. The effective date of eligibility for an applicant who moves into Arizona during the month of application is the date Arizona residency is established.
- C. The effective date of eligibility for an inmate applying for medical coverage is the date the applicant no longer meets the definition of an inmate of a public institution.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1417. Social Security Number

- A. As a condition of eligibility, an applicant or a member shall furnish a SSN under 42 CFR 435.910 and 435.920.
- B. A person who is not able to legally obtain a SSN is not required to furnish a SSN.
- C. The Department shall grant an applicant until the first review of eligibility to provide a SSN if the applicant is cooperating with the Department to obtain a SSN.
- D. If an applicant cannot recall the applicant's SSN or has not been issued a SSN, the Department shall assist in obtaining or verifying the applicant's SSN under 42 CFR 435.910.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1418. State Residency

An applicant or a member is not eligible unless the applicant or member is a resident of Arizona under 42 CFR 435.403 as of November 21, 1990, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments. The Department shall not consider an alien who does not have immigrant status under 8 U.S.C. 1101(a)(15) to be a resident.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1419. Citizenship and Immigrant Status

- A. An applicant or a member is not eligible for full services under Article 2 of this Chapter, unless the applicant or member is a citizen of the United States or is a qualified alien under A.R.S. § 36-2903.03(B) or meets the requirements of A.R.S. § 36-2903.03(C).
- B. The Department shall use the Systematic Alien Verification for Entitlements (SAVE) process to verify legal alien status.
- C. An applicant or member is eligible for emergency medical services under R9-22-217 if the applicant or member is either a qualified alien or noncitizen and:
 1. Meets all other eligibility requirements except those in subsection (A), and
 2. Is eligible under A.R.S. § 36-2901(6)(a)(i), (ii), or (iii).

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7

A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1419.01. Repealed

Historical Note

New Section made by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Section repealed by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1419.02. Repealed

Historical Note

New Section made by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Section repealed by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1419.03. Repealed

Historical Note

New Section made by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Section repealed by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1419.04. Repealed

Historical Note

New Section made by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Section repealed by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1420. Income Eligibility Criteria

A. Evaluation of income. In determining eligibility, the Department shall evaluate the following types of income received by a person identified in subsection (B):

1. Earned income, including in-kind income, before any deductions. For purposes of this Section, in-kind income means room, board, or provision for other needs in exchange for work performed. The person identified in subsection (B) shall ensure that the provider of the in-kind income establishes and verifies the monetary value of the item provided. The provider may be, but is not limited to:
 - a. A landlord who provides all or a portion of rent or utilities in exchange for services;
 - b. A store owner who gives goods such as groceries, clothes, or furniture in exchange for services; or
 - c. An individual who trades goods such as a car, tools, trailer, building material, or gasoline in exchange for services;
2. Self-employment income under R9-22-1424, including gross business receipts minus business expenses; and
3. Unearned income, including deemed income under R9-22-1425 from the sponsor of a non-citizen applicant.

B. A person whose income is counted. The Department shall include the income of the following persons under Section 1902(a)(17) of the Act if living with the applicant unless the person is a SSI cash recipient:

1. Applicant;
2. Applicant's parent if the applicant is an unmarried dependent child who is less than 18 years old;
3. Applicant's spouse;

4. A sponsor under 8 CFR 213a.1 of a person meeting the qualified alien requirements under A.R.S. § 36-2903.03 and the sponsor's spouse; and
5. A non-parent caretaker relative and spouse, as allowed under R9-22-1427, and their unmarried minor children if applying as a family, including a dependent child living with a caretaker relative.

C. Income exclusions. The Department shall not count the following income:

1. Agent Orange settlement fund payments;
2. AmeriCorps Network Program benefits;
3. Burial benefits dispersed solely for burial expenses;
4. Cash contributions from agencies or organizations other than the Department or the Administration if the contributions are not intended to cover the following items:
 - a. Food;
 - b. Rent or mortgage payments for shelter;
 - c. Utilities;
 - d. Household supplies such as bedding, towels, laundry, cleaning, and paper supplies;
 - e. Public transportation fares for personal use;
 - f. Basic clothing or diapers; or
 - g. Personal care and hygiene items, such as soap, toothpaste, shaving cream, and deodorant;
5. Disaster assistance provided under the Federal Disaster Relief Act, disaster assistance organizations, or comparable assistance provided by state or local governments;
6. Educational grants or scholarships funded by the United States Department of Education or from a Veterans Education assistance program or the Bureau of Indian Affairs student assistance program;
7. Energy assistance that is provided:
 - a. Either in cash or in-kind by a government agency or municipal utility, or
 - b. In-kind by a private nonprofit organization;
8. Earnings from high school on-the-job training programs;
9. Earned income of a dependent child who is a student enrolled and attending school at least half-time as defined by the institution;
10. Fair Labor Standard Act supplemental payment;
11. Food stamp benefits;
12. Foster care maintenance payments intended for a child who is not included in the family or Medical Expense Deduction (MED) unit;
13. Funds set aside in an Individual Development Account under A.A.C. R6-12-404;
14. Governmental rent and housing subsidies;
15. Income tax refunds, including any earned income tax credit;
16. Loans from a private person or a commercial or educational institution if there is a written agreement for repayment of the loan;
17. Nonrecurring cash gifts that do not exceed \$30 per person in any calendar quarter;
18. Payments made from a fund established by the Susan Walker v. Bayer Corporation class action lawsuit or the Ricky Ray Hemophilia Relief Fund Act of 1998;
19. Radiation exposure compensation payments;
20. Reimbursement for work-related expenses that do not exceed the actual expense amount;
21. Reimbursement for Job Opportunities and Basic Skills (JOBS) Program training-related expenses;
22. Reparation and restitution payments under Section 1902(r) of the Act;
23. SSI designated account and interest earned on the account;

24. Temporary Assistance for Needy Families (TANF) or SSI cash assistance payment;
 25. Vendor payment made by an organization or person who is not a member of the family or MED unit, to a third party to cover family expenses;
 26. Volunteers In Service To America (VISTA) income that does not exceed the state or federal minimum wage;
 27. Vocational rehabilitation program payments made as reimbursement for training-related expenses, subsistence and maintenance allowances, and incentive payments that are not intended as wages;
 28. Women, Infants, and Children (WIC) benefits; or
 29. Any other income specifically excluded under 20 CFR 416 Appendix to Subpart K, as of June 6, 1997, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
- D.** Special income provision for child support. The Administration or Administration's designee shall consider child support to be income of the child for whom the support is intended and count the child support income received after deducting \$50 per child receiving child support income from the monthly amount.
- E.** Determining income for a month.
1. Calculating monthly income. The Administration or Administration's designee shall calculate monthly income under R9-22-1421 through R9-22-1426,
 2. The Administration or Administration's designee shall deduct the applicable disregards and deductions to which a person is entitled for the month.
- F.** Earned income disregards.
1. General. The Department shall apply the earned income disregards to each employed person's gross earnings.
 2. Disregards. The Department shall apply the following method to calculate the amount of the countable earned income under subsection (A):
 - a. Subtract a \$90 cost of employment (COE) allowance from the gross amount of earned income for each person whose earned income is counted;
 - b. Subtract an amount billed for the care of each dependent child or incapacitated adult member who is the responsibility of the person whose income is counted, if the care is for the purpose of allowing the person to work. If more than one person in the household is responsible for and billed for the care of a dependent child the disregard may be split between the wage earners to the benefit of the family, but shall not exceed the maximum disregards as follows:
 - i. A maximum of \$200 for each child under age two and \$175 for each other dependent for a wage-earner employed full-time (86 or more hours per month); and
 - ii. A maximum of \$100 for each child under age two, and \$88 for each other dependent for a wage earner employed part-time (less than 86 hours a month).
 3. Loss of disregards. The Department shall not apply the earned income disregards if the member fails to report to the Department a change in earned income within 10 days from the date the change becomes known to the member. The change report to the Department shall be postmarked no later than the 10th day from the date the change becomes known.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1421. Income Eligibility

- A.** A person is eligible under this Article unless the person's monthly income exceeds the appropriate Federal Poverty Level (FPL) listed in R9-22-1427 and R9-22-1428. A person is eligible under R9-22-1437 unless the person's income during the period defined in R9-22-1437(C) exceeds the FPL under R9-22-1437(B).
- B.** The Administration or Administration's designee shall consider the following factors when determining the income period to use to determine monthly income:
1. Type of income,
 2. Frequency of income,
 3. If source of income is new or terminated, or
 4. Income fluctuation
- C.** Definitions.
1. "Monthly income" means the gross countable income received or projected to be received during the month or the monthly equivalent.
 2. "Monthly equivalent" means a monthly countable income amount established by averaging, prorating, or converting a person's income.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1422. Methods for Calculating Monthly Income

- A.** Projecting income.
1. Description. Projecting income is a method of determining the amount of income that a person will receive.
 2. Calculation. The Department shall project income by:
 - a. Converting income to a monthly equivalent,
 - b. Using unconverted income, or
 - c. Prorating income to determine a monthly equivalent.
 3. Exclusion. When calculating projected monthly income, the Administration or Administration's designee shall exclude an unusual variation in income under R9-22-1424(E), except for a month in which the variation is anticipated to occur.
- B.** Averaged income.
1. Description. Averaging income proportionally distributes the person's income received on a regular basis.
 2. Calculation. To average income, the Administration or Administration's designee shall add the amount of the income and divide by the total number of pay periods. If the amount of income received per pay period fluctuates, and the fluctuation is expected to continue, the Administration or designee shall:
 - a. Use the averaged weekly or bi-weekly amounts to convert weekly or bi-weekly income to a monthly equivalent;
 - b. Use the averaged monthly or semi-monthly amounts to project monthly income; and

- c. Use the averaged hours worked and multiply the average by the current rate of pay. If there is a change in the rate of pay, use the new rate of pay when calculating projected income under subsection (A).
- C. Prorated income.
 - 1. Description. Prorated income evenly distributes a person's income over the period the income is intended to cover to calculate a monthly equivalent.
 - 2. Calculation. To prorate income, the Administration or designee shall divide the total amount of the person's income received during the period by the number of months that the income is intended to cover.
- D. Converted income.
 - 1. Description. Converted income is income received weekly or biweekly that is changed to a monthly equivalent.
 - 2. Calculation.
 - a. The Administration or designee shall average the weekly or bi-weekly income amounts before converting to the monthly equivalent if the person's past income fluctuates and the fluctuation is expected to recur.
 - b. To convert income paid weekly to a monthly equivalent, the Administration or designee shall multiply the weekly average by 4.3 weeks.
 - c. To convert income paid bi-weekly to a monthly equivalent, the Administration or designee shall multiply the bi-weekly average by 2.15 weeks.
- E. Unconverted income.
 - 1. Description. Unconverted income is the actual amount of income received or projected to be received during a month.
 - 2. Calculation. The Administration or designee shall sum the actual amount of income received or projected to be received during a month.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1423. Calculations and Use of Methods Listed in R9-22-1422 Based on Frequency of Income

- A. Monthly income. If income is received monthly or in a lump sum, the Administration or designee shall use the unconverted method for calculating monthly income.
 - 1. Lump sum means a nonrecurring payment that serves as a complete payment.
 - 2. Lump sum payments include but are not limited to: rebates or credits; inheritances; insurance settlements; and payments for prior months from such sources as Social Security, Veterans Administration, Railroad Retirement, child support arrearages, or other benefits.
 - 3. A lump sum payment may include a portion intended for the current month.
- B. Weekly income. If income is received weekly, the Administration or designee shall convert the income to a monthly equivalent under R9-22-1422(D).
- C. Bi-weekly income. If income is received bi-weekly, the Administration or designee shall convert the income to a monthly equivalent under R9-22-1422(D).

- D. Semi-monthly or daily income. If income is received semi-monthly or daily, the Administration or designee shall use the unconverted method for calculating monthly income under R9-22-1422(E).
- E. Bimonthly, quarterly, semi-annual, or annual income. If income is received bimonthly, quarterly, semi-annually, or annually, the Administration or designee shall prorate the income received or projected to be received under R9-22-1422(C).

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1424. Use of Methods Listed in R9-22-1423 Based on Type of Income

- A. New income.
 - 1. Description. New income is income received from a new source during the first calendar month that the income is received from the source.
 - 2. Calculating monthly income.
 - a. If a full month's income is received, the Administration or Administration's designee shall use the appropriate method described in R9-22-1423 to calculate the monthly income.
 - b. If less than a full month's income is received, the Administration or Administration's designee shall use the unconverted method to calculate the monthly income.
- B. Terminated income.
 - 1. Description. Terminated income is income received during the last calendar month that income is received from a source when no more income is expected to be received from the source.
 - 2. Calculating monthly income.
 - a. If a full month's income is received, the Administration or Administration's designee shall use the appropriate method described in R9-22-1423 to calculate the monthly income.
 - b. If less than a full month's income is received, the Administration or Administration's designee shall use the unconverted method to calculate the monthly income.
- C. Break in income.
 - 1. Description. A break in income is a break in established frequency of income of one calendar month or more.
 - 2. Calculating monthly income.
 - a. If a full month's income is received, the Administration or Administration's designee shall use the appropriate method described in R9-22-1423 to calculate the monthly income.
 - b. If less than a full month's income is received, the Administration or Administration's designee shall use the unconverted method to calculate the monthly income.
- D. Contract income.
 - 1. Description. Contract income is income a person earns under a contract or other legal document that specifies a length of time the contract or legal document covers, the amount of income to be paid, and the frequency of payment.
 - 2. Calculating monthly income.

- a. The Administration or designee shall calculate the monthly income based on the frequency of payment if income is paid more frequently than monthly.
 - b. The Administration or designee shall prorate over the period of time specified by the contract if income is paid monthly or less frequently.
- E. Unusual variation in the amount of income.**
 - 1. Description. Unusual variation is an amount of income that is different from the established amount received and is not projected to continue or recur.
 - 2. Calculating monthly income.
 - a. When calculating income for the month in which an unusual variation in income occurs, the Administration or designee shall include the unusual variation in the income calculation.
 - b. When an unusual variation in income occurs during the month, the Administration or Administration's designee shall use the converted method for calculating monthly income if income is received weekly or bi-weekly.
 - c. When projecting income for the months following the month in which the unusual variation occurs, the Administration or designee shall exclude the unusual variation in income from the income calculation.
- F. Self-employment income.**
 - 1. Description. Self-employment income is income a person earns from the person's own trade or business less allowable expenses.
 - 2. Calculating monthly income. The Administration or Administration's designee shall use the following methods in the following order:
 - a. When the self-employed person filed a tax return for the prior year and the person states that the current income is the same, the Administration or Administration's designee shall prorate the income under R9-22-1422.
 - b. When the self-employed person did not file a tax return for the prior year or states that the current income is not the same, the Administration or Administration's designee shall:
 - i. Use the person's business ledger or other records to verify the current income received, less allowable expenses; and
 - ii. Use the appropriate method described in R9-22-1423 to calculate the monthly income.
 - c. When the self-employed person did not file a tax return or keep business records of the income received and expense incurred during the income period, the Administration or Administration's designee:
 - i. Shall use the person's written statement to verify income received,
 - ii. Shall not deduct incurred expenses from the income without hard-copy verification of the expense, and
 - iii. Shall use the appropriate method described in R9-22-1423 to calculate the monthly income.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1425. Sponsor Deemed Income

- A.** The Administration or Administration's designee shall use income of a USCIS sponsor to determine eligibility for a non-citizen applicant, whether or not the income is available, to the non-citizen applicant unless exempt under R9-22-1426.
- B.** Counting the income from a sponsor.
 - 1. This Section applies to non-citizens applicants who:
 - a. Are Lawful Permanent Residents under 8 CFR 101.3;
 - b. Applied for Lawful Permanent Resident Status on or after December 19, 1997;
 - c. Are sponsored by an individual who signed a USCIS I-864 Affidavit of Support; and
 - d. Are eligible for full AHCCCS medical coverage.
 - 2. Sponsor deemed income shall be considered the income of the non-citizen applicant only.
 - 3. The Administration shall not use the provisions of this Section and R9-22-1426 when:
 - a. The applicant becomes a naturalized U.S. citizen;
 - b. The applicant qualifies for an exemption listed in R9-22-1426; or
 - c. The sponsor dies.
- C.** Determining income from a sponsor.
 - 1. For an applicant who is exempt under R9-22-1426(C) and (D), only cash contributions actually received from the sponsor are countable income to the applicant.
 - 2. For an applicant to whom the sponsor's income is deemed, the Department shall exclude any cash contributions received from the sponsor.
- D.** Calculation of income from a sponsor.
 - 1. The Department shall include the total gross income of the sponsor and the following individuals who live in the sponsor's household:
 - a. The sponsor's spouse,
 - b. The sponsor's dependent children, and
 - c. The sponsor's spouse's dependent children;
 - 2. The Department shall subtract the total gross income from 100% of the FPL for the sponsor's family size; and
 - 3. The amount calculated under subsections (D)(1) and (D)(2) represents the remaining amount deemed to the applicant from the sponsor.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1426. Exemptions from Sponsor Deemed Income

- A.** An applicant shall provide proof to the Administration or designee when claiming an exemption from sponsor deemed income.
- B.** The Administration or designee shall grant an exemption from using a sponsor's income for a Lawful Permanent Resident applicant if the applicant:
 - 1. Entered the U.S. or applied for a visa or adjustment of status before December 19, 1997;
 - 2. Adjusted immigration status to Lawful Permanent Resident from status as a refugee or asylee;
 - 3. Qualifies only for Federal Emergency Services;
 - 4. Has a sponsor who signed an Affidavit of Support other than the USCIS Form I-864;
 - 5. Is the spouse or child of the sponsor and lives with the sponsor;

6. Is indigent as specified in subsection (C);
 7. Is a victim of domestic violence or extreme cruelty as specified in subsection (D); or
 8. Has acquired 40 qualified quarters of work credit based on earnings as specified in subsection (E).
- C.** The Administration or designee shall grant an exemption from sponsor deemed income for indigent applicants for a period of 12 months beginning with the application month. The Administration or designee shall redetermine indigent status at each eligibility renewal.
1. An applicant is indigent if all of the following are met:
 - a. The applicant does not reside with the applicant's sponsor;
 - b. The applicant does not receive free room and board; and
 - c. The applicant's total gross income including monies received from the sponsor and the value of any vendor payments received for food, utilities, or shelter does not exceed 100% of the FPL.
 2. The Administration shall send a notice to the Department of Homeland Security when approving an applicant who is exempt from sponsor deemed income due to indigency.
- D.** The Administration shall grant an exemption from sponsor deemed income for an applicant who is a victim of domestic violence or extreme cruelty under 8 CFR 204.2 for a period of 12 months beginning with the application month. The Administration shall redetermine the exemption status at each renewal.
1. The Administration considers an applicant to be a victim of domestic violence or extreme cruelty when all of the following are met:
 - a. The applicant is the victim, the parent of a child victim, or the child of a parent victim;
 - b. The perpetrator of the domestic violence or extreme cruelty was the spouse or parent of the victim or other family member related by blood, marriage or adoption to the victim;
 - c. The perpetrator was residing in the same household as the victim when the abuse occurred;
 - d. The abuse occurred in the United States;
 - e. The applicant did not participate in the domestic violence or cruelty; and
 - f. The victim does not currently live with the perpetrator.
 2. The applicant shall provide proof that the applicant or the applicant's child is a victim of domestic violence or extreme cruelty by presenting one of the following:
 - a. USCIS form I-360 Petition for Amerasian, Widow, or Special Immigrant;
 - b. USCIS form I-797 USCIS approval of the I-360 petition;
 - c. Reports or affidavits concerning the domestic violence or cruelty from police, judges, or other court officials, medical personnel, school officials, clergy, social workers, counseling or mental health personnel, or other social service agency personnel;
 - d. Legal documentation, such as an order of protection against the perpetrator or an order convicting the perpetrator of committing an act of domestic violence or extreme cruelty that chronicles the existence of domestic violence or extreme cruelty;
 - e. Evidence that indicates that the applicant sought safe haven in a battered women's shelter or similar refuge because of the domestic violence or extreme cruelty against the applicant or the applicant's child; or
 - f. Photographs of the applicant or applicant's child showing visible injury.
- E.** The Administration shall grant an exemption from sponsor deemed income for an applicant who has reached 40 qualifying quarters of work credit.
1. The Administration or Administration's designee shall not count quarters credited after January 1, 1997 that were earned while the applicant was receiving any federal means-tested benefits.
 2. The Administration shall not count the 40 qualifying quarters of work credit unless the credited quarters are:
 - a. Quarters that the applicant worked;
 - b. Quarters worked by the applicant's spouse or deceased spouse during their marriage; or
 - c. Quarters worked by the applicant's parents when the applicant was under age 18.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1427. Eligibility for a Family

- A.** A family unit with an eligible deprived dependent child is eligible for AHCCCS medical coverage when the requirements of this Section are met. A woman in her third trimester of pregnancy with no other dependent children is considered a family unit with a dependent child.
- B.** A family unit includes the following when living together:
1. A natural or adopted dependent child under age 18,
 2. A dependent child who is age 18 and:
 - a. A full-time student at a secondary school or attending a vocational or technical training school that includes shop practicum for at least 30 hours per week or does not include shop practicum and attendance is at least 25 hours per week, and
 - b. Reasonably expected to complete the education or training before age 19; and
 3. A natural or adoptive parent of a dependent child.
- C.** The Department shall include in the family unit, the spouse of the dependent child's parent if the spouse wants to apply for AHCCCS medical coverage. The Department shall include the spouse of the non-parent caretaker relative if:
1. The non-parent caretaker relative applies and is eligible, and
 2. The non-parent caretaker relative applies for the spouse.
- D.** The Department shall include in the family unit, a dependent child's non-parent caretaker relative if the non-parent caretaker relative wants to apply for AHCCCS medical coverage and:
1. Provides the dependent child with:
 - a. Physical care,
 - b. Support,
 - c. Guidance, and
 - d. Control; and
 2. The parent of a dependent child:
 - a. Does not live in the non-parent caretaker relative's home;
 - b. Lives with the non-parent caretaker relative but is also a dependent child; or
 - c. Lives with the non-parent caretaker relative but cannot function as a parent due to physical or mental impairment.

- E.** The Department shall not include a SSI-cash recipient in the family unit.
- F.** A child is considered a deprived dependent if deprived of parental support and care by:
1. Continued absence of a parent;
 2. Death of a parent;
 3. Disability of a parent, as determined by a healthcare practitioner;
 4. Unemployment or under-employment of a parent in a two-parent assistance unit under subsection (I).
- G.** Continued absence of a parent.
1. Continued absence under subsection (F) is established:
 - a. When absence of the parent from the home either interrupts or terminates the parent's functioning as a provider of support, physical care, or guidance for the child;
 - b. When absence of the parent from the house for a known or indefinite duration precludes relying on the parent for the present support or care of the child; or
 - c. When the parent's absence from the home is for a period of 30 days or more and for any reason other than those listed in subsection (G)(2).
 2. The Department shall not consider the following to be continued absence:
 - a. The parent is voluntarily absent to visit friends or relatives, to seek employment or maintain a job, or to attend school or training if the parent in the home and the absent parent are not separated;
 - b. The parent is absent due to active military duty;
 - c. The parents live in separate dwellings and the dwellings are considered part of a single home; or
 - d. One parent is absent from the home in order to allow the remaining family members to qualify for medical assistance.
- H.** Disability of a parent, as determined by a healthcare practitioner.
1. Disability is established if the parent or applicant provides a medical statement from a healthcare practitioner that includes:
 - a. A diagnosis of the parent's medical condition,
 - b. A finding that the parent has a physical or mental condition that prevents the parent from working, and
 - c. An opinion concerning the duration of unemployability or a date for re-evaluation of unemployability.
 2. Disability is established without further medical verification if the parent or applicant provides evidence that:
 - a. The Social Security Administration (SSA) has determined that the parent is eligible for Retirement, Survivors, Disability Insurance (RSDI) benefits due to blindness or disability;
 - b. The SSA has determined that the parent is eligible for Supplemental Security Income (SSI) due to blindness or disability;
 - c. The Veteran's Administration has determined that the parent has a 100% disability;
 - d. The parent's healthcare practitioner has released the parent from the hospital and imposed work restrictions for a specified recuperation period;
 - e. The parent's employer or physician has required the parent to terminate employment due to the onset of a disability and the healthcare practitioner has specified a recuperation period;
 - f. The parent's healthcare practitioner has determined that the parent is capable of employment only in a sheltered workshop under 26 U.S.C. 151(c)(5)(B), for a specified period of time, and the parent is so employed; or
 - g. A prior certification of the parent's disability by a healthcare practitioner is in the applicant's case record as maintained by the Department and is still valid to cover the period in which assistance is requested and will be received.
- I.** Unemployment or under-employment of a parent in a two-parent assistance unit.
1. A child is deprived if the primary wage earning parent is unemployed or underemployed and the two-parent assistance unit meets the following requirements:
 - a. The child's natural or adoptive mother and father both reside with the child, and
 - b. Neither parent meets the provisions of subsection (F)(3).
 2. "Underemployment" means the parent's earned income combined with the assistance unit's other countable income does not exceed the income standards provided in subsection (J).
 3. "Primary wage earner" means the parent in a two-parent assistance unit who earned the greater amount of income in the 24-month period immediately preceding the month in which an application for assistance is submitted.
- J.** Income standard. A family unit is not eligible if the family unit's countable income exceeds 100 percent of the FPL adjusted annually for the family unit.
- K.** Continued medical coverage. An eligible member of the family unit under this Section is entitled to continued AHCCCS coverage for up to 12 months if eligible under subsection (K)(3)(a) and up to four months if eligible under subsection (K)(3)(b) if the family unit's income exceeds 100 percent of the FPL and the following conditions are met:
1. The family continues to include a dependent child;
 2. The family received AHCCCS medical coverage under this Section for three calendar months out of the most recent six months; and
 3. The loss of AHCCCS coverage under this Section is due to:
 - a. Increased earned income of the caretaker relative and the person is a member of the family unit in accordance with 42 U.S.C. 1396a(e)(1) and 42 U.S.C. 1396r-6, or
 - b. Increased spousal or child support and the family unit member meets requirements under 42 CFR 435.115(f).
- L.** An applicant may be added to the continued medical coverage of a family unit, under subsection (K)(3)(a), if the applicant did not reside with the family unit at the time continued medical coverage under this Section was determined and the applicant is:
1. The spouse or dependent child of the family unit receiving continued medical coverage, or
 2. The parent of a dependent child who is a member of the family unit receiving continued medical coverage.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1428. Eligibility for a Person Not Eligible as a Family
Income standards. A person who is not approved in a family unit under R9-22-1427 but meets all the eligibility requirements in the Article is eligible for AHCCCS medical coverage if countable income does not exceed the following percentage of the FPL:

1. 150 percent for a pregnant woman,
2. 140 percent for a child under one year of age,
3. 133 percent for a child age one through five years of age, or
4. 100 percent for all other persons.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2).

R9-22-1429. Eligibility for a Newborn

A child born to a mother eligible for and receiving medical coverage under this Article, Article 15 of the Chapter, or 9 A.A.C. 28, is automatically eligible for AHCCCS medical coverage for a period not to exceed 12 months if the child continuously lives with the mother in the state of Arizona. Automatic eligibility begins on the child's date of birth and ends with the last day of the month in which the child turns age one. The Department shall conduct an informal review when the child is six months old to ensure the child resides with the mother in Arizona.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1430. Extended Medical Coverage for a Pregnant Woman

- A. A pregnant woman who applies for and is determined eligible for AHCCCS medical coverage during the pregnancy remains eligible throughout the postpartum period.
- B. The postpartum period begins the day the pregnancy terminates and ends the last day of the month in which the 60th day following pregnancy termination.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1431. Family Planning Services Extension Program (FPEP)

- A. A member who loses eligibility for AHCCCS medical coverage under R9-22-1430 due to the postpartum period ending and who has no other creditable coverage, as specified in 42 U.S.C. 300gg(c), may receive up to 24 months of family planning services as provided in this Section and A.R.S. § 36-2907.04.
- B. Review of eligibility.

1. The Department shall complete a review of each member's continued eligibility for FPEP at least once every 12 months.
2. If a member continues to meet all eligibility requirements, the Department shall authorize continued eligibility for the FPEP and notify the member of continued eligibility.
3. The Department shall discontinue eligibility and notify the member of the discontinuance under R9-22-1415 if the member:
 - a. Has income that exceeds 150 percent of the FPL at the time of the 12-month review,
 - b. Fails to comply with a review of eligibility under this subsection, or
 - c. Meets any of the criteria under subsection (D).
- C. Changes in the member's income after the initial or review eligibility determination shall not impact the member's eligibility during the following 12-month period.
- D. The Administration or its designee shall deny or terminate a member from FPEP under this Section if the member:
 1. Voluntarily withdraws from the program;
 2. Has whereabouts that are unknown;
 3. Fails to provide information to the Administration or the Administration's designee;
 4. Becomes an inmate of a public institution;
 5. Moves out-of-state;
 6. Has creditable coverage under 42 U.S.C. 300gg(c);
 7. Fails to meet the documentation requirements for U.S. citizenship or legal alien status under A.R.S. § 36-2903.03;
 8. Becomes eligible under 9 A.A.C. 22, 9 A.A.C. 28, or 9 A.A.C. 31 for full services under Article 2 of this Chapter;
 9. Becomes sterile; or
 10. Dies.
- E. The Administration or its designee shall not reinstate eligibility under this Section after the effective date of a discontinuance of eligibility unless the discontinuance is overturned on appeal or resulted from an administrative error.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 13 A.A.R. 2633, effective July 10, 2007 (Supp. 07-3). Amended by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2).

R9-22-1432. Young Adult Transitional Insurance

A person under the age of 21 who was in the custody of the Department of Economic Security under A.R.S. Title 8, Chapter 5 or Chapter 10 on the person's 18th birthday is eligible for AHCCCS medical coverage under A.R.S. § 36-2901(6)(a)(iii).

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1433. Special Groups for Children

The Administration shall provide AHCCCS medical coverage to children eligible for Title IV-E adoption subsidy or Title IV-E foster care under 42 CFR 435.145 and children eligible for state adoption subsidy under 42 CFR 435.227.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1434. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 7 A.A.R. 5701, effective December 1, 2001 (Supp. 01-4). Section repealed by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4).

R9-22-1435. Eligibility for a Person With Medical Expenses Whose Income is Over 100 Percent FPL

An applicant who is not eligible for AHCCCS medical coverage due to excess income may become AHCCCS eligible by deducting medical expenses from the applicant's income. This coverage is called Medical Expense Deduction (MED).

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1436. MED Family Unit

- A.** For the purpose of this Section, a child is an unmarried person under age 18.
- B.** The Department shall consider each of the following to be a family when living together:
 - 1. A parent and the parent's children;
 - 2. A married couple without children;
 - 3. A married couple and the children of either or both spouses;
 - 4. Unmarried parents who live with at least one child in common, and the parents' other children, whether in common or not; and
 - 5. A person without children.
- C.** If an applicant is pregnant, the family unit includes the number of unborn children.
- D.** A child of the children included in subsections (B)(1), (B)(3), or (B)(4) is considered part of the family unit when living together.
- E.** The Department shall not include a SSI-cash recipient in the MED family unit even if the SSI-cash recipient is a parent, spouse, or child.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by

final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1437. MED Income Eligibility Requirements

- A.** Income exclusions. The exclusions in R9-22-1420(C) apply to the MED family unit.
- B.** Income standard.
 - 1. The Department shall divide the annual FPL for the MED family unit that is in effect during each month of the income period by 12 to determine the monthly FPL.
 - 2. The Department shall add the monthly FPLs for the income period and multiply the resulting amount by 40 percent.
 - 3. Changes to the annual FPL are implemented in April of each year.
- C.** Income period. The income period is the month of application and the next two months. The Department shall add together the three months' income to establish the MED family unit's income amount.
- D.** Medical expense deduction period. The medical expense deduction period is a three-month period consisting of:
 - 1. For a new application, the month before the application month, the month of application, and month following the application month; or
 - 2. For a MED eligibility review, the last month of the prior MED eligibility period and the following two months.
- E.** The Department shall calculate the amount of countable monthly income as follows:
 - 1. Subtract a \$90 cost of employment allowance from the gross amount of earned income for each person whose earned income is counted;
 - 2. Disregard from the remaining earned income an amount billed by the provider for the care of each dependent child under age 18 or incapacitated adult member of the MED family unit if the care is for the purpose of allowing the person to work. If more than one person in the household is responsible for and billed for the care of a dependent child, the disregard may be split between the wage earners if splitting the disregard is to the benefit of the family, but shall not exceed the maximum disregards as follows:
 - a. A maximum of \$200 for a child under age two and \$175 for other dependents for a wage-earner employed full-time (86 or more hours per month); and
 - b. A maximum of \$100 for a child under age two, and \$88 for other dependents for a wage earner employed part-time (less than 86 hours a month);
 - 3. Add the remaining earned income for each MED family member to the unearned income of all MED family members;
 - 4. Compare the MED family's unit countable income amount to the income standard in subsection (B). The difference is the amount of medical expenses the family shall incur during the medical expense deduction period to become eligible;
 - 5. Subtract allowable medical expense deductions that were incurred by:
 - a. A member of the MED family unit;
 - b. A deceased spouse or minor child of a MED family unit if this person would have been a member of the MED unit during the MED expense deduction period;
 - c. A person who was a minor child of a MED family unit member when the expense was incurred but who is no longer a minor child; or

- d. A minor child, including a child who is a runaway, who left home before the date of application to live with someone other than a parent; and
- 6. Compare the net MED family income to the income standard listed in subsection (B).
- F. The family is eligible if the net income in subsection (E)(6) does not exceed the income standard in subsection (B).

Historical Note

New Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1438. MED Resource Eligibility Requirements

- A. Including countable resources. The Department shall include the resources not excluded that belong to and are available to members of the family of a qualified alien under A.R.S. § 36-2903.03 and the sponsor and sponsor's spouse of a person who is a qualified alien.
- B. Ownership and availability. The Department shall evaluate the ownership of resources to determine the availability of resources to a person listed in subsection (A).
 - 1. Jointly owned resources with ownership records containing the words "and" or "and/or" between the owners' names are available to each owner except if one of the owners refuses to sell. A consent to sale is not required if all owners are members of the MED family unit.
 - 2. Jointly owned resources with ownership records containing the word "or" between the owners' names are presumed to be available in full to each owner. The applicant or member may rebut the presumption by providing clear and convincing evidence of intent to establish a different type of ownership. If the presumption is rebutted, the resource is available to the owners:
 - a. Consistent with the intent of the owners, or
 - b. Based on each owner's proportionate net contribution if there is not clear and convincing evidence of a different allocation.
 - 3. The Department shall establish availability of a trust under 42 U.S.C. 1396p(d)(4)(A) or (C).
- C. Unavailability. The Department shall consider the following resources unavailable:
 - 1. Property subject to spendthrift restriction, such as:
 - a. Accounts established by the SSA, Veteran's Administration, or similar sources that mandate that the funds in the account be used for the benefit of a person not residing with the MED family unit; or
 - b. Trusts established by a will or funded solely by the income and resources of someone other than a member of the MED family unit.
 - 2. A resource being disputed in a divorce proceeding or probate matter;
 - 3. Real property located on a Native American reservation;
 - 4. A resource held by a conservator to the extent court-imposed restrictions make the resource unavailable to the applicant, member, or member of the family unit for:
 - a. Medical care,
 - b. Food,
 - c. Clothing, or
 - d. Shelter.
- D. Resource exclusion. The Department shall exclude the following resources from the calculation of resources under subsection (E):
 - 1. One burial plot for each person listed in R9-22-1436;
 - 2. Household furnishings and personal items that are necessary for day-to-day living;
 - 3. Up to \$1500 of the value of one prepaid funeral plan for each person listed in R9-22-1436 that specifically covers

only funeral-related expenses as evidenced by a written contract;

- 4. The value of one motor vehicle regularly used for transportation. If the MED family unit owns more than one vehicle, the exclusion is applied to the vehicle with the highest equity value;
- 5. The value of a vehicle used to earn income and not used simply for transportation to and from employment;
- 6. The value of a vehicle in which a SSI-cash recipient has an ownership interest; and
- 7. The value of any vehicle used for medical treatment, employment, or transportation of a SSI-cash disabled child, and that is excluded by SSI for that reason.
- 8. Funds set aside in an Individual Development Account under 6 A.A.C. 12, Article 4; and
- 9. Any other resource specifically excluded by federal law.
- E. Calculation of resources. The Department shall determine the value of all household resources as follows:
 - 1. Calculate the total amount of countable liquid resources;
 - 2. Calculate the equity value of each countable non-liquid resource. The Department shall determine the equity value of a countable non-liquid resource by subtracting the amount of valid encumbrances on that resource from:
 - a. The market value of real property if there is no assessor's evaluation of the property,
 - b. The market value of real property if the assessor's value of the real property does not include the value of permanent structures on that property,
 - c. The assessor's full cash value if subsections (E)(2)(a) and (E)(2)(b) do not apply, and
 - d. The market value of a non-liquid resource that is not real property;
 - 3. Not assign an equity value to a resource that is less than zero; and
 - 4. Determine the MED family unit's resources by adding the totals determined in subsections (1) and (2).
- F. Resource standard to be eligible for MED. A person is not eligible for MED if the resources determined in subsection (E) exceed \$100,000 or if more than \$5,000 are liquid resources.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1439. MED Effective Date of Eligibility

- A. A MED family unit is eligible on the day the income and resource eligibility requirements are met but no earlier than the first day of the month of application. If the family unit meets the income requirements in the application month but does not meet the resource limit until the following month, the family unit's effective date of eligibility is the first day of the month following the month of application.
- B. The Department shall adjust the effective date of eligibility under subsection (A) to an earlier date if:
 - 1. A member presents verification of additional allowable medical expenses incurred on an earlier date during the medical expense deduction period that allow the member to meet the income requirements, and
 - 2. The member presents the verification within 60 days of approval of eligibility under this Section.
- C. The Department shall not adjust an effective date of eligibility more than one time per application.
- D. The Department shall adjust the effective date no later than 30 days after the end of the 60-day period under subsection (B)(2).
- E. The Department shall deny an application and provide the applicant a denial notice when the applicant does not meet the

MED requirements under this Article during the month of application or the month following the month of application.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1440. MED Eligibility Period

The Department shall approve eligibility for six months. Changes in circumstances do not affect eligibility for the first three months.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1441. Eligibility Appeals

- A. Adverse actions. An applicant or member may appeal by requesting a hearing from the Department concerning any of the following adverse actions:
 1. Complete or partial denial of eligibility under R9-22-1413;
 2. Suspension, termination, or reduction of AHCCCS medical coverage under R9-22-1415;
 3. Delay in the eligibility determination beyond the timeframes under this Article;
 4. The imposition of or increase in a premium or copayment; or
 5. The effective date of eligibility.
- B. Notice of Adverse Action. The Department shall personally deliver or send, by regular mail, a Notice of Adverse Action to the person affected by the action. For the purpose of this Section, the date of the Notice of Adverse Action shall be the date of personal delivery to the applicant or the postmark date, if mailed.
- C. Automatic change and hearing rights.
 1. An applicant or a member is not entitled to a hearing if the sole issue is a federal or state law requiring an automatic change adversely affecting some or all recipients.
 2. An applicant or a member is entitled to a hearing if a federal or state law requires an automatic change and the applicant or member timely files an appeal that alleges a misapplication of the facts to the law.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1442. Cessation of MED Coverage

The Department shall not approve any individual or family who has applied on or after May 1, 2011 as eligible for MED coverage. With respect to any applications that are pending as of May 1, 2011, the Department shall not approve any individual or family as eligible for MED coverage who has not met all eligibility requirements prior to May 1, 2011.

Historical Note

New Section made by exempt rulemaking at 17 A.A.R. 1028, effective May 1, 2011 (Supp. 11-2).

R9-22-1443. Closing New Eligibility for Persons Not Covered under the State Plan

- A. Definition. For purposes of this Section, "AHCCCS Care" refers to the eligibility category that includes individuals encompassed within the expanded definition of "eligible person" under A.R.S. § 36-2901.01 and R9-22-1428(4), but who do not meet eligibility criteria for an optional or mandatory Title XIX coverage group described in the Arizona State Plan for Medicaid.
- B. General Rule. Except as provided by this Section, neither the Department nor the Administration shall approve an individual

for AHCCCS Care with an effective date of eligibility on or after July 8, 2011.

- C. Exception for pending applications. With respect to any applications that are pending as of July 8, 2011, the Department and the Administration shall approve any individual as eligible for AHCCCS Care who has met all eligibility requirements for AHCCCS Care during or after the month of application but prior to July 8, 2011, and has continuously met all eligibility requirements for AHCCCS Care since that date.
- D. Exception for children. The Department and the Administration shall approve an individual as eligible for AHCCCS Care on or after July 8, 2011 who:
 1. Was determined eligible under the Arizona State Plan for Medicaid based on being under the age of 19;
 2. Would otherwise be discontinued due to reaching the age of 19 on or after July 8, 2011, under subsection (B) of this Section; and
 3. Meets all eligibility requirements for AHCCCS Care on and after reaching age 19.
- E. Exception for KidsCare. The Department and the Administration shall approve an individual as eligible for AHCCCS Care on or after July 8, 2011 who:
 1. Was determined eligible under 9 A.A.C. 31 based on being under the age of 19;
 2. Would otherwise be discontinued due to reaching the age of 19 on or after July 8, 2011, under subsection (B) of this Section; and
 3. Meets all eligibility requirements for AHCCCS Care on and after reaching age 19.
- F. Exception for Young Adult Transitional Insurance (YATI). The Department and the Administration shall approve an individual as eligible for AHCCCS Care on or after July 8, 2011 who:
 1. Was determined eligible for YATI under R9-22-1432;
 2. Would otherwise be discontinued due to reaching the age of 21 on or after July 8, 2011 under subsection (A) of this Section; and
 3. Meets all eligibility requirements for AHCCCS Care on and after reaching age 21.
- G. Exception for certain SSI-MAO. The Department and the Administration shall approve as eligible for AHCCCS Care, on or after July 8, 2011, an individual who:
 1. Was determined eligible for AHCCCS Care; and
 2. Whose eligibility category is changed on or after June 28, 2011, from AHCCCS Care to eligibility based on R9-22-1501(A)(1) (SSI Medical Assistance Only) because the individual, at the time of the change in eligibility category, is age 65 or over, under the age of 65 with Medicare coverage, or who has been determined by ADHS to have a Serious Mental Illness; but who
 3. Subsequent to the change in eligibility category, is determined not to meet eligibility requirements under Article 15; but only if
 4. The individual meets all eligibility requirements for AHCCCS Care on and after the date the individual is determined not to meet eligibility requirements under Article 15.
- H. Exception for redeterminations. This Section does not prohibit the redetermination of an individual as eligible for AHCCCS Care on or after July 8, 2011, if the individual was determined eligible for AHCCCS Care prior to July 8, 2011 and has remained continuously eligible for AHCCCS Care since July 8, 2011 or the date on which the individual was determined eligible for AHCCCS Care under subsections (C), (D), and (E) of this Section.
- I. Discontinuance for other reasons. Nothing in this Section prohibits or restricts the Department or the Administration from

discontinuing AHCCCS Care for an individual who does not meet any other eligibility criteria set forth elsewhere in this Chapter including but not limited to discontinuance based on the individual's failure to verify eligibility information upon an application or redetermination.

- J. Review of anticipated expenditures. At least monthly, the Director shall review the most recent estimate of the anticipated expenditures for the remainder of the state fiscal year as compared to funds remaining in the appropriations made to the agency for the state fiscal year as well as any other known or reasonably anticipated sources of other funding. Based on that review the Director may, subject to approval by the Center for Medicare and Medicaid Services, re-open the AHCCCS Care program to new enrollment otherwise prohibited by this Section.
- K. At least 30 days prior to the effective date of any changes to eligibility for the AHCCCS Care program as described in this Section, public notice shall be provided via publication on the AHCCCS web site unless shorter notice is necessary to maintain a program that is reasonably anticipated to remain within available funding.

Historical Note

New Section made by exempt rulemaking at 17 A.A.R. 1345, effective July 8, 2011 (Supp. 11-3). Amended by exempt rulemaking at 17 A.A.R. 2624, effective July 8, 2011 (Supp. 11-4).

ARTICLE 15. AHCCCS MEDICAL COVERAGE FOR PEOPLE WHO ARE AGED, BLIND, OR DISABLED

R9-22-1501. General Information

- A. General. The Administration shall determine eligibility for AHCCCS medical coverage for the following applicants or members using the eligibility criteria and requirements in this Article:
 1. A person who is aged, blind, or disabled and does not receive SSI cash; and
 2. A person terminated from the SSI cash program under R9-22-1505.
- B. Definitions. In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:
 - “Aged” means a person who is 65 years of age or older as specified in 42 U.S.C. 1382c(a)(1)(A).
 - “Blind” means a person who has been determined blind by the Department of Economic Security, Disability Determination Services Administration, under 42 U.S.C. 1382c(a)(2).
 - “Disabled” means a person who has been determined disabled by the Department of Economic Security, Disability Determination Services Administration, under 42 U.S.C. 1382c(a)(3)(A) through (E).
- C. Confidentiality. The Administration shall maintain the confidentiality of an applicant's or member's records and limit the release of safeguarded information under R9-22-512.
- D. Application process.
 1. A person may apply for AHCCCS medical coverage by submitting a signed application to any Administration office or outstation location under R9-22-1406.
 2. The provisions in R9-22-1406(B), (C), and (E) apply to this Section.
 3. The application date is the date a signed application is received at any Administration office or outstation location approved by the Director.

4. An applicant who files an application may withdraw the application, either orally or in writing. If an applicant withdraws an application, the Administration shall send the applicant a denial notice under subsection (G).
 5. Except as provided in 42 CFR 435.911, the Administration shall determine eligibility within 90 days for an applicant applying on the basis of disability and 45 days for all other applicants.
 6. If an applicant dies while an application is pending, the Administration shall complete an eligibility determination for the deceased applicant.
 7. The Administration shall complete an eligibility determination on an application filed on behalf of a deceased applicant, if the application is filed in the month of the applicant's death.
- E. Redetermination of eligibility for a person terminated from the SSI cash program.
 1. Continuation of AHCCCS medical coverage. The Administration shall continue AHCCCS medical coverage for a person terminated from the SSI cash program until a redetermination of eligibility under subsection (E)(2) is completed.
 2. Coverage group screening. The Administration shall screen a person for eligibility under any coverage group under A.R.S. §§ 36-2901(6)(a)(i), (ii), (iii), (iv), and (v) and 36-2934.
 - a. If a person files an application for Arizona Long-Term Care System (ALTCS) coverage, the Administration shall determine eligibility under 9 A.A.C. 28, Article 4.
 - b. If an applicant or member is aged, blind, or disabled, but not in need of long-term care services, the Administration shall determine eligibility under this Article.
 - c. For all other persons, the Administration shall refer the applicant's case to the Department for an eligibility decision under Article 14.
 3. Eligibility decision.
 - a. If a person is eligible under this Article or 9 A.A.C. 28, Article 4, the Administration shall send a notice as under subsection (G) informing the applicant that AHCCCS medical coverage is approved.
 - b. If a person is ineligible, the Administration shall send a notice as under subsection (G) to deny AHCCCS medical coverage.
 - F. Eligibility effective date. Eligibility is effective on the first day of the month that all eligibility requirements are met, but no earlier than the month of application.
 - G. Notice for approval or denial. The Administration shall send an applicant a written notice of the decision regarding the application. This notice shall include a statement of the intended action, and:
 1. If approved, the notice shall contain the effective date of eligibility.
 2. If approved under FESP, the notice shall also contain:
 - a. The emergency services certification end date,
 - b. A statement detailing the reason for the denial of full services,
 - c. The legal authority supporting the decision,
 - d. Where the legal authority supporting the decision can be found,
 - e. An explanation of the right to request a hearing, and
 - f. The date by which a request for hearing shall be received by the Administration.
 3. If denied, the notice shall contain:
 - a. The effective date of the denial;

- b. The reason for the denial, including specific financial calculations and the financial eligibility standard, if applicable;
 - c. Legal authority supporting the decision;
 - d. Where the legal authority supporting the decision can be found;
 - e. An explanation of the right to request a hearing; and
 - f. The date by which a request for hearing shall be received by the Administration.
- H. Reporting and verifying changes.**
 - 1. An applicant or a member shall report to the Administration the following changes for the applicant or member, the applicant's or member's spouse, and the applicant or member's dependent children:
 - a. Change of address;
 - b. Change in the household's members;
 - c. Change in income;
 - d. Death;
 - e. Change in marital status;
 - f. Change in school attendance;
 - g. Change in Arizona state residency; and
 - h. Any other change that may affect the member's or applicant's eligibility.
 - 2. A member shall report to the Administration the following changes:
 - a. Admission to a penal institution,
 - b. Change in U.S. citizenship or immigrant status,
 - c. Receipt of a Social Security number, and
 - d. Change in first- or third-party liability that may contribute to the payment of all or a portion of the person's medical costs.
 - 3. A person other than a member or an applicant who reports a change to the Administration either orally or in writing shall include the:
 - a. Name of the affected applicant or member;
 - b. Description of the change;
 - c. Date the change occurred;
 - d. Name of the person reporting the change; and
 - e. Social Security or case number of the applicant or member, if known.
 - 4. An applicant or a member shall provide verification of changes if requested by the Administration.
 - 5. An applicant or a member shall report anticipated changes in eligibility to the Administration as soon as the person knows that the change will occur.
 - 6. An applicant or a member shall report an unanticipated change to the Administration within 10 days following the date the change occurred.
- I. Processing of changes and redeterminations.** If a member receives AHCCCS medical coverage under subsection (A), the Administration shall redetermine the member's eligibility at least once every 12 months or more frequently when changes occur that may affect eligibility.
- J. Actions that may result from a redetermination or change.** In processing a redetermination or change, the Administration shall determine whether there should be:
 - 1. No change in eligibility,
 - 2. Discontinuance of eligibility if a condition of eligibility is no longer met, or
 - 3. A change in the program under which a person receives AHCCCS medical coverage.
- K. Notice of discontinuance.**
 - 1. Contents of notice. The Administration shall issue a notice when it takes action to discontinue a member's eligibility. The notice shall contain the following information:
 - a. A statement of the action that is being taken;
 - b. The effective date of the action;
 - c. The reason for the discontinuance, including specific financial calculations and the financial eligibility standard if applicable;
 - d. The legal authority that supports the action proposed by the Administration;
 - e. Where the legal authority supporting the decision can be found;
 - f. An explanation of the right to request a hearing; and
 - g. The date by which a hearing request shall be received by the Administration and the right to continue medical coverage pending appeal.
- 2. Advance notice of changes in eligibility. Advance notice means a notice of proposed action that is issued to the member at least 10 days before the effective date of the proposed action. Except under subsection (K)(3), the Administration shall issue an advance notice when an adverse action is taken to suspend, reduce or discontinue eligibility.
- 3. Exceptions from advance notice. The Administration shall issue a notice to a member to discontinue eligibility no later than the effective date of the action if:
 - a. The member provides to the Administration a clearly written statement, signed by that member, that:
 - i. Services are no longer wanted; or
 - ii. Gives information that requires a discontinuance or reduction of services and indicates that the member understands that this is the result of supplying the information;
 - b. The member provides information to the Administration that requires a discontinuance of eligibility and a member signs a written statement waiving advance notice;
 - c. The member cannot be located and mail sent to the member's last known address has been returned as undeliverable under 42 CFR 431.213(d) subject to reinstatement of discontinued eligibility;
 - d. The member has been admitted to a public institution where a member is ineligible for coverage;
 - e. The member has been approved for Medicaid in another state; or
 - f. The Administration receives information confirming the death of the member.
- L. Request for hearing.** An applicant or member may request a hearing under Chapter 34 for any of the following adverse actions:
 - 1. Complete or partial denial of eligibility,
 - 2. Discontinuance or reduction of AHCCCS medical coverage, or
 - 3. Delay in the eligibility determination beyond the timeframes listed in R9-22-1501(D).
- M. Assignment of rights.** A person determined eligible assigns rights to all types of medical benefits to which the person is entitled under operation of law under A.R.S. § 36-2903.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Amended by exempt rulemaking at 10 A.A.R. 23, effective December 9, 2003 (Supp. 03-4). Amended by exempt rulemaking at 10

A.A.R. 4588, effective October 12, 2004 (Supp. 04-4).
Amended by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1502. General Eligibility Criteria

- A.** Social Security Number.
 - 1. An applicant applying under R9-22-1501(A)(1) or (A)(2), or R9-22-1505(A) shall furnish a SSN or apply for one, as required under 42 CFR 435.910 and 435.920.
 - 2. An applicant who meets all other eligibility criteria except the criteria in subsection (C) shall provide a SSN unless the applicant cannot legally obtain one.
 - 3. If an applicant cannot recall or has not been issued a SSN, the Administration shall assist in obtaining or verifying the applicant's SSN under 42 CFR 435.910.
- B.** State residency. A person is not eligible unless the person is a resident of Arizona under 42 CFR 435.403.
- C.** Citizenship and immigrant status.
 - 1. An applicant or a member is not eligible for full services under Article 2 of this Chapter unless the applicant or member is a citizen of the United States or is a qualified alien under A.R.S. § 36-2903.03(B) or meets the requirements of A.R.S. § 36-2903.03(C).
 - 2. An applicant or member is eligible for emergency medical services under R9-22-217 if the applicant or member is either a qualified alien or noncitizen and:
 - a. Meets all other eligibility requirements except those in subsection (A); and
 - b. Is eligible under A.R.S. § 36-2901(6)(a)(i), (ii), or (iii).
- D.** Applicant and member responsibility. As a condition of eligibility, an applicant and a member shall:
 - 1. Authorize the Administration to obtain verification of information for initial or continued eligibility;
 - 2. Give the Administration complete and truthful information. The Administration may deny an application or discontinue eligibility if:
 - a. The applicant or member fails to provide information necessary for initial or continuing eligibility;
 - b. The applicant or member fails to provide the Administration with written authorization to permit the Administration to obtain necessary verification;
 - c. The applicant or member fails to provide verification after the Administration had made an effort to obtain the necessary verification but has not obtained the necessary information; or
 - d. The applicant or member does not assist the Administration in resolving incomplete, inconsistent, or unclear information that is necessary for initial or continuing eligibility;
 - 3. Comply with the DCSE under 42 CFR 433.148 in establishing paternity and enforcing medical support obligations when requested. The Administration shall not deny AHCCCS eligibility to any applicant who would otherwise be eligible, is a minor child, and whose parent or legal representative does not cooperate with the medical support requirements or first- and third-party liability under Article 10;
 - 4. Provide information concerning third-party coverage for medical care; and
 - 5. Take all necessary steps to obtain annuity, pension, retirement, and disability benefits for which the applicant or member may be entitled.
- E.** Inmate of a public institution. An inmate of a public institution is not eligible to AHCCCS coverage if federal financial participation (FFP) is not available.
- F.** Verification of eligibility information.

- 1. The applicant or member has the primary responsibility to provide the Administration with verification of all information necessary to complete the determination of eligibility.
- 2. The Administration shall provide an applicant or a member no less than 10 days following the date of written request for the information to provide required verification. If an applicant or member does not provide the required information timely, the Administration may deny the application or discontinue eligibility.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1503. Financial Eligibility Criteria

- A.** General income eligibility. The Administration shall count the identified income under 42 U.S.C. 1382a and 20 CFR 416 Subpart K with the exceptions in subsection (B).
- B.** Exceptions.
 - 1. In-kind support and maintenance under 42 U.S.C. 1382a(a)(2)(A) is excluded.
 - 2. For a person living with a spouse, the Administration calculates net income for an eligible couple under 42 CFR 416.1160 as of June 15, 1999, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments, even if the spouse is not eligible for or applying for SSI or coverage under this Article.
 - 3. In determining the net income of a married couple living with a child or the net income of a person who is not living with a spouse but living with a child, a child allocation is allowed as a deduction from the combined net income of the couple for each child regardless of whether the child is ineligible or eligible. For the purposes of this Section, a child means a person who is unmarried, natural or adopted, and under age 18 or under age 22 if a full-time student. Each child's allocation deduction is reduced by that child's income, including public income maintenance payments, using the methodology under 20 CFR 416.1163(b)(1) and (2) as of June 15, 1999, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
 - 4. In determining the income deemed available to an applicant who is a child from an ineligible parent or parents, an allocation for each eligible or ineligible child of the parent is allowed as a deduction from the parent's income under 20 CFR 416.1165(b). The child's allocation is reduced by that child's income, including public income maintenance payments.
 - 5. In determining the income of a person who receives an annual Title II Cost of Living Allowance (COLA) increase, the COLA amount is disregarded for the months of January through March, but is countable income effective in April to correspond with the FPL implementation date.
 - 6. Sponsor deemed income. The Administration shall use income of a USCIS sponsor to determine eligibility for a

non-citizen applicant under R9-22-1425, whether or not the income is available, unless exempt under R9-22-1426.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1504. Eligibility For A Person Who is Aged, Blind, or Disabled

- A.** To be eligible for AHCCCS medical coverage, an applicant shall meet the conditions of eligibility and requirements in this Article and:
1. Meet one of the income tests described in subsection (B) or (C), or
 2. The special requirements in R9-22-1505.
- B.** The Administration shall determine whether the applicant's countable income, as described in R9-22-1503, is less than or equal to 100 percent of the SSI FBR, as adjusted annually.
- C.** The Administration shall determine whether the applicant's countable income, as described in R9-22-1503, without deducting the amount from earned income under 42 U.S.C. 1382a(b)(4)(B)(iii), is less than or equal to 100 percent FPL as adjusted annually.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1505. Eligibility for Special Groups

- A.** The following are considered special groups:
1. A person meeting the requirements in A.R.S. § 36-2903.03 who:
 - a. Is aged, blind, or disabled under 42 CFR 435.520, 42 CFR 435.530, or 42 CFR 435.540 as of October 1, 2004, which are incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
 - b. Received SSI cash or AHCCCS medical coverage under this subsection, or subsections (A)(2), (A)(3), or (A)(4) on or before August 21, 1996;
 - c. Was residing in the United States under color of law on or before August 21, 1996; and
 - d. Meets the requirements under this Article;
 2. A disabled child (DC) under 42 U.S.C. 1396a(a)(10)(A)(i)(II). A disabled child is a child who:
 - a. Was receiving SSI cash benefits as a disabled child on August 22, 1996;
 - b. Lost SSI cash benefits effective July 1, 1997, or later, due to a disability determination under Section 211(d)(2)(B) of Subtitle B of P.L. 104-193;
 - c. Continues to meet the disability requirements for a child that were in effect on August 21, 1996; and
 - d. Meets the requirements under this Article;
 3. A disabled adult child (DAC), under 42 U.S.C. 1383c(c) who:

- a. Was determined disabled by the Social Security Administration before attaining the age of 22 years,
 - b. Became entitled to or received an increase in child's insurance benefits under Title II of the Act on the basis of blindness or disability,
 - c. Was terminated from SSI cash benefits due to entitlement to or an increase in income under Title II of the Act,
 - d. Meets the requirements under this Article, and
 - e. Is 18 years of age or older;
4. A disabled widow or widower (DWW) under 42 U.S.C. 1383c(d) who:
- a. Is blind or disabled,
 - b. Is ineligible for Medicare Part A benefits,
 - c. Received SSI cash benefits the month before Title II of the Act benefit payments began, and
 - d. Meets the requirements under this Article; and
5. Under 42 CFR 435.135, a person who:
- a. Is aged, blind, or disabled;
 - b. Receives benefits under Title II of the Act;
 - c. Received SSI cash benefits in the past;
 - d. Received SSI cash benefits and Title II of the Social Security Act benefits concurrently for at least one month anytime after April 1977;
 - e. Became ineligible for SSI cash benefits while receiving SSI and benefits under Title II of the Act concurrently; and
 - f. Meets the requirements under this Article.
- B.** Income for special groups.
1. Except as provided in subsection (B)(2), income eligibility is determined using the income criteria in R9-22-1503(A).
 2. Exceptions to income for special groups.
 - a. For a person in the DAC coverage group under subsection (A)(3), the applicant's Title II of the Act benefits are disregarded in determining income eligibility under 42 U.S.C. 1383c(c).
 - b. For a person in the DWW coverage group, under subsection (A)(4), the applicant's Title II of the Act benefits are disregarded in determining income eligibility under 42 U.S.C. 1383c(b) and (d).
 - c. For an applicant or member in the coverage group under subsection (A)(5), the portion of the applicant's or member's Title II of the Act benefits attributed to cost-of-living adjustments received by the applicant since the effective date of SSI ineligibility is disregarded in determining income eligibility under 42 CFR 435.135.
- C.** 100 percent FBR. As a condition of eligibility for all special groups, countable income shall be equal to or less than 100 percent of the SSI FBR, as adjusted annually.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1506. Repealed

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1507. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1508. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

ARTICLE 16. SOCIAL SECURITY DISABILITY INSURANCE - TEMPORARY MEDICAL COVERAGE**R9-22-1601. Expired****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1602. Expired**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1603. Expired**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1604. Expired**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1605. Expired**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section

repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1606. Expired**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1607. Expired**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1608. Expired**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1609. Expired**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1610. Expired**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1611. Expired**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1612. Expired**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1613. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1614. Expired**Historical Note**

New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1615. Expired**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1616. Expired**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1617. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section

repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1618. Expired**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1619. Expired**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1620. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1621. Reserved**R9-22-1622. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1623. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1624. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1625. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1626. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section

repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1627. Repealed

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1628. Repealed

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1629. Repealed

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1630. Repealed

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1631. Repealed

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1632. Reserved

R9-22-1633. Repealed

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1634. Repealed

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1635. Reserved

R9-22-1636. Repealed

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

ARTICLE 17. ENROLLMENT

R9-22-1701. Enrollment-Related Definitions

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

“Annual enrollment choice” means the annual opportunity for a person to change contractors.

“Auto-assignment algorithm” or “Algorithm” means a formula used by the Administration to assign to a contractor a member who did not make a timely choice under R9-22-1702.

“CMDP” means Comprehensive Medical and Dental Program.

“Disenrollment” means the discontinuance of a person’s entitlement to receive covered services from a contractor of record.

“Enrollment” means the process by which an eligible person becomes a member of a contractor’s plan.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended to correct a typographical error, filed in the Office of the Secretary of State October 30, 2001 (Supp. 01-4). Amended by exempt rulemaking at 7 A.A.R. 5701, effective December 1, 2001 (Supp. 01-4). Amended by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4). Section repealed; new Section made by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2).

R9-22-1702. Enrollment of a Member with an AHCCCS Contractor

A. General enrollment requirements. The Administration shall enroll a member with a contractor as described in this Section, unless the member has pre-selected a contractor on the application:

1. Except as provided in subsections (A)(3), (A)(5), and (C), a member who is determined to be eligible under this Chapter and resides in an area served by more than one contractor, may choose an available contractor serving the member’s GSA within 30 days from the date of notice of enrollment. A Native American member may select IHS or another available contractor.
2. If the member does not make a choice under subsection (A)(1), the Administration shall immediately auto-assign the member to:
 - a. IHS if the member is a Native American living on a reservation,
 - b. A contractor based on family continuity, or
 - c. A contractor by using the auto-assignment algorithm.
3. If the member’s period of ineligibility and disenrollment from the contractor of record is for a period of less than 90 days, the Administration shall enroll the member with the member’s most recent contractor of record, if available, except if:
 - a. The member no longer resides in the contractor’s GSA;
 - b. The contractor’s contract is suspended or terminated;
 - c. The member was previously enrolled with CMDP but at the time of re-enrollment the member is not a foster care child;

- d. The member chooses another contractor or chooses IHS, if available to the member, during the annual enrollment choice period; or
 - e. The member was previously enrolled with a contractor but at the time of re-enrollment the member is a foster care child.
- 4. When the member's disenrollment period is more than 90 days, the member may select a contractor as described in subsection (A)(1).
- 5. The Administration shall not enroll a member with a contractor if a member:
 - a. Is eligible for the FESP under R9-22-1419;
 - b. Is eligible for less than 30 days from the date the Administration receives notification of a member's eligibility, except for a member who is enrolled with CMDP or IHS;
 - c. Is eligible only for a retroactive period of eligibility, except for a member who is enrolled with CMDP or IHS; or
 - d. Resides in an area not served by a contractor.
- B.** Fee-for-service coverage. A member not enrolled with a contractor under subsection (A)(5) shall obtain covered medical services from an AHCCCS-registered provider on a fee-for-service basis under Article 7.
- C.** Foster care child. The Administration shall enroll a member with CMDP if the member is a foster care child under A.R.S. § 8-512.
- D.** Family Planning Services Extension Program. A member eligible for the Family Planning Services Extension Program under R9-22-1431, shall remain enrolled with the member's contractor of record or IHS.
- E.** Contractor or IHS enrollment change for a member.
 - 1. The Administration shall change a member's enrollment if the member requests a change to an available contractor or IHS during an annual enrollment period. A Native American may change from an available contractor to IHS or from IHS to an available contractor at any time.
 - 2. The Administration shall approve a change in enrollment for any member if the change is a result of the final outcome of a grievance under 9 A.A.C. 34.
 - 3. A member may choose a different contractor if the member moves into a GSA not served by the current contractor or if the contractor is no longer available. If the member does not select a contractor, the Administration shall auto-assign the member as provided in subsection (A)(2).
 - 4. The Administration shall provide the member 60-day advance notice of the member's option to change plans by the member's annual enrollment date.
 - 5. A member may disenroll from a plan if:
 - a. The member moves out of the GSA;
 - b. The plan does not, because of moral or religious objections, cover the service a member seeks; or
 - c. The member needs related services to be performed at the same time; not all related services are available within the network; and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk.
 - 6. For exceptions to this Article, the Administration shall approve a change for an enrolled member as determined by the Director.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by

exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2).

R9-22-1703. Effective Date of Enrollment with a Contractor

- A.** Effective date of enrollment. A member's date of enrollment is the date enrollment action is taken by the Administration. However, if a plan change occurs for an annual enrollment choice, the effective date is the month of the member's enrollment anniversary date.
- B.** Financial liability of the contractor. The contractor shall be financially liable for an enrolled member's care as specified in contract.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2).

R9-22-1704. Newborn Enrollment

- A.** General.
 - 1. The Administration shall enroll a newborn child of an eligible mother with an available contractor or IHS, based on the mother's enrollment.
 - 2. The Administration shall auto-assign a newborn child of an eligible mother who is not enrolled with a contractor or IHS or who is enrolled with CMDP. When a mother enrolled in CMDP has a newborn and the newborn is surrendered to Administration on Children, Youth and Families (ACYF), the newborn is then enrolled with CMDP.
 - 3. The Administration shall notify the mother of the right to choose a different contractor for her newborn child. The mother may make her choice within 30 days from the date of notice of enrollment.
- B.** Financial liability for newborns. The contractor shall be financially liable for the medical care of a newborn as specified in contract.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended to correct a typographical error, filed in the Office of the Secretary of State October 30, 2001 (Supp. 01-4). Section repealed; new Section made by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2).

R9-22-1705. Guaranteed Enrollment Period

- A.** General. Except for members enrolled with IHS or CMDP, the Administration shall provide a guaranteed enrollment period for a one-time period that begins on the effective date of the member's initial enrollment with a contractor and ends on the last day of the fifth full calendar month after the date of the member's initial enrollment.
- B.** Exceptions to guaranteed period. The Administration shall not grant a guaranteed enrollment period or shall terminate a guaranteed enrollment period as provided in subsection (C), if the member:
 - 1. Did not meet the conditions of eligibility when initially enrolled with the contractor;

2. Except as provided in 9 A.A.C. 22, Article 12, is an inmate of a public institution as defined in 42 CFR 435.1010;
 3. Dies;
 4. Moves out-of-state;
 5. Voluntarily withdraws from the AHCCCS program;
 6. Is adopted; or
 7. Has whereabouts that are unknown.
- C.** Disenrollment effective date. The Administration shall terminate any guaranteed enrollment period to which the member is not entitled effective on:
1. The date the member is admitted to a public institution under subsection (B);
 2. The member's date of death;
 3. The last day of the month in which the Administration receives notification that a member moved out-of-state;
 4. The date the Administration receives written notification of the member's voluntary withdrawal from the AHCCCS program;
 5. The last day of the month in which the Administration receives notification that a member's adoption proceedings are finalized; or
 6. The last day of the month in which the Administration receives notification that a member's whereabouts are unknown.
- D.** Retroactive adjustments. The Administration shall adjust the member's eligibility and enrollment retroactively under subsection (C).

Historical Note

New Section made by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2).

ARTICLE 18. RESERVED**ARTICLE 19. FREEDOM TO WORK**

Article 19, consisting of Sections R9-22-1901 through R9-22-1922, made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

R9-22-1901. General Freedom to Work Requirements

Under 42 U.S.C. 1396a(a)(10)(A)(ii)(XV) and (XVI), the Administration shall determine eligibility for AHCCCS medical services, under Article 2 of this Chapter, using the eligibility criteria and requirements under this Article for an applicant or member who is:

1. At least 16 years of age, but less than 65 years of age,
2. Employed, and
3. Not income eligible under A.R.S. § 36-2901(6)(a).

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

R9-22-1902. General Administration Requirements

The Administration shall comply with the confidentiality rule under R9-22-512(C).

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1903. Application for Coverage

- A.** A person may apply by submitting an application to an Administration office.
- B.** The application date is the date the application is received at an Administration office or outstation location approved by the Director as described under R9-22-1406(A).

- C.** The provisions in R9-22-1406(B) and (D) apply to this Section.
- D.** The applicant or representative who files the application may withdraw the application for coverage either orally or in writing. An applicant withdrawing an application shall receive a denial notice under R9-22-1904.
- E.** Except as provided in 42 CFR 435.911, the Administration shall determine eligibility within 45 days.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1904. Notice of Approval or Denial

The Administration shall send an applicant a written notice of the decision regarding the application. This notice shall include a statement of the action, and:

1. If approved, the notice shall contain:
 - a. The effective date of eligibility,
 - b. The amount the person shall pay, and
 - c. An explanation of the person's hearing rights specified in 9 A.A.C. 34.
2. If denied, R9-22-1501(G)(3) applies.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1905. Reporting and Verifying Changes

An applicant or member shall report and verify changes, as described under R9-22-1501(H), to the Administration.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1906. Actions that Result from a Redetermination or Change

The processing of a redetermination or change shall result in one of the following actions:

1. No change in eligibility or premium,
2. Discontinuance of eligibility if a condition of eligibility is no longer met,
3. A change in premium amount, or
4. A change in the coverage group under which a person receives AHCCCS medical coverage.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

R9-22-1907. Notice of Adverse Action Requirements

- A.** The requirements under R9-22-1501(K)(1) apply.
- B.** Advance notice of a change in eligibility or premium amount. Advance notice means a notice of proposed action that is issued to the member at least 10 days before the effective date of the proposed action. Except under subsection (C), advance notice shall be issued whenever an adverse action is taken to discontinue eligibility, or increase the premium amount.
- C.** Exceptions from advance notice. A notice shall be issued to the member to discontinue eligibility no later than the effective date of action if:

1. A member provides a clearly written statement, signed by that member, that services are no longer wanted.
2. A member provides information that requires termination of eligibility or reduction of services, indicates that the member understands that this must be the result of supplying that information, and the member signs a written statement waiving advance notice;
3. A member cannot be located and mail sent to the member's last known address has been returned as undeliverable subject to reinstatement of discontinued services under 42 CFR 431.231(d);
4. A member has been admitted to a public institution where a person is ineligible for coverage;
5. A member has been approved for Medicaid in another state; or
6. The Administration receives information confirming the death of a member.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1908. Request for Hearing

An applicant or member may request a hearing under 9 A.A.C. 34.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1909. Conditions of Eligibility

An applicant or member shall meet the following conditions to qualify for the Freedom to Work program:

1. Furnish a valid Social Security Number (SSN);
2. Be a resident of Arizona;
3. Be a citizen of the United States, or meet requirements for a qualified alien under A.R.S. § 36-2903.03(B);
4. Be at least 16 years of age, but less than 65 years of age;
5. Have countable income that does not exceed 250 percent of FPL. The Administration shall count the income under 42 U.S.C. 1382a and 20 CFR 416 Subpart K with the following exceptions:
 - a. The unearned income of the applicant or member shall be disregarded,
 - b. The income of a spouse or other family member shall be disregarded, and
 - c. The deduction for a minor child shall not apply;
6. Comply with the member responsibility provisions under R9-22-1502(D) and (F).

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1). Section repealed; new Section made by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1910. Repealed**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1911. Repealed**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1912. Repealed**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1913. Premium Requirements

- A. As a condition of eligibility, an applicant or member shall:
 1. Pay the premium required under subsection (B).
 2. Not have any unpaid premiums for more than one month's premium amount.
- B. The Administration shall process premiums under 9 A.A.C. 31, Article 14 with the following exceptions:
 1. A member who has countable income:
 - a. Under \$500, the monthly premium payment shall be \$0.
 - b. Over \$500 but not greater than \$750, the monthly premium payment shall be \$10.
 2. The premium for a member shall be increased by \$5 for each \$250 increase in countable income above \$750.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1914. Repealed**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1915. Institutionalized Person

A person is not eligible for AHCCCS medical coverage if the person is:

1. An inmate of a public institution if federal financial participation (FFP) is not available, or
2. Age 21 through age 64 and is residing in an Institution for Mental Disease under 42 CFR 435.1009 except when allowed under the Administration's Section 1115 IMD waiver or allowed under a managed care contract approved by CMS.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1916. Repealed**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1917. Repealed**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1918. Additional Eligibility Criteria for the Basic Coverage Group

An applicant or member shall meet the following eligibility criteria:

1. Disabled. As a condition of eligibility, an applicant or member shall be disabled. Disabled means a person who has been determined disabled by the Department of Economic Security, Disability Determination Services Administration, under 42 U.S.C. 1382c(a)(3)(A) through (E), except employment activity, earnings, and substantial gainful activity shall not be considered in determining whether the individual meets the definition of disability.
2. Employed. As a condition of eligibility, an applicant or member shall be employed. Employed means that an applicant or member is paid for working and Social Security or Medicare taxes are paid on the applicant or member's work.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

R9-22-1919. Additional Eligibility Criteria for the Medically Improved Group

As a condition of eligibility for the Medically Improved Group, a member shall:

1. Be employed. Under this Section, employed means an individual who:
 - a. Earns at least the minimum wage and works at least 40 hours per month, or
 - b. Has gross monthly earnings at least equal to those earned by an individual who is earning the minimum wage working 40 hours per month.
2. Cease to be eligible for medical coverage under R9-22-1918 or a similar Basic Coverage Group program administered by another state because the member, by reason of medical improvement, is determined at the time of a regularly scheduled continuing disability review to no longer be disabled; and
3. Continues to have a severe medically determinable impairment, as determined under Social Security Act section 1902(a)(10)(A)(ii)(XVI).

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1920. Repealed**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1921. Enrollment

The Administration shall enroll members under Article 17 of this Chapter. If a member has not paid a required premium, the Administration shall not grant a guaranteed enrollment period.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

R9-22-1922. Redetermination of Eligibility

- A. Redetermination. Except as provided in subsection (B), the Administration shall complete a redetermination of eligibility at least once a year.
- B. Change in circumstance. The Administration may complete a redetermination of eligibility if there is a change in the member's circumstances, including a change in disability or employment that may affect eligibility.
- C. Medical Improvement. If a member is no longer disabled under R9-22-1918, the Administration shall determine if the member is eligible under other coverage groups including the medically improved group.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

ARTICLE 20. BREAST AND CERVICAL CANCER TREATMENT PROGRAM**R9-22-2001. Breast and Cervical Cancer Treatment Program Related Definitions**

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

"AZ-NBCCEDP" means the Arizona programs of the National Breast and Cervical Cancer Early Detection Program. AZ-NBCCEDP provides breast and cervical cancer screening and diagnosis in Arizona.

"Cryotherapy" means the destruction of abnormal tissue using an extremely cold temperature.

"LEEP" means the loop electrosurgical excision procedure that passes an electric current through a thin wire loop.

"Peer-reviewed study" means that, prior to publication, a medical study has been subjected to the review of medical experts who:

- Have expertise in the subject matter of the study,
- Evaluate the science and methodology of the study,
- Are selected by the editorial staff of the publication, and
- Review the study without knowledge of the identity or qualifications of the author.

"WWHP" means the Well Women Healthcheck Program administered by the Arizona Department of Health Services. The WWHP is one of the programs within AZ-NBCCEDP that provides breast and cervical cancer screening and diagnosis.

Historical Note

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Section repealed; new Section made by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

R9-22-2002. General Requirements

- A. Confidentiality. The Administration shall maintain the confidentiality of a woman's records and shall not disclose a woman's financial, medical, or other confidential information except as allowed under R9-22-512.
- B. Covered services. A woman who is eligible under this Article receives all medically necessary services under Articles 2 and 12 of this Chapter.
- C. Choice of health plan. A woman who is eligible under this Article shall be enrolled with a contractor under Article 17 of this Chapter.
- D. A Native American woman who receives services through Indian Health Service (IHS) or through a tribal health program

qualifies for services provided under this Article if all eligibility requirements are met.

- E. A woman qualified under this Article shall pay co-pays as described in R9-22-711.

Historical Note

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Section repealed; new Section made by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

R9-22-2003. Eligibility Criteria

- A. General. To be eligible under this Article, a woman shall meet the requirements of this Article and:
1. Be screened for breast and cervical cancer through AZ-NBCCEDP;
 2. Be less than 65 years of age;
 3. Be ineligible for Title XIX under Articles 14 and 15 in this Chapter;
 4. Receive a positive screen under subsection (A)(1), a confirmed diagnosis through AZ-NBCCEDP, and need treatment for breast cancer or cervical cancer, including a pre-cancerous cervical lesion, as specified in R9-22-2004;
 5. Not be covered under creditable coverage as specified in Section 2701(c) of the Public Health Services Act, 42 U.S.C. 300gg(c). For purposes of this Article, IHS or Tribal health coverage is not considered creditable coverage as specified in 42 U.S.C. 1396a(a)(10)(A)(ii), as amended by the Native American Breast and Cervical Cancer Treatment Technical Amendment Act of 2002; and
 6. Meet the requirements under R9-22-1417 and R9-22-1418.
- B. Ineligible woman. A woman is ineligible under this Article if the woman:
1. Is an inmate of a public institution and federal financial participation (FFP) is not available,
 2. Is at least age 21 but less than age 65 and resides in an Institution for Mental Disease (IMD) as defined in R9-22-112, except if allowed under the Administration's Section 1115 waiver, or
 3. No longer meets an eligibility requirement under this Article.
- C. Metastasized cancer. The AHCCCS Chief Medical Officer may continue a woman's eligibility under this Article if a metastasized cancer is found in another part of the woman's body and that metastasized cancer is a known or a presumed complication of the breast or cervical cancer as determined by the treating physician.
- D. Reoccurrence of cancer. A woman shall have eligibility reestablished after eligibility under this Article ends if the woman is screened under the AZ-NBCCEDP program and additional breast cancer or cervical cancer, including a pre-cancerous cervical lesion, is found.
- E. Ineligible male. A male is precluded from receiving screening and diagnostic services under the AZ-NBCCEDP program and is ineligible under this Article.

Historical Note

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Amended by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

R9-22-2004. Treatment

- A. Breast cancer. Coverage for treatment for breast cancer under this Article shall conclude on the last provider visit for the specific treatment of the cancer or at the end of hormonal therapy

for the cancer, whichever is later. For purposes of this subsection treatment means:

1. Lumpectomy or surgical removal of breast cancer;
2. Chemotherapy;
3. Radiation therapy; and
4. A treatment for breast cancer that, as determined by the AHCCCS Chief Medical Officer, is considered the standard of care as supported by a peer-reviewed study published in a medical journal.

- B. Pre-cancerous cervical lesion. Coverage for treatment for a pre-cancerous cervical lesion under this Article, including moderate or severe cervical dysplasia or carcinoma in situ, shall conclude on the last provider visit for specific treatment for the pre-cancerous lesion. For purposes of this subsection treatment means:

1. Conization;
2. LEEP;
3. Cryotherapy; and
4. A treatment for pre-cancerous cervical lesion that, as determined by the AHCCCS Chief Medical Officer, is considered the standard of care as supported by a peer-reviewed study published in a medical journal.

- C. Cervical cancer. Coverage for treatment for cervical cancer under this Article shall conclude on the last provider visit for the specific treatment for the cancer. For purposes of this subsection treatment means:

1. Surgery;
2. Radiation therapy;
3. Chemotherapy; and
4. A treatment for cervical cancer that, as determined by the AHCCCS Chief Medical Officer, is considered the standard of care as supported by a peer-reviewed study published in a medical journal.

Historical Note

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Section repealed; new Section made by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

R9-22-2005. Application Process

- A. Application. A woman may apply for eligibility under this Article by submitting a complete application as specified in R9-22-1406.
- B. Submitting the application. The woman may complete and submit an application at the time of the AZ-NBCCEDP screening. The AZ-NBCCEDP staff may mail or fax the application directly to the Administration.
- C. Date of application. The date of the application is the date of the diagnostic procedure that results in a positive diagnosis for breast cancer or cervical cancer, including a pre-cancerous cervical lesion.
- D. Responsibility of a woman who is applying or who is a member. A woman who is applying or who is a member shall:
1. Provide medical insurance information, including any changes in medical insurance; and
 2. Inform the Administration about a change in address, residence, and alienage status.

Historical Note

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Section repealed; new Section made by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

R9-22-2006. Approval, Denial, or Discontinuance of Eligibility

- A. Eligibility determination. The Administration shall determine eligibility under this Article and send the notice under subsec-

tion (B) or (C) within seven days of receiving a complete application.

- B.** Approval. If a woman meets all the eligibility requirements in this Article, the Administration shall provide the woman with an approval notice. The approval notice shall contain:
 1. The name of the eligible woman, and
 2. The effective date of eligibility.
- C.** Denial. If the Administration denies eligibility, the Administration shall provide the woman with a denial notice. The denial notice shall contain:
 1. The name of the ineligible woman,
 2. The specific reason why the woman is ineligible,
 3. The legal citations supporting the reason for the denial,
 4. The location where the woman can review the legal citations, and
 5. Information regarding the woman's appeal and request for hearing rights.
- D.** Discontinuance.
 1. Except as specified in subsection (D)(2), if a woman no longer meets an eligibility requirement under this Article, the Administration shall provide the woman a Notice of Action no later than 10 days before the effective date of the discontinuance.
 2. The Administration may mail the Notice of Action no later than the effective date of the discontinuance if the Administration:
 - a. Receives a written statement from the woman voluntarily withdrawing from AHCCCS,
 - b. Receives information confirming the death of the woman,
 - c. Receives returned mail with no forwarding address from the post office and the woman's whereabouts are unknown, or
 - d. Receives information confirming that the woman has been approved for Title XIX services outside the state of Arizona.
 3. The Notice of Action shall contain the:
 - a. Name of the ineligible woman,
 - b. Effective date of the discontinuance,
 - c. Specific reason why the woman is discontinued,
 - d. Legal citations supporting the reason for the discontinuance,
 - e. Location where the woman can review the legal citations, and
 - f. Information regarding the woman's appeal and request for hearing rights.
- E.** Request for hearing. A woman who is denied, or discontinued for the Breast and Cervical Cancer Treatment Program may request a hearing under Chapter 34.

Historical Note

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Section repealed; new Section made by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

R9-22-2007. Effective and End Date of Eligibility

- A.** The effective date of eligibility is the later of:
 1. The first day of the month in which a application is made; or
 2. The first day of the first month the woman meets all the eligibility requirements in this Article.
- B.** The end date of eligibility:
 1. For breast cancer, is 12 months after the last provider visit for a treatment specified in R9-22-2004 for the cancer or at the end of hormonal therapy for the cancer, whichever is later.

2. For pre-cancerous cervical lesion, is four months after the last provider visit for a treatment specified in R9-22-2004 for the pre-cancerous lesion.
3. For cervical cancer, is 12 months after the last provider visit for a treatment specified in R9-22-2004 for the cancer.

Historical Note

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Section repealed; new Section made by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

R9-22-2008. Redetermination of Eligibility

- A.** Redetermination. Except as provided in subsection (B), the Administration shall redetermine eligibility at least once a year. If a woman continues to meet the requirements of eligibility for the Breast and Cervical Cancer Treatment Program under this Article, the Administration shall notify the woman of continued eligibility. A woman is not required to be screened for breast and cervical cancer through AZ-NBC-CEDP at redetermination.
- B.** Change in circumstance. The Administration shall complete a redetermination of eligibility if there is a change in the woman's circumstances that may affect eligibility, including a change in treatment.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

ARTICLE 21. TRAUMA AND EMERGENCY SERVICES FUND

Article 21, consisting of Sections R9-22-2101 through R9-22-2103, made by exempt rulemaking at 9 A.A.R. 4001, effective October 19, 2003 (Supp. 03-3).

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.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 4001, effective October 19, 2003 (Supp. 03-3).

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.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 4001, effective October 19, 2003 (Supp. 03-3).

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 cost of uncompensated emergency care as a percentage of the total statewide cost of uncompensated emergency 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.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 4001, effective October 19, 2003 (Supp. 03-3). Amended by exempt rulemaking at 18 A.A.R. 1748, effective July 1, 2012 (Supp. 12-2).

R9-22-2104. Additional Trauma and Emergency Services Payments under the Section 1115 Waiver

- A. Notwithstanding R9-22-2101(D), for the reporting years ending June 30, 2011 and June 30, 2012, the Administration shall distribute an amount equal to the balance of the Trauma and Emergency Services fund in the following manner:
1. Ninety percent of the amount shall be distributed to Level I trauma centers based upon each center's pro rata share of each center's acuity-adjusted volume as a percentage of the total acuity-adjusted volume for all centers in the state. The acuity-adjusted volume is calculated by multiplying the Injury Severity Score employed by trauma.org by the number of trauma cases at that level treated at the center during the reporting year. Hospitals shall report trauma scores and case volume on a worksheet prescribed by the Administration.
 2. Ten percent of the amount shall be distributed proportionately to hospitals that had an emergency department from July 1 through June 30 of the reporting year based the pro rata share of each hospital's cost of emergency care as a percentage of the total statewide cost of emergency care provided by hospitals as reported on the Worksheet B, column 27, line 61 of the hospital's most current Medicare Cost Report as of January 31 following the end of each reporting year.
- B. For the reporting years ending June 30, 2011 and June 30, 2012, the Administration shall distribute an amount equal to the federal financial participation made available under the section 1115 waiver for the purpose of making payments for unrecovered trauma and emergency services as follows:
1. Thirty percent of such funds to a Level I trauma center, in amounts calculated in the same manner as described in subsection (A)(1) of this Section, for any unrecovered

- trauma center readiness costs not reimbursed under subsection (A) of this Section;
2. Thirty percent of such funds to a hospital having an emergency department from July 1 through June 30 of the reporting year, in amounts calculated in the same manner as described in subsection (A)(2) of this Section, for any unrecovered emergency services costs not reimbursed under subsection (A) of this Section; and
 3. Forty percent of such funds to rural hospitals, as defined in R9-22-718 that are not Level 1 trauma centers as defined in R9-22-2101(F), having an emergency department from July 1 through June 30 of the reporting year, in amounts calculated in the same manner as described in subsection (A)(2) of this Section, for any unrecovered emergency services costs not reimbursed under subsections (A) and (B)(2) of this Section.
- C. For the reporting years ending June 30, 2011 and June 30, 2012, payments made under this Article shall not be made in an amount that results in aggregate payments to the hospital by the Administration and contractors exceeding of the upper payment limit for the hospital services as calculated in accordance with 42 CFR 447.
 - D. For the reporting years ending June 30, 2011 and June 30, 2012, to ensure compliance with subsection (C), payments under this Article shall be reconciled to the federal fiscal year that is two years subsequent to the payment.
 - E. Any payments that are determined under subsection (D) to exceed the limit in subsection (C) shall be distributed as described in this Article to hospitals that have not received payments in excess of the limit in subsection (C).

Historical Note

New Section made by exempt rulemaking at 18 A.A.R. 1748, effective July 1, 2012 (Supp. 12-2).

TITLE 9. HEALTH SERVICES**CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
ARIZONA LONG-TERM CARE SYSTEM**

Editor's Note: The Office of the Secretary of State publishes all Code Chapters on white paper (Supp. 01-3).

Editor's Note: This Chapter contains rules which were adopted under an exemption from the rulemaking provisions of the Arizona Administrative Procedure Act (A.R.S. Title 41, Chapter 6, §§ 1001 et seq.) as specified in Laws 1992, Ch. 301, § 61 and Ch. 302, § 13, and Laws 1994, Ch. 322, § 21. Exemption from A.R.S. Title 41, Chapter 6 means that AHCCCS did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; AHCCCS did not submit these rules to the Governor's Regulatory Review Council; AHCCCS was not required to hold public hearings on these rules; and the Attorney General did not certify these rules. Because this Chapter contains rules which are exempt from the regular rulemaking process, the Chapter is printed on blue paper. The rules affected by this exemption appear throughout this Chapter.

ARTICLE 1. DEFINITIONS

Former Section R9-28-101 repealed; new Sections R9-28-101 thru R9-28-111 adopted effective December 8, 1997 (Supp. 97-4).

Section

- R9-28-101. General Definitions
- R9-28-102. Covered Services Related Definitions
- R9-28-103. Preadmission Screening Related Definitions
- R9-28-104. Repealed
- R9-28-105. Repealed
- R9-28-106. Request for Proposals and Contract Process Related Definitions
- R9-28-107. Repealed
- R9-28-108. Repealed
- R9-28-109. Repealed
- R9-28-110. Reserved
- R9-28-111. Behavioral Health Services Related Definitions

ARTICLE 2. COVERED SERVICES

Section

- R9-28-201. General Requirements
- R9-28-202. Medical Services
- R9-28-203. Repealed
- R9-28-204. Institutional Services
- R9-28-205. Home and Community Based Services (HCBS)
- R9-28-206. ALTCS Services that may be Provided to a Member Residing in either an Institutional or HCBS Setting

ARTICLE 3. PREADMISSION SCREENING (PAS)

Section

- R9-28-301. Definitions
- R9-28-302. General Provisions
- R9-28-303. Preadmission Screening (PAS) Process
- R9-28-304. Preadmission Screening Criteria for an Applicant or Member who is Elderly and Physically Disabled (EPD)
- R9-28-305. Preadmission Screening Criteria for an Applicant or Member who is Developmentally Disabled (DD)
- R9-28-306. Reassessments
- R9-28-307. The ALTCS Transitional Program for a Member who is Elderly and Physically Disabled (EPD) or Developmentally Disabled (DD)

ARTICLE 4. ELIGIBILITY AND ENROLLMENT

Section

- R9-28-401. Eligibility and Enrollment-Related Definitions
- R9-28-401.01. General
- R9-28-402. Categorical Requirements and Coverage Groups
- R9-28-403. State Residency
- R9-28-404. Citizenship and Qualified Alien Status
- R9-28-405. Social Security Enumeration
- R9-28-406. ALTCS Living Arrangements
- R9-28-407. Resource Criteria for Eligibility

- R9-28-408. Income Criteria for Eligibility
- R9-28-409. Transfer of Assets
- R9-28-410. Community Spouse
- R9-28-411. Changes, Redeterminations, and Notices
- R9-28-412. General Enrollment
- R9-28-413. Enrollment with an EPD Program Contractor
- R9-28-414. Enrollment with the DD Program Contractor
- R9-28-415. Enrollment with a Tribal Program Contractor
- R9-28-416. Enrollment with the FFS Program
- R9-28-417. Notification Requirements
- R9-28-418. Disenrollment

ARTICLE 5. PROGRAM CONTRACTOR AND PROVIDER STANDARDS

Section

- R9-28-501. Program Contractor and Provider Standards – Related Definitions
- R9-28-501.01. Pre-Existing Conditions
- R9-28-502. Long-term Care Provider Requirements
- R9-28-503. Licensure and Certification for Long-term Care Institutional Facilities
- R9-28-504. Standards of Participation, Licensure, and Certification for HCBS Providers
- R9-28-505. Standards, Licensure, and Certification for Providers of Hospital and Medical Services
- R9-28-506. Requirements for Spouse as Paid Caregiver
- R9-28-507. Program Contractor General Requirements
- R9-28-508. Self-directed Attendant Care (SDAC)
- R9-28-509. Agency with Choice
- R9-28-510. Case Management
- R9-28-511. Quality Management/Utilization Management (QM/UM) Requirements
- R9-28-512. Expired
- R9-28-513. Program Compliance Audits
- R9-28-514. Release of Safeguarded Information by the Administration and Contractors
- R9-28-515. Repealed

ARTICLE 6. RFP AND CONTRACT PROCESS

Article 6, consisting of Sections R9-28-601 through R9-28-610, repealed; new Article 6, consisting of Sections R9-28-601 through R9-28-608, adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1).

Section

- R9-28-601. General Provisions
- R9-28-602. RFP
- R9-28-603. Contract Award
- R9-28-604. Contract or Proposal Protests; Appeals
- R9-28-605. Waiver of Contractor's Subcontract with Hospitals
- R9-28-606. Contract Compliance Sanction
- R9-28-607. Repealed
- R9-28-608. Repealed
- R9-28-609. Repealed

R9-28-610. Repealed

ARTICLE 7. STANDARDS FOR PAYMENTS

Section

- R9-28-701. Standards for Payment Related Definitions
- R9-28-701.10. General Requirements
- R9-28-702. Repealed
- R9-28-703. Repealed
- R9-28-704. Repealed
- R9-28-705. Repealed
- R9-28-706. Repealed
- R9-28-707. Repealed
- R9-28-708. Repealed
- R9-28-709. Repealed
- R9-28-710. Repealed
- R9-28-711. Repealed
- R9-28-712. County of Fiscal Responsibility
- R9-28-713. Repealed
- R9-28-714. Repealed
- R9-28-715. Repealed

ARTICLE 8. TEFRA LIENS AND RECOVERIES

Article 8, consisting of Sections R9-28-801 through R9-28-807, made by final rulemaking at 14 A.A.R. 3791, effective November 8, 2008 (Supp. 08-3).

Article 8, consisting of Sections R9-28-801 through R9-28-803, repealed by final rulemaking at 10 A.A.R. 820, effective April 3, 2004. The subject matter of Article 8 is now in 9 A.A.C. 34 (Supp. 04-1).

Section

- R9-28-801. Definitions Related to TEFRA Liens
- R9-28-801.01. TEFRA Liens – General
- R9-28-802. TEFRA Liens – Affected Members
- R9-28-803. TEFRA Liens – Prohibitions
- R9-28-804. TEFRA Liens – AHCCCS Notice of Intent
- R9-28-805. TEFRA Liens and Estate Recovery – Member's Request for a State Fair Hearing
- R9-28-806. TEFRA Liens – Recovery
- R9-28-807. TEFRA Liens – Release

ARTICLE 9. FIRST- AND THIRD-PARTY LIABILITY AND RECOVERIES

Section

- R9-28-901. Definitions
- R9-28-902. General Provisions
- R9-28-903. Cost Avoidance
- R9-28-904. Member Participation
- R9-28-905. Collections
- R9-28-906. AHCCCS Monitoring Responsibilities
- R9-28-907. Notification for Perfection, Recording, and Assignment of AHCCCS Liens
- R9-28-908. Notification Information for Liens
- R9-28-909. Notification of Health Insurance Information
- R9-28-910. Recoveries
- R9-28-911. Estate Recovery and Undue Hardship
- R9-28-912. Partial Recovery
- R9-28-913. Repealed
- R9-28-914. Repealed
- R9-28-915. Repealed
- R9-28-916. Repealed
- R9-28-917. Repealed
- R9-28-918. Repealed
- R9-28-919. Repealed

ARTICLE 10. CIVIL MONETARY PENALTIES AND ASSESSMENTS

Section

- R9-28-1001. Basis for Civil Monetary Penalties and Assessments for Fraudulent Claims
- R9-28-1002. Repealed
- R9-28-1003. Repealed
- R9-28-1004. Repealed

ARTICLE 11. BEHAVIORAL HEALTH SERVICES

Article 11, consisting of Sections R9-28-1101 through R9-28-1106, repealed; new Article 11, consisting of Sections R9-28-1101 through R9-28-1108, adopted by final rulemaking at 6 A.A.R. 200, effective December 13, 1999 (Supp. 99-4).

Section

- R9-28-1101. General Requirements
- R9-28-1102. Program or Tribal Contractor Responsibilities
- R9-28-1103. Eligibility for Covered Services
- R9-28-1104. General Service Requirements
- R9-28-1105. Scope of Behavioral Health Services
- R9-28-1106. General Provisions and Standards for Service Providers
- R9-28-1107. General Provisions for Payment
- R9-28-1108. Repealed

ARTICLE 12. REPEALED

Article 12, consisting of Section R9-28-1201, repealed by final rulemaking at 10 A.A.R. 820, effective April 3, 2004. The subject matter of Article 12 is now in 9 A.A.C. 34 (Supp. 04-1).

Article 12, consisting of Section R9-28-1201, adopted effective September 9, 1998 (Supp. 98-3).

Section

- R9-28-1201. Repealed

ARTICLE 13. FREEDOM TO WORK

Article 13, consisting of Sections R9-28-1301 through R9-28-1324, made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4).

Section

- R9-28-1301. General Freedom to Work Requirements
- R9-28-1302. General Administration Requirements
- R9-28-1303. Application for Coverage
- R9-28-1304. Notice of Approval or Denial
- R9-28-1305. Reporting and Verifying Changes
- R9-28-1306. Actions that Result from a Redetermination or Change
- R9-28-1307. Notice of Adverse Action
- R9-28-1308. Request for Hearing
- R9-28-1309. Conditions of Eligibility
- R9-28-1310. Repealed
- R9-28-1311. Repealed
- R9-28-1312. Repealed
- R9-28-1313. Premium Requirements
- R9-28-1314. Repealed
- R9-28-1315. Repealed
- R9-28-1316. Institutionalized Person
- R9-28-1317. Repealed
- R9-28-1318. Repealed
- R9-28-1319. Repealed
- R9-28-1320. Additional Eligibility Criteria for the Basic Coverage Group
- R9-28-1321. Share of Cost
- R9-28-1322. Repealed
- R9-28-1323. Enrollment

Arizona Health Care Cost Containment System – Arizona Long-term Care System

R9-28-1324. Redetermination of Eligibility

ARTICLE 1. DEFINITIONS**R9-28-101. General Definitions**

A. Location of definitions. Definitions applicable to Chapter 28 are found in the following:

Definition	Section or Citation
"210"	42 CFR 435.211
"217"	42 CFR 435.217
"236"	42 CFR 435.236
"Acute"	R9-28-301
"ADHS"	R9-22-101
"ADL"	R9-28-101
"Administration"	A.R.S. § 36-2931
"Advance notice"	R9-28-411
"Aged"	R9-28-402
"Aggregate"	R9-22-701
"Aggression"	R9-28-301
"AHCCCS"	R9-22-101
"AHCCCS registered provider"	R9-22-101
"ALTCS"	R9-28-101
"ALTCS acute care services"	R9-28-401
"Alternative HCBS setting"	R9-28-101
"Ambulance"	A.R.S. § 36-2201
"Ambulation"	R9-28-301
"Applicant"	R9-22-101
"Assessor"	R9-28-301
"Auto-assignment algorithm" or "Algorithm"	R9-22-1701
"Bathing"	R9-28-301
"Bathing or showering"	R9-28-301
"Bed hold"	R9-28-102
"Behavior intervention"	R9-28-102
"Behavior management services"	R9-22-1201
"Behavioral health evaluation"	R9-22-1201
"Behavioral health medical practitioner"	R9-22-1201
"Behavioral health professional"	R9-20-101
"Behavioral health service"	R9-20-101
"Behavioral health technician"	R9-20-101
"Billed charges"	R9-22-701
"Blind"	42 U.S.C. 1382c(a)(2)
"Capped fee-for-service"	R9-22-101
"Case management plan"	R9-28-101
"Case management"	R9-28-1101
"Case manager"	R9-28-101
"Case record"	R9-22-101
"Categorically-eligible"	R9-22-101
"Certification"	R9-28-501
"Certified psychiatric nurse practitioner"	R9-22-1201
"CFR"	R9-28-101
"Child"	R9-22-1503
"Clarity of communication"	R9-28-301
"Clean claim"	A.R.S. § 36-2904
"Clinical supervision"	R9-22-201
"CMS"	R9-22-101
"Community mobility"	R9-28-301
"Community spouse"	R9-28-401
"Consecutive days"	R9-28-801
"Continence"	R9-28-301
"Contract"	R9-22-101
"Contract year"	R9-22-101
"Contractor"	A.R.S. § 36-2901
"Cost avoid"	R9-22-1201 or R9-22-1001
"County of fiscal responsibility"	R9-28-701
"Covered services"	R9-28-101
"CPT"	R9-22-701
"Crawling and standing"	R9-28-301

"CSRD"	R9-28-401
"Current"	R9-28-301
"Day"	R9-22-101 or R9-22-1101
"De novo hearing"	42 CFR 431.201
"Department"	A.R.S. § 36-2901
"Developmental disability" or "DD"	A.R.S. § 36-551
"Diagnostic services"	R9-22-101
"Director"	R9-22-101
"Disabled"	R9-28-402
"Disenrollment"	R9-22-1701
"Disruptive behavior"	R9-28-301
"DME"	R9-22-101
"Dressing"	R9-28-301
"Eating"	R9-28-301
"Eating or drinking"	R9-28-301
"Emergency medical services for the non-FES member"	R9-22-201
"Emotional and cognitive functioning"	R9-28-301
"Employed"	R9-28-1320
"Encounter"	R9-22-701
"Enrollment"	R9-22-1701
"EPD"	R9-28-301
"E.P.S.D.T. services"	42 CFR 440.40(b)
"Estate"	A.R.S. § 14-1201
"Experimental services"	R9-22-203
"Expressive verbal communication"	R9-28-301
"Facility"	R9-22-101
"Factor"	42 CFR 447.10
"Fair consideration"	R9-28-401
"FBR"	R9-22-101
"Federal financial participation" or "FFP"	42 CFR 400.203
"Fee-For-Service" or "FFS"	R9-22-101
"File" R9-28-801 "First continuous period of institutionalization"	R9-28-401
"Food preparation"	R9-28-301
"Frequency"	R9-28-301
"Functional assessment"	R9-28-301
"Grievance"	R9-34-202
"Grooming"	R9-28-301
"GSA"	R9-22-101
"Guardian"	A.R.S. § 14-5311
"Hand use"	R9-28-301
"HCBS" or "Home and community based services"	A.R.S. § 36-2931
"Health care practitioner"	R9-22-1201
"History"	R9-28-301
"Home"	R9-28-101 and R9-28-801
"Home health services"	R9-22-201
"Hospice"	A.R.S. § 36-401
"Hospital"	R9-22-101
"ICF-MR" or "Intermediate care facility for the mentally retarded"	42 U.S.C. 1396d(d)
"IADL"	R9-28-101
"IHS"	R9-22-101
"IMD" or "Institution for mental diseases"	42 CFR 435.1010
"Immediate risk of institutionalization"	R9-28-301
"Individual Representative"	R9-28-509
"Institutionalized"	R9-28-401
"Institutionalized spouse"	R9-28-101
"Interested Party"	R9-28-106
"Intergovernmental agreement" or "IGA"	R9-28-1101
"Intervention"	R9-28-301
"JCAHO"	R9-28-101
"License" or "licensure"	R9-22-101
"Medical assessment"	R9-28-301

Arizona Health Care Cost Containment System – Arizona Long-term Care System

“Medical or nursing services and treatments”		“Toileting”	R9-28-301
or “services and treatments”	R9-28-301	“Transferring”	R9-28-301
“Medical record”	R9-22-101	“TRBHA”	R9-22-1201
“Medical services”	A.R.S. § 36-401	“Tribal contractor”	R9-28-1101
“Medically eligible”	R9-28-401	“Tribal facility”	A.R.S. § 36-2981
“Medically necessary”	R9-22-101	“Utilization management/review”	R9-22-501
“Member”	A.R.S. § 36-2931 and R9-28-901	“Ventilator dependent”	R9-28-102
“Mental disorder”	A.R.S. § 36-501	“Verbal or physical threatening”	R9-28-301
“MMMNA”	R9-28-401	“Vision”	R9-28-301
“Mobility”	R9-28-301	“Wandering”	R9-28-301
“Natural Support Services”	R9-28-101	“Wheelchair mobility”	R9-28-301
“Noncontracting provider”	A.R.S. § 36-2931	B. General definitions. In addition to definitions contained in A.R.S. §§ 36-551, 36-2901, 36-2931, and 9 A.A.C. 22, Article 1, the following words and phrases have the following meanings unless the context of the Chapter explicitly requires another meaning:	
“Nursing facility” or “NF”	42 U.S.C. 1396r(a)		
“Occupational therapy”	R9-22-201	“ADL” or “Activities of Daily Living” mean activities a member must perform daily for the member’s regular day-to-day necessities, including but not limited to mobility, transferring, bathing, dressing, grooming, eating, and toileting.	
“Orientation”	R9-28-301	“ALTCS” means the Arizona Long-term Care System as authorized by A.R.S. § 36-2932.	
“Partial care”	R9-22-1201	“Alternative HCBS setting” means a living arrangement approved by the Director and licensed or certified by a regulatory agency of the state, where a member may reside and receive HCBS, including:	
“PAS”	R9-28-103	For a person with a developmental disability specified in A.R.S. § 36-551:	
“Personal hygiene”	R9-28-301	Community residential setting defined in A.R.S. § 36-551;	
“Pharmaceutical service”	R9-22-201	Group home defined in A.R.S. § 36-551;	
“Physical therapy”	R9-22-201	State-operated group home under A.R.S. § 36-591;	
“Physically disabled”	R9-28-301	Group foster home under R6-5-5903;	
“Physician”	R9-22-101	Licensed residential facility for a person with traumatic brain injury under A.R.S. § 36-2939;	
“Physician consultant”	R9-28-301	Behavioral health adult therapeutic home under 9 A.A.C. 20, Articles 1 and 15;	
“Post-stabilization care services”	42 CFR 438.114	Level 2 and Level 3 behavioral health residential agencies under 9 A.A.C. 20, Articles 1, 4, 5, and 6; and	
“Practitioner”	R9-22-101	Rural substance abuse transitional centers under 9 A.A.C. 20, Articles 1 and 14; and	
“Primary care provider” or “(PCP)”	R9-22-101	For a person who is Elderly and Physically Disabled (EPD) under R9-28-301, and the facility, setting, or institution is registered with AHCCCS:	
“Primary care provider services”	R9-22-201	Adult foster care defined in A.R.S. § 36-401 and as authorized in A.R.S. § 36-2939;	
“Prior authorization”	R9-22-101	Assisted living home or assisted living center, units only, under A.R.S. § 36-401, and as authorized in A.R.S. § 36-2939;	
“Prior period coverage” or “PPC”	R9-22-101	Licensed residential facility for a person with a traumatic brain injury specified in A.R.S. § 36-2939;	
“Program contractor”	A.R.S. § 36-2931	Behavioral health adult therapeutic home under 9 A.A.C. 20, Articles 1 and 15;	
“Provider”	A.R.S. § 36-2931	Level 2 and Level 3 behavioral health residential agencies under 9 A.A.C. 20, Articles 1, 4, 5, and 6; and	
“Psychiatrist”	R9-22-1201		
“Psychologist”	R9-22-1201		
“Psychosocial rehabilitation services”	R9-22-201		
“Qualified behavioral health service provider”	R9-28-1101		
“Quality management”	R9-22-501		
“Radiology”	R9-22-101		
“Reassessment”	R9-28-103		
“Recover”	R9-28-901		
“Redetermination”	R9-28-401		
“Referral”	R9-22-101		
“Regional behavioral health authority”			
or “RBHA”	A.R.S. § 36-3401		
“Reinsurance”	R9-22-701		
“Representative”	R9-28-401		
“Resistiveness”	R9-28-301		
“Respiratory therapy”	R9-22-201		
“Respite care”	R9-28-102		
“RFP”	R9-22-101		
“Room and board”	R9-28-102		
“Rolling and sitting”	R9-28-301		
“Running or wandering away”	R9-28-301		
“Scope of services”	R9-28-102		
“Section 1115 Waiver”	A.R.S. § 36-2901		
“Self-injurious behavior”	R9-28-301		
“Sensory”	R9-28-301		
“Seriously mentally ill” or “SMI”	A.R.S. § 36-550		
“Social worker”	R9-28-301		
“Special diet”	R9-28-301		
“Speech therapy”	R9-22-201		
“Spouse”	R9-28-401		
“SSA”	42 CFR 1000.10		
“SSI”	42 CFR 435.4		
“Subcontract”	R9-22-101		
“TEFRA lien”	R9-28-801		
“Therapeutic leave”	R9-28-501		

Rural substance abuse transitional centers under 9 A.A.C. 20, Articles 1 and 14.

“Case management plan” means a service plan developed by a case manager that involves the overall management of a member’s care, and the continued monitoring and reassessment of the member’s need for services.

“Case manager” means a person who is either a degreed social worker, a licensed registered nurse, or has a minimum of two years of experience in providing case management services to a person who is EPD.

“CFR” means Code of Federal Regulations, unless otherwise specified in this Chapter.

“Covered services” means the health and medical services described in Articles 2 and 11 of this Chapter as being eligible for reimbursement by AHCCCS.

“Home” means a residential dwelling that is owned, rented, leased, or occupied by a member, at no cost to the member, including a house, a mobile home, an apartment, or other similar shelter. A home is not a facility, a setting, or an institution, or a portion of any of these that is licensed or certified by a regulatory agency of the state as:

Health care institution under A.R.S. § 36-401;

Residential care institution under A.R.S. § 36-401;

Community residential setting under A.R.S. § 36-551; or

Behavioral health facility under 9 A.A.C. 20, Articles 1, 4, 5, and 6.

“IADL” or “Instrumental Activities of Daily Living” mean activities related to independent living that a member must perform, including but not limited to:

Preparing meals,
Managing money,
Shopping for groceries or personal items,
Performing light or heavy housework, and
Use of the telephone.

“IHS” means the Indian Health Service.

“Institutionalized spouse” means the same as defined in 42 U.S.C. 1396r-5.

“JCAHO” means the Joint Commission on Accreditation of Healthcare Organizations.

“Natural Support Services” are services provided voluntarily by a person not legally obligated to provide those services. The services are specified in the service plan as described under R9-28-510 and cannot supplant other covered services.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Amended effective July 13, 1992 (Supp. 92-3). Amended effective November 5, 1993 (Supp. 93-4). Section repealed; new Section adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1). Amended by final rulemaking at 5 A.A.R. 874, effective March 4, 1999 (Supp. 99-1). Subsection (A)(69) amended to correct a printing error, filed in the Office of the Secretary of State August 13, 1999 (Supp. 99-3). Amended by final rulemaking at 6 A.A.R. 200, effective December 13, 1999 (Supp. 99-4). Amended by final rulemaking at 6 A.A.R. 2461, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 6 A.A.R.

3365, effective August 7, 2000 (Supp. 00-3). Amended by exempt rulemaking at 7 A.A.R. 4691, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 8 A.A.R. 2356, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 8 A.A.R. 3340, effective July 15, 2002 (Supp. 02-3). Amended by final rulemaking at 9 A.A.R. 3810, effective October 4, 2003 (Supp. 03-3). Amended by final rulemaking at 10 A.A.R. 1312, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 11 A.A.R. 3165, effective October 1, 2005 (Supp. 05-3). Amended by final rulemaking at 11 A.A.R. 4286, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 13 A.A.R. 1090, effective May 5, 2007 (Supp. 07-1). Amended by final rulemaking at 14 A.A.R. 2090, effective July 5, 2008 (Supp. 08-2). Amended by final rulemaking at 18 A.A.R. 3380, effective January 1, 2013 (Supp. 12-4).

R9-28-102. Covered Services Related Definitions

Definitions. The following words and phrases, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, and 9 A.A.C. 22, Article 1, have the following meanings unless the context of the Chapter explicitly requires another meaning:

“Bed hold” means a 24 hour per day unit of service that is authorized by an ALTCS case manager or designee during a period of short-term hospitalization or therapeutic leave that meets the requirement specified in 42 CFR 483.12.

“Behavior intervention” means the planned interruption of a member’s inappropriate behavior using techniques such as reinforcement, training, behavior modification, and other systematic procedures intended to result in more acceptable behavior.

“Respite care” means a short-term service provided in a NF or a home and community based service setting to an individual if necessary to relieve a family member or other person caring for the individual.

“Room and board” means lodging and meals.

“Scope of services” means the covered, limited, and excluded services under Articles 2 and 12 of this Chapter.

“Ventilator dependent,” for purposes of ALTCS eligibility, means an individual is medically dependent on a ventilator for life support at least six hours per day and has been dependent on ventilator support as an inpatient in a hospital, NF, or ICF-MR for at least 30 consecutive days.

Historical Note

Adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 6 A.A.R. 2461, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 9 A.A.R. 3810, effective October 4, 2003 (Supp. 03-3).

R9-28-103. Preadmission Screening Related Definitions

Definitions. The following words and phrases, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, and 9 A.A.C. 22, Article 1, have the following meanings unless the context of the Chapter explicitly requires another meaning:

“Developmental disability” is defined in A.R.S. § 36-551.

“PAS” means preadmission screening, which is the process of determining an individual’s risk of institutionalization at a NF or ICF-MR level of care, as specified in Article 3 of this Chapter.

“Reassessment” means the process of redetermining PAS eligibility for ALTCS services as appropriate, for all members.

Historical Note

Adopted effective December 8, 1997 (Supp. 97-4).
Amended by final rulemaking at 6 A.A.R. 2461, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 9 A.A.R. 3810, effective October 4, 2003 (Supp. 03-3).
Amended by final rulemaking at 10 A.A.R. 1312, effective May 1, 2004 (Supp. 04-1).

R9-28-104. Repealed

Adopted effective December 8, 1997 (Supp. 97-4).
Amended effective November 4, 1998 (Supp. 98-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1).
Amended by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Amended by final rulemaking at 6 A.A.R. 2461, effective June 9, 2000 (Supp. 00-2). Repealed by final rulemaking at 14 A.A.R. 2090, effective July 5, 2008 (Supp. 08-2).

R9-28-105. Repealed

Historical Note

Adopted effective December 8, 1997 (Supp. 97-4).
Amended by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Section repealed by final rulemaking at 11 A.A.R. 4286, effective December 5, 2005 (Supp. 05-4).

R9-28-106. Request for Proposals and Contract Process Related Definitions

Definitions. The following words and phrases, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, and 9 A.A.C. 22 Article 1, have the following meanings unless the context of the Chapter explicitly requires another meaning: “Interested Party” means an actual or prospective offeror whose economic interest may be affected substantially and directly by the issuance of a request for proposals, the award of a contract, or the failure to award a contract.

Historical Note

Adopted effective December 8, 1997 (Supp. 97-4).
Amended by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1).

R9-28-107. Repealed

Historical Note

Adopted effective December 8, 1997 (Supp. 97-4).
Amended effective November 4, 1998 (Supp. 98-4).
Amended by final rulemaking at 6 A.A.R. 2461, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 9 A.A.R. 3810, effective October 4, 2003 (Supp. 03-3).
Section repealed by final rulemaking at 11 A.A.R. 3165, effective October 1, 2005 (Supp. 05-3).

R9-28-108. Repealed

Historical Note

Adopted effective December 8, 1997 (Supp. 97-4).
Amended by final rulemaking at 6 A.A.R. 3365, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 820, effective April 3, 2004 (Supp. 04-1).

R9-28-109. Repealed

Historical Note

Adopted effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 10 A.A.R. 1308, effective May 1, 2004 (Supp. 04-1).

R9-28-110. Reserved

R9-28-111. Behavioral Health Services Related Definitions

Definitions. The words and phrases in this Chapter, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, have the same meaning as specified in 9 A.A.C. 22, Article 1.

Historical Note

Adopted effective December 8, 1997 (Supp. 97-4).
Amended by final rulemaking at 6 A.A.R. 200, effective December 13, 1999 (Supp. 99-4).

ARTICLE 2. COVERED SERVICES

R9-28-201. General Requirements

In addition to the exclusions and limitations specified in this Article, services provided to a member are covered services if:

1. Medically necessary, cost effective, and federally reimbursable;
2. Coordinated by a case manager in accordance with requirements specified in R9-28-510;
3. The provider obtains prior authorization as required by a member’s program contractor or by the Administration:
 - a. Failure of the provider to obtain prior authorization is cause for denial.
 - b. Services provided during prior period coverage are exempt from prior authorization requirements;
4. Provided in facilities or areas of facilities that are licensed or certified under Article 5 of this Chapter, or meet other requirements described in Article 5 of this Chapter;
5. Rendered by AHCCCS registered providers as permitted under this Chapter and within their scope of practice; and
6. Provided at an appropriate level of care, as determined by the case manager or the primary care provider.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Section repealed; new Section adopted effective September 22, 1997 (Supp. 97-3).
Amended by final rulemaking at 8 A.A.R. 2356, effective May 9, 2002 (Supp. 02-2).

R9-28-202. Medical Services

The Administration or a contractor shall cover medical services specified in 9 A.A.C. 22, Article 2 for a member, subject to the limitations and exclusions specified in Article 2, unless otherwise specified in this Chapter.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Amended under an exemption from the provisions of the Administrative Procedure Act effective March 22, 1993; received in the Office of the Secretary of State March 24, 1993 (Supp. 93-1). Amended effective November 5, 1993 (Supp. 93-4). Section repealed; new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 2356, effective May 9, 2002 (Supp. 02-2).

R9-28-203. Repealed**Historical Note**

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Amended effective July 13, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act effective March 22, 1993; received in the Office of the Secretary of State March 24, 1993 (Supp. 93-1). Repealed effective September 22, 1997 (Supp. 97-3).

R9-28-204. Institutional Services**A.** Institutional services are provided in:

1. A NF;
 2. An ICF-MR; or
 3. A facility identified in R9-28-1105(A)(1)(b), (B), or (C).
- B.** The Administration and a contractor shall include the following services in the per diem rate for a facility listed in subsection (A):
1. Nursing care services;
 2. Rehabilitative services prescribed as a maintenance regimen;
 3. Restorative services, such as range of motion;
 4. Social services;
 5. Nutritional and dietary services;
 6. Recreational therapies and activities;
 7. Medical supplies and non-customized durable medical equipment under 9 A.A.C. 22, Article 2;
 8. Overall management and evaluation of a member's care plan;
 9. Observation and assessment of a member's changing condition;
 10. Room and board services, including supporting services such as food and food preparation, personal laundry, and housekeeping;
 11. Non-prescription and stock pharmaceuticals; and
 12. Respite care services not to exceed 600 hours per benefit year.

C. Each facility listed in subsection (A) is responsible for coordinating the delivery of at least the following auxiliary services:

1. Under 9 A.A.C. 22, Article 2:
 - a. Attending physician, practitioner, and primary care provider services;
 - b. Pharmaceutical services;
 - c. Diagnostic services under A.A.C. R9-22-208;
 - d. Emergency medical services; and
 - e. Emergency and medically necessary transportation services.
2. Therapy services under R9-28-206.

D. Limitations. The following limitations apply:

1. A private room in a NF, ICF-MR, or facility identified in R9-28-1105(A)(1)(b), (B), or (C) is covered only if:
 - a. The member or has a medical condition that requires isolation, and
 - b. The member's primary care provider or attending physician provides written authorization;
2. Each ICF-MR shall meet the standards in A.R.S. § 36-2939(B)(1), and in 42 CFR 483, Subpart I, February 28, 1992, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments;
3. Bed hold days as authorized by the Administration or its designee for a fee-for-service provider shall meet the following criteria:

- a. Short-term hospitalization leave for a member age 21 and over is limited to 12 days per AHCCCS benefit year, and is available if a member is admitted to a hospital for a short stay. After the short-term hospitalization, the member is returned to the institutional facility from which leave is taken, and to the same bed if the level of care required can be provided in that bed; and
 - b. Therapeutic leave for a member age 21 and older is limited to nine days per AHCCCS benefit year. A physician order is required for therapeutic leave from the facility for one or more overnight stays to enhance psycho-social interaction, or as a trial basis for discharge planning. After the therapeutic leave, the member is returned to the same bed within the institutional facility;
 - c. Therapeutic leave and short-term hospitalization leave are limited to any combination of 21 days per benefit year for a member under age 21;
4. The Administration or a contractor shall cover services that are not part of a per diem rate but are ALTCS covered services included in this Article, and deemed necessary by a member's case manager or the case manager's designee if:
- a. The services are ordered by the member's primary care provider; and
 - b. The services are specified in a case management plan under R9-28-510;
5. A member age 21 through 64 is eligible for behavioral health services provided in a facility under subsection (A)(3) that has more than 16 beds, for up to 30 days per admission and no more than 60 days per benefit year as allowed under the Administration's Section 1115 Waiver with CMS and except as specified by 42 CFR 441.151, May 22, 2001, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments; and
6. The limitations in subsection (D)(5) do not apply to a member:
- a. Under age 21 or age 65 or over, or
 - b. In a facility with 16 beds or less.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended subsections (A) and (D) effective June 6, 1989 (Supp. 89-2). Amended effective November 5, 1993 (Supp. 93-4). Section repealed; new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by exempt rulemaking at 7 A.A.R. 4691, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 8 A.A.R. 2356, effective May 9, 2002 (Supp. 02-2). Amended by exempt rulemaking at 17 A.A.R. 1876, effective October 1, 2011 (Supp. 11-3).

R9-28-205. Home and Community Based Services (HCBS)

- A.** Subject to the availability of federal funds, HCBS are covered services if provided to a member residing in the member's own home or an alternative residential setting. Room and board services are not covered in a HCBS setting.
- B.** The case manager shall authorize and specify in a case management plan any additions, deletions, or changes in home and community based services provided to a member or in accordance with R9-28-510.
- C.** Home and community based services include the following:
1. Home health services provided on a part-time or intermittent basis. These services include:

- a. Nursing care;
- b. Home health aide;
- c. Medical supplies, equipment, and appliances;
- d. Physical therapy;
- e. Occupational therapy;
- f. Respiratory therapy; and
- g. Speech and audiology services;
2. Private duty nursing services;
3. Medical supplies and durable medical equipment, including customized DME, as described in 9 A.A.C. 22, Article 2;
4. Transportation services to obtain covered medically necessary services;
5. Adult day health services provided to a member in an adult day health care facility licensed under 9 A.A.C. 10, Article 5, including:
 - a. Supervision of activities specified in the member's care plan;
 - b. Personal care;
 - c. Personal living skills training;
 - d. Meals and health monitoring;
 - e. Preventive, therapeutic, and restorative health related services; and
 - f. Behavioral health services, provided either directly or through referral, if medically necessary;
6. Personal care services;
7. Homemaker services;
8. Home delivered meals, that provide at least one-third of the recommended dietary allowance, for a member who does not have a developmental disability under A.R.S. § 36-551;
9. Respite care services for no more than 600 hours per benefit year;
10. Habilitation services including:
 - a. Physical therapy;
 - b. Occupational therapy;
 - c. Speech and audiology services;
 - d. Training in independent living;
 - e. Special development skills that are unique to the member;
 - f. Sensory-motor development;
 - g. Behavior intervention; and
 - h. Orientation and mobility training;
11. Developmentally disabled day care provided in a group setting during a portion of a 24-hour period, including:
 - a. Supervision of activities specified in the member's care plan;
 - b. Personal care;
 - c. Activities of daily living skills training; and
 - d. Habilitation services; and
12. Supported employment services provided to a member in the ALTCS transitional program under R9-28-306 who is developmentally disabled under A.R.S. § 36-551.

Historical Note

Adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 2356, effective May 9, 2002 (Supp. 02-2). Amended by exempt rulemaking at 17 A.A.R. 1876, effective October 1, 2011 (Supp. 11-3).

R9-28-206. ALTCS Services that may be Provided to a Member Residing in either an Institutional or HCBS Setting

The Administration shall cover the following services if the services are provided to a member within the limitations listed:

1. Occupational and physical therapies, speech and audiology services, and respiratory therapy;

- a. The duration, scope, and frequency of each therapeutic modality or service is prescribed by the member's primary care provider or attending physician;
- b. The therapy or service is authorized by the member's contractor or the Administration; and
- c. The therapy or service is included in the members case management plan;
- d. AHCCCS will not cover more than 15 outpatient physical therapy visits for the contract year with the exception of the required Medicare coinsurance and deductible payment as described in 9 A.A.C. 29, Article 3.
2. Medical supplies, durable medical equipment, and customized durable medical equipment, which conform with the requirements and limitations of 9 A.A.C. 22, Article 2;
3. Ventilator dependent services:
 - a. Inpatient or institutional services are limited to services provided in a general hospital, special hospital, NF, or ICF-MR. Services provided in a general or special hospital are included in the hospital's unit tier rate under 9 A.A.C. 22, Article 7;
 - b. A ventilator dependent member may receive the array of home and community based services under R9-28-205 as appropriate.
4. Hospice services:
 - a. Hospice services are covered only for a member who is in the final stages of a terminal illness and has a prognosis of death within six months;
 - b. Covered hospice services for a member are those allowable under 42 CFR 418.202, December 20, 1994, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments; and
 - c. Covered hospice services do not include:
 - i. Medical services provided that are not related to the terminal illness, or
 - ii. Home delivered meals.
 - d. Medicare is the primary payor of hospice services for a member if applicable.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Amended effective July 13, 1992 (Supp. 92-3). Amended effective November 5, 1993 (Supp. 93-4). Section repealed; new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 2356, effective May 9, 2002 (Supp. 02-2). Amended by exempt rulemaking at 16 A.A.R. 1664, effective October 1, 2010 (Supp. 10-3).

ARTICLE 3. PREADMISSION SCREENING (PAS)

R9-28-301. Definitions

- A. Common definitions. In addition to definitions contained in A.R.S. Title 36, Chapter 29, and 9 A.A.C. 28, Article 1, the words and phrases in this Article have the following meanings for an individual who is elderly or physically disabled (EPD) or developmentally disabled (DD) unless the context explicitly requires another meaning:

"Applicant" is defined in A.A.C. R9-22-101.

"Assessor" means a social worker as defined in this subsection or a licensed registered nurse (RN) who:

Is employed by the Administration to conduct PAS assessments,

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Completes a minimum of 30 hours of classroom training in both EPD and DD PAS for a total of 60 hours, and

Receives intensive oversight and monitoring by the Administration during the first 30 days of employment and ongoing oversight by the Administration during all periods of employment.

“Current” means belonging to the present time.

“Disruptive behavior” means inappropriate behavior by the applicant or member including urinating or defecating in inappropriate places, sexual behavior inappropriate to time, place, or person or excessive whining, crying, or screaming that interferes with an applicant’s or member’s normal activities or the activities of others and requires intervention to stop or interrupt the behavior.

“Frequency” means the number of times a specific behavior occurs within a specified interval.

“Functional assessment” means an evaluation of information about an applicant’s or member’s ability to perform activities related to:

- Developmental milestones,
- Activities of daily living,
- Communication, and
- Behavior.

“Immediate risk of institutionalization” means the status of an applicant or member under A.R.S. § 36-2934(A)(5) and as specified in A.R.S. § 36-2936 and in the Administration’s Section 1115 Waiver with Centers for Medicare and Medicaid Services (CMS).

“Intervention” means therapeutic treatment, including the use of medication, behavior modification, and physical restraints to control behavior. Intervention may be formal or informal and includes actions taken by friends or family to control the behavior.

“Medical assessment” means an evaluation of an applicant’s or member’s medical condition and the applicant’s or member’s need for medical services.

“Medical or nursing services and treatments” or “services and treatments” means specific, ongoing medical, psychiatric, or nursing intervention used actively to resolve or prevent deterioration of a medical condition. Durable medical equipment and activities of daily living assistive devices are not treatment unless the equipment or device is used specifically and actively to resolve the existing medical condition.

“Physician consultant” means a physician who contracts with the Administration.

“Social worker” means an individual with two years of case management-related experience or a baccalaureate or master’s degree in:

- Social work,
- Rehabilitation,
- Counseling,
- Education,
- Sociology,
- Psychology, or
- Other closely related field.

“Special diet” means a diet planned by a dietitian, nutritionist, or nurse that includes high fiber, low sodium, or pureed food.

“Toileting” means the process involved in an applicant’s or member’s managing of the elimination of urine and feces in an appropriate place.

“Vision” means the ability to perceive objects with the eyes.

- B.** EPD. In addition to definitions contained in subsection (A), the following also apply to an applicant or member who is EPD:

“Aggression” means physically attacking another, including:

- Throwing an object,
- Punching,
- Biting,
- Pushing,
- Pinching,
- Pulling hair,
- Scratching, and
- Physically threatening behavior.

“Bathing” means the process of washing, rinsing, and drying all parts of the body, including an applicant’s or member’s ability to transfer to a tub or shower and to obtain bath water and equipment.

“Continence” means the applicant’s or member’s ability to control the discharge of body waste from bladder and bowel.

“Dressing” means the physical process of choosing, putting on, securing fasteners, and removing clothing and footwear. Dressing includes choosing a weather-appropriate article of clothing but excludes aesthetic concerns. Dressing includes the applicant’s or member’s ability to put on artificial limbs, braces, and other appliances that are needed daily.

“Eating” means the process of putting food and fluids by any means into the digestive system.

“Emotional and cognitive functioning” means an applicant’s or member’s orientation and mental state, as evidenced by aggressive, self-injurious, wandering, disruptive, and resistive behaviors.

“EPD” means an applicant or member who is elderly and physically disabled.

“Grooming” means an applicant’s or member’s process of tending to appearance. Grooming includes: combing or brushing hair; washing face and hands; shaving; oral hygiene (including denture care); and menstrual care. Grooming does not include aesthetics such as styling hair, skin care, nail care, and applying cosmetics.

“Mobility” means the extent of an applicant’s or member’s purposeful movement within a residential environment.

“Orientation” means an applicant’s or member’s awareness of self in relation to person, place, and time.

“Physically disabled” means an applicant or member who is determined to be physically impaired by the Administration through the PAS assessment as allowed under the Administration’s Section 1115 Waiver with CMS.

“Resistiveness” means inappropriately obstinate and uncooperative behaviors, including passive or active obstinate behaviors, or refusing to participate in self-care or to take necessary medications. Resistiveness does not

include difficulties with auditory processing or reasonable expressions of self-advocacy.

“Self-injurious behavior” means repeated self-induced, abusive behavior that is directed toward infliction of immediate physical harm to the body.

“Sensory” means of or relating to the senses.

“Transferring” means an applicant’s or member’s ability to move horizontally or vertically between two surfaces within a residential environment, excluding transfer for toileting or bathing.

“Wandering” means an applicant’s or member’s moving about with no rational purpose and with a tendency to go beyond the physical parameter of the residential environment.

C. DD. In addition to definitions contained in subsection (A), the following also apply to an applicant or member who is DD:

“Acute” means an active medical condition having a sudden onset, lasting a short time, and requiring immediate medical intervention.

“Aggression” means physically attacking another, including:

- Throwing objects,
- Punching,
- Biting,
- Pushing,
- Pinching,
- Pulling hair, and
- Scratching.

“Ambulation” means the ability to walk and includes quality of the walking and the degree of independence in walking.

“Bathing or showering” means an applicant’s or member’s ability to complete the bathing process including drawing the bath water, washing, rinsing, and drying all parts of the body, and washing the hair.

“Clarity of communication” means an ability to speak in recognizable language or use a formal symbolic substitution, such as American-Sign Language.

“Community mobility” means the applicant’s or member’s ability to move about a neighborhood or community independently, by any mode of transportation.

“Crawling and standing” means an applicant’s or member’s ability to crawl and stand with or without support.

“DD” means developmentally disabled.

“Developmental milestone” means a measure of an applicant’s or member’s functional abilities, including:

- Fine motor skills,
- Gross motor skills,
- Communication,
- Socialization,
- Daily living skills, and
- Behaviors.

“Dressing” means the ability to put on and remove an article of clothing. Dressing does not include the ability to put on or remove braces nor does it reflect an applicant’s or member’s ability to match colors or choose clothing appropriate for the weather.

“Eating or drinking” means the process of putting food and fluid by any means into the digestive system.

“Expressive verbal communication” means an applicant’s or member’s ability to communicate thoughts with words or sounds.

“Food preparation” means the ability to prepare a simple meal including a sandwich, cereal, or a frozen meal.

“Hand use” means the applicant’s or member’s ability to use both hands, or one hand if an applicant or member has only one hand or has the use of only one hand.

“History” means a medical condition that occurred in the past, regardless of whether the medical condition required treatment in the past, and is not now active.

“Personal hygiene” means the process of tending to one’s appearance. Personal hygiene may include: combing or brushing hair, washing face and hands, shaving, performing routine nail care, oral hygiene including denture care, and menstrual care. This does not include aesthetics such as styling hair, skin care, and applying cosmetics.

“Rolling and sitting” means an applicant’s or member’s ability to roll and sit independently or with the physical support of another person or with a device such as a pillow or specially-designed chair.

“Running or wandering away” means an applicant or member leaving a physical environment without notifying or receiving permission from the appropriate individuals.

“Self-injurious behavior” means an applicant’s or member’s repeated behavior that causes injury to the applicant or member.

“Verbal or physical threatening” means any behavior in which an applicant or member uses words, sounds, or action to threaten harm to self, others, or an object.

“Wheelchair mobility” means an applicant’s or member’s mobility using a wheelchair and does not include the ability to transfer to the wheelchair.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended subsection (C) effective June 6, 1989 (Supp. 89-2). Amended effective July 13, 1992 (Supp. 92-3). Amended effective November 5, 1993 (Supp. 93-4). Section repealed by emergency action, new Section adopted by emergency action, subsection (A) effective June 30, 1995, subsection (B) effective September 1, 1995, pursuant to A.R.S. § 41-1026, valid for 180 days; entire Section filed in the Secretary of State’s Office June 30, 1995 (Supp. 95-2). Section repealed by emergency action, new Section adopted again by emergency action with changes effective January 2, 1996, pursuant to A.R.S. § 41-1026, valid for 180 days (Supp. 96-1). Emergency expired June 1, 1996. Section in effect before emergency action restored. Section repealed; new Section adopted effective January 14, 1997 (Supp. 97-1). Amended by final rulemaking at 7 A.A.R. 5824, effective December 7, 2001 (Supp. 01-4). Amended by final rulemaking at 12 A.A.R. 4007, effective October 5, 2006 (Supp. 06-4). Amended by final rulemaking at 17 A.A.R. 167, effective March 12, 2011 (Supp. 11-1).

R9-28-302. General Provisions

To qualify for services described in A.R.S. § 36-2939:

1. An applicant shall meet the financial criteria described in Article 4, and

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2. AHCCCS shall determine that the applicant is at immediate risk of institutionalization under the PAS assessment as specified in this Article.

Historical Note

New Section adopted by emergency action, subsection (A) effective June 30, 1995, subsection (B) effective September 1, 1995, pursuant to A.R.S. § 41-1026, valid for 180 days; entire Section filed in the Office of the Secretary of State June 30, 1995 (Supp. 95-2). New Section adopted again by emergency action with changes effective January 2, 1996, pursuant to A.R.S. § 41-1026 (Supp. 96-1). Emergency expired June 1, 1996. New Section adopted effective January 14, 1997 (Supp. 97-1). Amended by final rulemaking at 7 A.A.R. 5824, effective December 7, 2001 (Supp. 01-4).

R9-28-303. Preadmission Screening (PAS) Process

- A. The assessor shall use the PAS instrument to determine whether the following applicants or members are at immediate risk of institutionalization:

1. The assessor shall use the PAS instrument prescribed in R9-28-304 to assess an applicant or member who is EPD except as specified in subsection (A)(2) for an applicant or member who is physically disabled and who is less than 6 years old. After assessing a child who is physically disabled and age 6 years to less than 12 years, the assessor shall refer the child for physician consultant review under subsections (G) through (J).
2. The assessor shall use the age-specific PAS instrument prescribed in R9-28-305 to assess an applicant or member who is physically disabled and less than 6 years old. After assessing the child, the assessor shall refer the child for physician consultant review under subsections (G) through (J).
3. The assessor shall use the PAS instrument prescribed in R9-28-305 to assess an applicant or member who is DD, except as specified in subsection (A)(4) for an applicant or member who is DD and residing in a NF. After assessing a child who is DD and less than 6 months of age, the assessor shall refer the child for physician consultant review under subsections (G) through (J).
4. The assessor shall use the PAS instrument prescribed in R9-28-304 for an applicant or a member who is DD and residing in a NF.
5. The assessor shall use the PAS instrument prescribed in R9-28-304 or R9-28-305, whichever is applicable, to assess an applicant or member who is classified as ventilator-dependent, under Section 1902(e)(9) of the Social Security Act.

- B. For an initial assessment of an applicant who is in a hospital or other acute care setting:

1. A registered nurse assessor shall complete the PAS assessment; or
2. In the event that a registered nurse assessor is not available, a social worker assessor shall complete the PAS assessment; and
3. The assessor shall conduct the PAS assessment and determine medical eligibility when discharge is scheduled within seven days.

- C. An assessor shall conduct a face-to-face PAS assessment with an applicant or member, except as provided in subsection (F). The assessor shall make reasonable efforts to obtain the applicant's or member's available medical records. The assessor may also obtain information for the PAS assessment from face-to-face interviews with the:

1. Applicant or member,

2. Parent,
3. Guardian,
4. Caregiver, or
5. Any person familiar with the applicant's or member's functional or medical condition.

- D. Using the information described in subsection (C), an assessor shall complete the PAS assessment based on the assessor's education, experience, professional judgment, and training.

- E. After the assessor completes the PAS assessment, the assessor shall calculate a PAS score. The assessor shall compare the PAS score to an established threshold score. The scoring methodology and threshold scores are specified in R9-28-304 and R9-28-305. Except as determined by physician consultant review as provided in subsections (G) through (J), the threshold score is the point at which an applicant or member is determined to be at immediate risk of institutionalization.

- F. Upon request from a person acting on behalf of the applicant, the Administration shall conduct a PAS assessment to determine whether a deceased applicant who was residing in a NF or who received services in an ICF-MR any time during the time period covered by the application would have been eligible to receive ALTCS benefits for those months.

- G. In the following circumstances, the Administration shall request that a physician consultant review the PAS assessment, the available medical records, and use professional judgment to make the determination that an applicant or member has a developmental disability or has a nonpsychiatric medical condition that, by itself or in combination with other medical conditions, places an applicant or member at immediate risk of institutionalization:

1. The PAS score of an applicant or member who is EPD is less than the threshold specified in R9-28-304, but is at least 56;
2. The PAS score of an applicant or member who is DD is less than the threshold specified in R9-28-305, but is at least 38;
3. An applicant or member scores below the threshold specified in R9-28-304, but the Administration has reasonable cause to believe that the applicant's or member's unique functional abilities or medical condition may place the applicant or member at immediate risk of institutionalization;
4. An applicant or member scores below the threshold specified in R9-28-304 and has a documented diagnosis of autism, autistic-like behavior, or pervasive developmental disorder;
5. An applicant or member who is seriously mentally ill as defined in A.R.S. § 36-550 who scores at or above the threshold specified in R9-28-304, but may not meet the requirements of A.R.S. § 36-2936. When an applicant or member who is seriously mentally ill scores at or above the threshold, the physician consultant shall exercise professional judgment to determine whether the applicant or member meets the requirements of A.R.S. § 36-2936.
6. An applicant is an AHCCCS acute care member and scores at or above the threshold specified in R9-28-304 but the Administration has reasonable cause to believe that the applicant's condition is convalescent and requires less than 90 days of institutional care;
7. An applicant or member is a child who is physically disabled and is at least 6 but less than 12 years of age;
8. An applicant or member is a child who is physically disabled and is under 6 years of age; and
9. An applicant is under 6 months of age.

- H. The physician consultant shall consider the following:

1. Activities of daily living dependence;

2. Delay in development;
 3. Continence;
 4. Orientation;
 5. Behavior;
 6. Any medical condition, including stability and prognosis of the condition;
 7. Any medical nursing treatment provided to the applicant or member including skilled monitoring, medication, and therapeutic regimens;
 8. The degree to which the applicant or member must be supervised;
 9. The skill and training required of the applicant or member's caregiver; and
 10. Any other factor of significance to the individual case.
- I.** If the physician consultant is unable to make the determination from the PAS assessment and the available medical records, the physician consultant may conduct a face-to-face review with the applicant or member or contact others familiar with the applicant's or member's needs, including a primary care physician or other caregiver, to make the determination.
- J.** The physician consultant shall state the reasons for the determination in the physician review comment section of the PAS instrument.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective July 13, 1992 (Supp. 92-3). Amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective July 1, 1993 (Supp. 93-3). Amended effective November 5, 1993 (Supp. 93-4). Section repealed by emergency action, new Section adopted by emergency action effective June 30, 1995, pursuant to A.R.S. § 41-1026, valid for 180 days (Supp. 95-2). Section repealed by emergency action, new Section adopted again by emergency action effective January 2, 1996, pursuant to A.R.S. § 41-1026, valid for 180 days (Supp. 96-1). Emergency expired June 1, 1996. Section in effect before emergency action restored. Section repealed; new Section adopted effective January 14, 1997 (Supp. 97-1). Former Section R9-28-303 renumbered to R9-28-304; new Section R9-28-303 made by final rulemaking at 7 A.A.R. 5824, effective December 7, 2001 (Supp. 01-4). Amended by final rulemaking at 12 A.A.R. 4007, effective October 5, 2006 (Supp. 06-4). Amended by final rulemaking at 17 A.A.R. 167, effective March 12, 2011 (Supp. 11-1).

R9-28-304. Preadmission Screening Criteria for an Applicant or Member who is Elderly and Physically Disabled (EPD)

- A.** The PAS instrument for an applicant or member who is EPD includes the following categories:
1. Intake information category. The assessor solicits intake information category information on an applicant's or member's demographic background. The components of the intake information category are not included in the calculated PAS score.
 2. Functional assessment category. The assessor solicits functional assessment category information on an applicant's or member's:
 - a. Need for assistance with activities of daily living, including:
 - i. Bathing,
 - ii. Dressing,
 - iii. Grooming,
 - iv. Eating,
 - v. Mobility,
 - vi. Transferring, and
 - vii. Toileting in the residential environment or other routine setting;
 - b. Communication and sensory skills, including hearing, expressive communication, and vision; and
 - c. Continence, including bowel and bladder functioning.
 3. Emotional and cognitive functioning category. The assessor solicits emotional and cognitive functioning category information on an applicant's or member's:
 - a. Orientation to person, place, and time. In soliciting this information, the assessor shall also take into account the caregiver's judgment; and
 - b. Behavior, including:
 - i. Wandering,
 - ii. Self-injurious behavior,
 - iii. Aggression,
 - iv. Resistiveness, and
 - v. Disruptive behavior.
 4. Medical assessment category. The assessor solicits medical assessment category information on an applicant's or member's:
 - a. Medical conditions that have an impact on the applicant's or member's functional ability in relation to activities of daily living, continence, and vision;
 - b. Medical condition that requires medical or nursing service and treatment;
 - c. Medication, treatment, and allergies;
 - d. Specific services and treatments that the applicant or member is currently receiving; and
 - e. Physical measurements, hospitalization history, and ventilator dependency.
- B.** The assessor shall use the PAS instrument to assess an applicant or member who is EPD as specified in this Section. A copy of the PAS instrument is available from the Administration. The Administration uses the assessor's PAS assessment to calculate three scores: a functional score, a medical score, and a total score.
1. Functional score.
 - a. The Administration calculates the functional score from responses to scored items in the functional assessment and emotional and cognitive functioning categories. For each response to a scored item, a number of points is assigned, which is multiplied by a weighted numerical value. The result is a weighted score for each response.
 - b. In the functional assessment matrix, all items in the following categories are scored according to subsection (C):
 - i. Activities of daily living,
 - ii. Continence,
 - iii. Sensory,
 - iv. Orientation, and
 - v. Behavior.
 - c. The sum of the weighted scores equals the functional score. The weighted score per item can range from 0 to 15. The maximum functional score attainable by an applicant or member is 166.
 2. Medical score.
 - a. In the medical assessment matrix, all items in the following categories are scored according to:
 - i. Medical conditions as specified in subsection (C), and
 - ii. Medical or nursing services and treatments in subsection (C).

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- b. The Administration calculates the medical score based on the applicant's or member's:
 - i. Diagnosis of Alzheimer's, dementia, or organic brain syndrome (OBS);
 - ii. Diagnosis of paralysis; and
 - iii. Current use of oxygen.
 - c. The maximum medical score attainable by an applicant or member is 31.5.
3. Total score.
 - a. The sum of an applicant's or member's functional and medical scores equals the total score.
 - b. The total score is compared to the established threshold score as calculated under this Section. The threshold score is 60.
 - c. As defined in R9-28-303, an applicant or member is determined at immediate risk of institutionalization if the total score is equal to or greater than 60.
- C. The following matrices represent the number of points available and the respective weight for each scored item.
 1. Functional assessment points. The lowest value in the range of points available per item in the functional assessment category, zero, indicates minimal to no impairment. Conversely, the highest value indicates severe impairment.
 2. Medical assessment points. The lowest value in the range of points available per item in the medical assessment category, zero, indicates that the applicant or member:
 - a. Does not have the scored medical condition,
 - b. Does not need the scored medical or nursing services, or
 - c. Does not receive the scored medical or nursing services.

FUNCTIONAL ASSESSMENT	# of Points Available Per Item (P)	Weight (W)	Range of Possible Weighted Score per Item (P)x(W)
Activities of Daily Living Section			
Mobility	0-3	5	0-15
Transfer	0-3	5	0-15
Bathing	0-3	5	0-15
Dressing	0-3	5	0-15
Grooming	0-3	5	0-15
Eating	0-3	5	0-15
Toileting	0-3	5	0-15
Continence Section			
Bowel	0-3	1	0-3
Bladder	0-3	1	0-3
Sensory Section			
Vision	0-3	2	0-6
Orientation Section			
Place	0-4	.5	0-2
Time	0-4	.5	0-2
Emotional or Cognitive Behavior Section			
Aggression-Frequency	0-3	1.5	0-4.5
Aggression-Intervention	0-3	1.5	0-4.5
Self-injurious-Frequency	0-3	1.5	0-4.5
Self-injurious-Intervention	0-3	1.5	0-4.5
Wandering-Frequency	0-3	1.5	0-4.5
Wandering-Intervention	0-3	1.5	0-4.5
Resistiveness-Frequency	0-3	1.5	0-4.5
Resistiveness-Intervention	0-3	1.5	0-4.5
Disruptive-Frequency	0-3	1.5	0-4.5
Disruptive-Intervention	0-3	1.5	0-4.5

MEDICAL ASSESSMENT	# of Points Available Per Item (P)	Weight (W)	Range of Possible Weighted Score Per Item (P)x(W)
Medical Conditions Section			
Paralysis	0-1	6.5	0 or 6.5
Alzheimer's, or OBS, or Dementia	0-1	20	0 or 20
Services and Treatments Section			
Oxygen	0-1	5	0 or 5

Historical Note

New Section adopted by emergency action, subsection (A) effective June 30, 1995, subsection (B) effective September 1, 1995, pursuant to A.R.S. § 41-1026, valid for 180 days; entire Section filed as an emergency rule with the Secretary of State's Office June 30, 1995 (Supp. 95-2). New Section adopted again by emergency action with changes effective January 2, 1996, pursuant to A.R.S. § 41-1026, valid for 180 days (Supp. 96-1). Emergency expired. New Section adopted effective January 14, 1997 (Supp. 97-1). Former Section R9-28-304 renumbered to R9-28-305; new Section R9-28-304 renumbered from R9-28-303 and amended by final rulemaking at 7 A.A.R. 5824, effective December 7, 2001 (Supp. 01-4). Amended by final rulemaking at 12 A.A.R. 4007, effective October 5, 2006 (Supp. 06-4).

R9-28-305. Preadmission Screening Criteria for an Applicant or Member who is Developmentally Disabled (DD)

- A. The Administration shall conduct a PAS assessment of an applicant or member who is DD using one of three PAS instruments specifically designed to assess an applicant or member in the following age groups:
 1. Twelve years of age and older,
 2. Six through 11 years of age, and
 3. Birth through 5 years of age.
- B. The PAS instruments for an applicant or member who is DD include three major categories:
 1. Intake information category. The assessor solicits intake information category information on an applicant's or member's demographic background. The components of this category are not included in the calculated PAS score.
 2. Functional assessment category. The functional assessment category differs by age group as indicated in subsections (B)(2)(a) through (e):
 - a. For an applicant or member 12 years of age and older, the assessor solicits the functional assessment category information on an applicant's or member's:
 - i. Need for assistance with independent living skills, including hand use, ambulation, wheelchair mobility, transfer, eating or drinking, dressing, personal hygiene, bathing or showering, food preparation, community mobility, and toileting;
 - ii. Communication skills and cognitive abilities, including expressive verbal communication, clarity of communication, associating time with an event and action, and remembering an instruction and a demonstration; and
 - iii. Behavior, including aggression, verbal or physical threatening, self-injurious behavior, and resistive or rebellious behavior.
 - b. For an applicant or member 6 through 11 years of age, the assessor solicits the functional assessment category information on an applicant's or member's:
 - i. Need for assistance with independent living skills, including rolling and sitting, crawling and standing, ambulation, climbing stairs or ramps, wheelchair mobility, dressing, personal hygiene, bathing or showering, toileting, level of bladder control, and orientation to familiar settings;
 - ii. Communication, including expressive verbal communication and clarity of communication; and
 - iii. Behavior, including aggression, verbal or physical threatening, self-injurious behavior, running or wandering away, and disruptive behavior.
 - c. For an applicant or member 6 months through 5 years of age, the assessor solicits the functional assessment category information on an applicant's or member's performance with respect to a series of developmental milestones that measure an applicant's or member's degree of functional growth.
 3. Medical assessment category. The assessor solicits medical assessment category information on an applicant's or member's:
 - a. Medical condition;
 - b. Specific services and treatments the applicant or member receives or needs and the frequency of those services and treatments;
 - c. Current medication;
 - d. Medical stability;
 - e. Sensory functioning;
 - f. Physical measurements; and
 - g. Current living arrangement, ventilator dependency and eligibility for DES Division of Developmental Disabilities program services.
- C. The assessor shall use the PAS instrument to assess an applicant or member who is DD. A copy of the PAS instrument is available from the Administration. The Administration uses the assessor's PAS instrument responses to calculate three scores: a functional score, a medical score, and a total score.
 1. Functional score.
 - a. The Administration calculates the functional score from responses to scored items in the functional assessment category. Each response is assigned a number of points which is multiplied by a weighted numerical value, resulting in a weighted score for each response.
 - b. The following items are scored as indicated in subsection (D), under the Functional Assessment matrix:
 - i. For an applicant or member 12 years of age and older, all items in the behavior section are scored. Designated items in the independent living skills, communication skills, and cognitive abilities sections are also scored;
 - ii. For an applicant or member 6 through 11 years of age, all items in the communication section are scored. Designated items in the independent living skills and behavior sections are scored;
 - iii. For an applicant or member 6 months of age through 5 years of age, items in the developmental milestones section are scored based on the age of the applicant.
 - c. The sum of the weighted scores equals the functional score. The range of weighted score per item and maximum functional score for each age group is presented below:

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AGE GROUP	RANGE FOR WEIGHTED SCORE PER ITEM	MAXIMUM FUNCTIONAL SCORE ATTAINABLE
12+	0 - 11.2	124.1
6-11	0 - 24	112.5
0-5	0 - 5.0	106.02

- d. No minimum functional score is required.
2. Medical score.
- a. Subsections (C)(2)(a)(i) through (iii) are scored as indicated in subsection (D), under the Medical Assessment matrix:
- The assessor shall score designated items in the medical conditions for an applicant or member 12 years of age and older and 6 years of age through 11 years of age.
 - The assessor shall score designated items in the medical conditions and medical stability sections for an applicant or member 6 months of age through 5 years of age.
 - The assessor shall complete only the medical assessment section of the PAS for an applicant or member less than 6 months of age. There is no weighted or calculated score assigned. The assessor shall refer the applicant or member for physician consultant review.
 - The assessor shall complete only the medical assessment section of the PAS for an applicant or member less than 6 months of age. There is no weighted or calculated score assigned. The assessor shall refer the applicant or member for physician consultant review.
- b. The Administration calculates the medical score from information obtained in the medical assessment category. Each response to a scored item is assigned a number of points. The sum of the points

equals the medical score. The range of points per item and the maximum medical score attainable by an applicant or member is presented below:

AGE GROUP	RANGE OF POINTS PER ITEM	MAXIMUM MEDICAL SCORE ATTAINABLE
12+	0 - 20.6	21.4
6-11	0 - 2.5	5
0-5	0 - 10	60

- c. No minimum medical score is required.
3. Total score.
- The sum of an applicant's or member's functional and medical scores equals the total score.
 - The total score is compared to an established threshold score in R9-28-304. For an applicant or member who is DD, the threshold score is 40. Based upon the PAS instrument an applicant or member with a total score equal to or greater than 40 is at immediate risk of institutionalization.
- D. The following matrices represent the number of points available and the weight for each scored item.
- Functional assessment points. An applicant or member age group 0 to 5: The value is received for each negative response. An applicant or member age groups 6 to 11 and 12+: the lowest value in the range of points available per item in the functional assessment category indicates minimal to no impairment. Conversely, the highest value indicates severe impairment.
 - Medical assessment points. The lowest value in the range of points available per item in the medical assessment category, zero, indicates that the applicant or member:
 - Does not have a medical condition specified in the following matrices,
 - Does not need medical or nursing service as specified in the following matrices, or
 - Does not receive any medical or nursing service as specified in the following matrices.

AGE GROUP 12 AND OLDER FUNCTIONAL ASSESSMENT	# of Points Available Per Item (P)	Weight (W)	Range of Possible Weighted Score Per Item (P) x (W)
Independent Living Skills Section			
Hand Use, Food Preparation	0-3	3.5	0-10.5
Ambulation, Toileting, Eating, Dressing, Personal Hygiene	0-4	2.8	0-11.2
Communicative Skills and Cognitive Abilities Section			
Associating Time, Remembering Instructions	0-3	0.5	0 - 1.5
Behavior Section			
Aggression, Threatening, Self Injurious	0-4	2.8	0-11.2
Resistive	0-3	3.5	0-10.5

AGE GROUP 12 AND OLDER MEDICAL ASSESSMENT	# of Points Available Per Item (P)	Weight (W)	Range of Possible Weighted Score Per Item (P) x (W)
Medical Conditions Section			
Cerebral Palsy, Epilepsy	0-1	0.4	0-.4
Moderate, Severe, Profound Mental Retardation	0-1	20.6	0-20.6

AGE GROUP 6-11 FUNCTIONAL ASSESSMENT	# of Points Available Per Item (P)	Weight (W)	Range of Possible Weighted Score Per Item (P) x (W)
Independent Living Skills Section			
Climbing Stairs, Wheelchair Mobility, Bladder Control	0-3	1.875	0-5.625
Ambulation, Dressing, Bathing, Toileting	0-4	1.5	0-6
Crawling or Standing	0-5	1.25	0-6.25
Rolling or Sitting	0-8	0.833	0-6.66
Communication Section			
Clarity	0-4	1.5	0-6
Expressive Communication	0-5	1.25	0-6.25
Behavior Section			
Wandering	0-4	6	0-24
Disruptive	0-3	7.5	0-22.5

AGE GROUP 6 - 11 MEDICAL ASSESSMENT	# of Points Available Per Item (P)	Weight (W)	Range of Possible Weighted Score Per Item (P) x (W)
Medical Conditions Section			
Cerebral Palsy, Epilepsy	0-1	2.50	0-2.5

AGE GROUP 0 – 5 FUNCTIONAL ASSESSMENT	Weight
6 -9 Months	5.0
9-11 Months	4.1
12-17 Months	2.9
18-23 Months	2.125
24-29 Months	1.75
30-35 Months	1.55
36-47 Months	1.34
48-59 Months	1.14
60 Months+	1.03

AGE GROUP 0 - 5 MEDICAL ASSESSMENT	Weight
Cerebral Palsy	5.0
Epilepsy	5.0
Moderate, Severe, or Profound Mental Retardation (36 Months and older only)	15.0
Autism + M-CHAT (18 Months and older only) Fails at least six M-CHAT based questions	7.0
Autism + Behaviors (30-35 Months only) Exhibits at least 3 of 4 specific behaviors	5.0
Autism + Behaviors (36 Months and older only) Exhibits at least 6 of 8 specific behaviors	10.0
Drug Regulation + Administration (6 Months to 35 Months)	1.0
Drug Regulation + Administration (36 Months and older)	1.5
Non-Bowel/Bladder Ostomy Care (6 Months to 35 Months)	7.0
Non-Bowel/Bladder Ostomy Care (36 Months and older)	5.0
Tube Feeding (6 Months to 35 Months)	7.0
Tube Feeding (36 Months and older)	5.0
Physical Therapy or Occupational Therapy (6 Months to 35 Months)	1.0
Physical Therapy or Occupational Therapy (36 Months and older)	1.5
Acute Hospital Admission (One)	1.0
Acute Hospital Admissions (Two or more)	2.0
Direct Care Staff Trained (6 Months to 11 Months)	0.5
Direct Care Staff Trained (12 Months and older)	1.0
Special Diet	2.0

Historical Note

Section adopted by emergency action effective June 30, 1995, pursuant to A.R.S. § 41-1026, valid for 180 days (Supp. 95-2). Section adopted again by emergency action effective January 2, 1996, pursuant to A.R.S. § 41-1026, valid for 180 days (Supp. 96-1). Emergency expired. New Section adopted effective January 14, 1997 (Supp. 97-1). Former Section R9-28-305 renumbered to R9-28-306; new Section R9-28-305 renumbered from R9-28-304 and amended by final rulemaking at 7 A.A.R. 5824, effective December 7, 2001 (Supp. 01-4). Amended by final rulemaking at 17 A.A.R. 167, effective March 12, 2011 (Supp. 11-1).

R9-28-306. Reassessments

- A.** An assessor shall reassess an ALTCS member to determine continued eligibility:
 1. In connection with a routine audit of the PAS assessment by AHCCCS;
 2. In connection with a request by a provider, program contractor, case manager, or other party, if AHCCCS determines that continued eligibility is uncertain due to substantial evidence of a change in the member's circumstances or error in the PAS assessment; or
 3. Annually when part of a population group identified by the Director in a written report as having an increased likelihood of becoming ineligible.
- B.** An assessor shall determine continued eligibility for ALTCS using the same criteria used for the initial PAS assessment as prescribed in R9-28-303.
- C.** An assessor shall refer the reassessment to physician consultant review if the member is:
 1. Determined ineligible,
 2. In the ALTCS Transitional Program under R9-28-307 and resides in a NF or ICF-MR, or
 3. Seriously mentally ill and no longer has a non-psychiatric medical condition that impacts the member's ability to function.

Historical Note

Adopted effective September 1, 1995, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1994, Ch. 322, § 21; filed with the Office of the Secretary of State June 29, 1995 (Supp. 95-3). Former Section R9-28-306 renumbered to R9-28-307; new Section R9-28-306 renumbered from R9-28-305 and amended by final rulemaking at 7 A.A.R. 5824, effective December 7, 2001 (Supp. 01-4). Amended by final rulemaking at 10 A.A.R. 1312, effective May 1, 2004 (Supp. 04-1).

R9-28-307. The ALTCS Transitional Program for a Member who is Elderly and Physically Disabled (EPD) or Developmentally Disabled (DD)

- A.** The ALTCS transitional program serves members enrolled in the ALTCS program who, at the time of reassessment as described in R9-28-306, no longer meet the threshold specified in R9-28-304 for EPD or in R9-28-305 for DD but do meet all other ALTCS eligibility criteria. The Administration shall compare the member's PAS assessment to a scoring methodology for eligibility in the ALTCS transitional program as defined in subsections (B) and (C).
- B.** The Administration shall transfer a member who is DD from the ALTCS program to the ALTCS transitional program if, at the time of a reassessment, the total PAS score is less than the threshold described in R9-28-305 but is at least 30, or the member is diagnosed with moderate, severe, or profound mental retardation.
- C.** The Administration shall transfer a member who is EPD from the ALTCS program to the ALTCS transitional program if, at the time of a reassessment, the PAS score is less than the threshold described in R9-28-304 but is at least 40.
- D.** For a member residing in a NF or ICF-MR, the program contractor or the Administration shall ensure that the member is moved to an approved home- and community-based setting

within 90 continuous days from the enrollment date of the member's eligibility for the ALTCS transitional program.

- E.** A member in the ALTCS transitional program shall continue to receive all medically necessary covered services as specified in Article 2.
- F.** A member in the ALTCS transitional program is eligible to receive up to 90 continuous days per NF or ICF-MR admission when the member's condition worsens to the extent that an admission is medically necessary.
- G.** For a member requiring medically necessary NF or ICF-MR services for longer than 90 days, the program contractor shall request the Administration to conduct a reassessment under R9-28-306.

Historical Note

New Section renumbered from R9-28-306 and amended by final rulemaking at 7 A.A.R. 5824, effective December 7, 2001 (Supp. 01-4). Amended by final rulemaking at 12 A.A.R. 4007, effective October 5, 2006 (Supp. 06-4).

ARTICLE 4. ELIGIBILITY AND ENROLLMENT**R9-28-401. Eligibility and Enrollment-Related Definitions**

Definitions. For purposes of this Article, the following words and phrases, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, and 9 A.A.C. 22, Article 1, have the following meanings unless the context of the Chapter explicitly requires another meaning:

"ALTCS acute care services" means services under 9 A.A.C. 22, Articles 2 and 12, that are provided to a person who meets ALTCS eligibility requirements in 9 A.A.C. 28, Article 4 and who:

Lives in an acute care living arrangement described in R9-28-406; or

Is not eligible for long-term care benefits, described in R9-28-409, due to a transfer under R9-28-409 without receiving fair consideration, or

Has refused institutionalized or HCBS services.

"Community spouse" means the husband or wife of an institutionalized person who has entered into a contract of marriage, recognized as valid by the state of Arizona, and who does not live in a medical institution.

"CSRD" means Community Spouse Resource Deduction, the amount of a married couple's resources that is excluded in the eligibility determination to prevent impoverishment of the community spouse as determined under R9-28-410.

"Fair consideration" means income, real or personal property, services, or support and maintenance equal to or exceeding the fair market value of the income or resources that were transferred.

"First continuous period of institutionalization" means the first period beginning on or after September 30, 1989 that the applicant was institutionalized for 30 consecutive days or more. To be considered institutionalized, the applicant must:

Have resided in a medical institution;

Have received paid formal Home and Community Based Services (HCBS);

Have received a combination of medical institutionalization and HCBS, or

Intend to receive HCBS and either:

Requests a Resource Assessment and is determined in need of institutional services by a Resource Assessment Medical Evaluation; or

Applies for ALTCS and is determined medically eligible by the Pre-Admission Screening (PAS).

“Institutionalized” means residing in a medical institution or receiving or expecting to receive HCBS that prevent the person from being placed in a medical institution as determined by the PAS.

“Medically eligible” means meeting the ALTCS medical eligibility criteria under Article 3 of this Chapter.

“MMMNA” means Minimum Monthly Maintenance Needs Allowance.

“Redetermination” means a periodic review of all eligibility factors for a recipient.

“Representative” means a person other than a spouse or a parent of a dependent child, who applies for ALTCS on behalf of another person.

“Spouse” means a person legally married under Arizona law, a person eligible for Social Security benefits as the spouse of another person, or a person living with another person of the opposite sex and the couple represents themselves in the community as husband and wife.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1). Amended by exempt rulemaking at 7 A.A.R. 4691, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 9 A.A.R. 5138, effective January 3, 2004 (Supp. 03-4). Section repealed; new Section made by final rulemaking at 14 A.A.R. 2090, effective July 5, 2008 (Supp. 08-2).

R9-28-401.01. General

A. Application for ALTCS coverage.

1. The Administration shall provide a person the opportunity to apply for ALTCS without delay.
2. A person may be accompanied, assisted, or represented by another in the application process.
3. To apply for ALTCS, a person shall submit an application to an ALTCS eligibility office.
 - a. The application shall contain the applicant's name and address.
 - b. Before the application is approved, a person listed in A.A.C. R9-22-1406(D) shall sign the application.
 - c. A witness shall also sign the application if an applicant signs the application with a mark.
 - d. The date of application is the date the application is received by the Administration or Department as described in R9-22-1406(C).
4. Except as provided in R9-22-1501(D)(5), the Administration shall determine eligibility within 45 days from the date of application.
5. An applicant or representative who files an ALTCS application may withdraw the application for ALTCS cover-

age either orally or in writing to the ALTCS eligibility office where the application was filed. The Administration shall provide the applicant with a denial notice under subsection (G).

6. If an applicant dies while an application is pending, the Administration shall complete an eligibility determination for the deceased applicant.
7. If a person dies before an application is filed, the Administration shall complete an eligibility determination on an application filed on behalf of the deceased applicant, if the application is filed in the month of the person's death.

B. Conditions of ALTCS eligibility. Except for persons identified in subsection (C), the Administration shall approve a person for ALTCS if all conditions of eligibility for one of the ALTCS coverage groups listed in R9-28-402(B) are met. The conditions of eligibility are:

1. Categorical requirements under R9-28-402;
2. Citizenship and alien status under R9-28-404;
3. SSN under R9-28-405;
4. Living arrangements under R9-28-406;
5. Resources under R9-28-407;
6. Income under R9-28-408;
7. Transfers under R9-28-409;
8. A legally authorized person shall assign rights to the Administration for medical support and for payment of medical care from any first- and third-parties and shall cooperate by:
 - a. Obtaining medical support and payments and establishing paternity for a child born out of wedlock, except for pregnant women under A.A.C. R9-22-1421, unless the person establishes good cause under 42 CFR 433.147 for not cooperating; and
 - b. Identifying and providing information to assist the Administration in pursuing first- and third-parties who may be liable to pay for care and services unless the person establishes good cause for not cooperating;
9. A person shall take all necessary steps to obtain annuity, pension, retirement, and disability benefits for which a person may be entitled unless the person establishes good cause for not doing so;
10. State residency under R9-28-403;
11. Medical eligibility as specified in Article 3 of this Chapter; and
12. Providing information and verification as specified in subsection (D).

C. Persons eligible for Title IV-E or Title XVI. To be determined eligible for ALTCS, a person eligible for benefits under Title IV-E or Title XVI of the Social Security Act shall provide information to allow the Administration to determine:

1. Medical eligibility as specified in Article 3 of this Chapter,
2. Post-eligibility treatment of income as specified in R9-28-408,
3. The existence of trusts in accordance with federal and state law, and
4. Transfer of property as specified in R9-28-409.

D. Verification. If requested by the Administration, a person shall provide information and documentation to verify the following criteria or shall authorize the Administration to verify the following criteria:

1. Conditions of eligibility as specified in subsection (B); and
2. Other individual circumstances necessary to determine a person's eligibility and post-eligibility treatment of income (share-of-cost).

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- E. Documentation of the eligibility decision. The ALTCS eligibility interviewer shall include facts in a person's case record to support the decision on the person's application.
- F. Eligibility effective date. Eligibility is effective the first day of the month that all eligibility requirements are met but no earlier than the month of application.
- G. Notice. The Administration shall send a person a written notice of the decision regarding the person's application. The notice shall include a statement of the action and an explanation of the person's hearing rights as specified in 9 A.A.C. 34 and:
 - 1. If the applicant's eligibility is approved, the notice shall contain:
 - a. The effective date of eligibility; and
 - b. Post-eligibility treatment of income (share-of-cost) information, which is the amount the person shall pay toward the cost of care.
 - 2. If the applicant's eligibility is denied, the notice shall contain:
 - a. The effective date of the denial;
 - b. A statement detailing the reason for the person's denial, including specific financial calculations and the financial eligibility standard if applicable; and
 - c. The legal authority supporting the decision.
- H. Confidentiality. The Administration shall maintain the confidentiality of a person's record and shall not disclose information regarding the person's financial, medical, or other privacy interests except under A.A.C. R9-22-512.

Historical Note

New Section made by final rulemaking at 14 A.A.R. 2090, effective July 5, 2008 (Supp. 08-2).

R9-28-402. Categorical Requirements and Coverage Groups

- A. Categorical requirements. As a condition of ALTCS eligibility, a person shall meet one of the following categorical requirements in this Section under 42 CFR 435, Subpart F.
 - 1. Aged.
 - a. "Aged" means a person who is 65 years of age or older.
 - b. A person is considered to be age 65 on the day before the anniversary of birth.
 - c. Age shall be verified under 20 CFR 404.715 and 20 CFR 404.716.
 - 2. Blind. Blindness shall be determined by the DES Disability Determination Services Administration, under 42 U.S.C. 1382c(a)(2).
 - 3. Disabled. A person is considered to be disabled for ALTCS if the person is determined medically eligible under Article 3.
 - 4. Child. A child is a person defined in A.A.C. R9-22-1420.
 - 5. Pregnant.
 - a. Pregnancy shall be medically verified by one of the following licensed health care professionals:
 - i. Licensed physician;
 - ii. Certified physician's assistant;
 - iii. Certified nurse practitioner;
 - iv. Licensed midwife; or
 - v. Licensed registered nurse, under the direction of a licensed physician.
 - b. Written verification of pregnancy shall include the expected date of delivery.
 - 6. A specified relative who is the caretaker relative of a deprived child under Section 2 of the AFDC State Plan as it existed on July 16, 1996, incorporated by reference and on file with the Administration and the Secretary of State.

This incorporation by reference contains no future editions or amendments.

- B. ALTCS coverage groups. In addition to other requirements in this Article, a person shall meet ALTCS eligibility criteria in one of the following coverage groups:
 - 1. A coverage group under A.R.S. §§ 36-2901(6)(a)(i) or 36-2901(6)(a)(ii).
 - 2. The 210 coverage group specified in 42 CFR 435.210. A person in the 210 coverage group is medically eligible as specified in Article 3 and would be eligible for SSI cash assistance or meets the criteria for AFDC under Section 2 of the AFDC State Plan as it existed on July 16, 1996.
 - 3. The 236 coverage group under 42 CFR 435.236. A person in the 236 coverage group is medically eligible as specified in Article 3 and the person resides in a medical institution.
 - 4. The 217 coverage group under 42 CFR 435.217. A person in the 217 coverage group is medically eligible as specified in Article 3 and the person resides in a home and community-based setting described in R9-28-406(A)(2).

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Amended effective July 13, 1992 (Supp. 92-3). Amended effective November 5, 1993 (Supp. 93-4). Repealed effective November 4, 1998 (Supp. 98-4). New Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1). Amended by exempt rulemaking at 7 A.A.R. 4691, effective October 1, 2001 (Supp. 01-3).

R9-28-403. State Residency

As a condition of eligibility, a person shall be a resident of Arizona as specified in 42 CFR 435.403, December 21, 1990, incorporated by reference and on file with the Administration and Secretary of State. This incorporation contains no future editions or amendments.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective April 25, 1990 (Supp. 90-2). Amended effective July 13, 1992 (Supp. 92-3). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1).

R9-28-404. Citizenship and Qualified Alien Status

As a condition of eligibility, a person shall be:

- 1. A citizen of the United States;
- 2. A qualified alien specified in 8 U.S.C. 1641 and A.R.S. § 36-2903.03, to the extent consistent with federal law; or
- 3. A nonqualified alien who received ALTCS services on or before August 21, 1996, as specified in Laws 1997, Ch. 300, § 70.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective April 25, 1990 (Supp. 90-2). Amended effective July 13, 1992 (Supp. 92-3). Amended effective November 5, 1993 (Supp. 93-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1).

R9-28-405. Social Security Enumeration

As a condition of eligibility, a person shall furnish an SSN, as specified in 42 CFR 435.910 and 435.920.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1).

R9-28-406. ALTCS Living Arrangements

A. Long-term care living arrangements. A person may be eligible for ALTCS services, under Article 2, while living in one of the following settings:

1. Institutional settings:
 - a. A NF defined in 42 U.S.C. 1396r(a),
 - b. An IMD for a person who is either under age 21 or age 65 or older or a person aged 21 through 64 for up to 30 days per admission and no more than 60 days per contract year under the Administration's Section 1115 Waiver with CMS,
 - c. An ICF-MR for a person with developmental disabilities,
 - d. A hospice (free-standing, hospital, or nursing facility subcontracted beds) defined in A.R.S. § 36-401; or
2. Home and community-based services (HCBS) settings:
 - a. A person's home defined in R9-28-101(B), or
 - b. Alternative HCBS settings defined in R9-28-101(B).

B. ALTCS acute care living arrangements. A person applying for or receiving ALTCS coverage shall be eligible for only ALTCS acute care coverage in the following living arrangements, settings, or locations:

1. The gross income limit is 300 percent of the FBR for a person meeting the requirements of the 236 coverage group under R9-28-402(B) and who resides in one of the following settings:
 - a. A noncertified medical facility, or
 - b. A medical facility that is registered with AHCCCS but does not have a contract with an ALTCS program contractor, or
 - c. A location outside of Arizona if the person is temporarily absent from Arizona.
2. The net income limit is 100 percent of the FBR for a person who does not meet the requirements of the 217 or 236 coverage groups specified in R9-28-402(B) and who resides in one of the following settings:
 - a. At home or in an alternative HCBS setting if a person refuses HCBS service; or
 - b. A room in an assisted living center, or a licensed assisted living home or center which is not registered with AHCCCS.

C. Inmate of a public institution. An inmate of a public institution is not eligible for the ALTCS program if federal financial participation (FFP) is not available.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1). Amended by exempt rulemaking at 7 A.A.R. 4691, effective October 1, 2001 (Supp. 01-3).

R9-28-407. Resource Criteria for Eligibility

A. The following Medicaid-eligible persons shall be deemed to meet the resource requirements for ALTCS eligibility unless ineligible due to federal and state laws regarding trusts.

1. A person receiving Supplemental Security Income (SSI);
2. A person receiving Title IV-E Foster Care Maintenance payment; or

3. A person receiving a Title IV-E Adoption Assistance.

B. Except as provided in subsection (C), if a person's ALTCS eligibility is most closely related to SSI and is not included in subsection (A), the Administration shall determine eligibility using resource criteria in 42 U.S.C. 1382(a)(3), 42 U.S.C. 1382b, and 20 CFR 416 Subpart L.

C. The Administration permits the following exceptions to the resource criteria for a person identified in subsection (B):

1. Resources of the spouse or parent of a minor child are disregarded beginning the first day in the month the person is institutionalized.
2. The value of household goods and personal effects is excluded.
3. The value of oil, timber, and mineral rights is excluded.
4. The value of all of the following shall be disregarded:
 - a. Term insurance;
 - b. Burial insurance;
 - c. Assets that a person has irrevocably assigned to fund the expense of a burial;
 - d. The cash value of all life insurance if the face value does not exceed \$1,500 total per insured person and the policy has not been assigned to fund a pre-need burial plan or has a legally binding designation as a burial fund;
 - e. The value of any burial space held for the purpose of providing a place for the burial of the person, a spouse, or any other member of the immediate family;
 - f. \$1,500 of the equity value of an asset that has a legally binding designation as a burial fund or a revocable burial arrangement if there is no irrevocable burial arrangement;
 - g. During the time a person remains continuously eligible, all appreciation in the value of the assets in subsection (C)(4)(f) will be disregarded; and
 - h. The amount of a payment refunded by a nursing facility after ALTCS approval is only excluded for six months beginning with the month the refund was received. The Administration shall evaluate the refund in accordance with R9-28-409 if transferred without receiving something of equal value.

D. For an institutionalized spouse, a resource disregard is allowed under 42 U.S.C. 1396r-5(c).

E. Trusts are evaluated in accordance with federal and state laws to determine eligibility.

F. A person is not eligible for long-term care services if countable resources exceed the following limits:

1. For a SSI-related person identified in subsection (B), the limit is \$2,000 or \$3,000 per couple under 20 CFR 416.1205.
2. For a person eligible under 42 U.S.C. 1396a(a)(10)(A)(i)(IV), 42 U.S.C. 1396a(a)(10)(A)(i)(VI), and 42 U.S.C. 1396a(a)(10)(A)(i)(VII), there is no resource limit.

G. A person shall provide information and verification necessary to determine the countable value of resources.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1). Amended by exempt rulemaking at 7 A.A.R. 4691, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 14 A.A.R. 2090, effective July 5, 2008 (Supp. 08-2).

R9-28-408. Income Criteria for Eligibility

- A.** The following Medicaid-eligible persons shall be deemed to meet the resource requirements for ALTCS eligibility unless ineligible due to federal and state laws regarding trusts.
1. A person receiving Supplemental Security Income (SSI);
 2. A person receiving Title IV-E Foster Care Maintenance Payments; or
 3. A person receiving Title IV-E Adoption Assistance.
- B.** If a person's ALTCS eligibility is most closely related to SSI and the person is not included in subsection (A), the Administration shall count the income described in 42 U.S.C. 1382a and 20 CFR 416 Subpart K to determine eligibility with the following exceptions:
1. Income types excluded by 42 U.S.C. 1382a(b) for determining net income are also excluded in determining gross income to determine eligibility;
 2. Income of the parent or spouse of a minor child is counted as part of income under 42 CFR 435.602, except that the income of the parent or spouse is disregarded for the month the person is institutionalized;
 3. In-kind support and maintenance, under 42 U.S.C. 1382a(a)(2)(A), are excluded for both net and gross income tests;
 4. The income exceptions under A.A.C. R9-22-1503(B) apply to the net income test; and
 5. Income described in subsection (D) is excluded.
- C.** For a person whose eligibility is determined under 42 U.S.C. 1396a(a)(10)(A)(i)(IV), 42 U.S.C. 1396a(a)(10)(A)(i)(VI), or 42 U.S.C. 1396a(a)(10)(A)(i)(VII), the methodology in A.A.C. R9-22-1420 through R9-22-1426 is used to determine eligibility in accordance with 42 CFR 435.602. Income standards are then applied as described in A.A.C. R9-22-1428.
- D.** The following are income exceptions:
1. Disbursements from a trust are considered in accordance with federal and state law; and
 2. For an institutionalized spouse, a person defined in 42 U.S.C. 1396r-5(h)(1), income is calculated in accordance with 42 U.S.C. 1396r-5(b).
- E.** As a condition of eligibility for ALTCS, countable income shall be less than or equal to the following limits:
1. For a person in either the 217 or 236 coverage group specified in R9-28-402(B), 300 percent of the FBR;
 2. For a person or a couple in the SSI-related 210 coverage group specified in R9-28-402(B), 100 percent of the FBR;
 3. For a person who is under 42 U.S.C. 1396a(a)(10)(A)(i)(IV), 42 U.S.C. 1396a(a)(10)(A)(i)(VI), and 42 U.S.C. 1396a(a)(10)(A)(i)(VII) and is:
 - a. A child who is at least age six but less than age 19; 100 percent of the FPL, adjusted by household size;
 - b. A child age one through five, 133 percent of the FPL, adjusted by household size;
 - c. A child less than age one, 140 percent of the FPL, adjusted by household size; or
 - d. A pregnant woman, 150 percent of the FPL, adjusted by household size.
- F.** The Director shall determine the amount a person shall pay for the cost of ALTCS services and the post-eligibility treatment of income (share-of-cost) under A.R.S. § 36-2932(L) and 42 CFR 435.725 or 42 CFR 435.726. The Director shall consider the following in determining the share-of-cost:
1. Income types excluded by 42 U.S.C. 1382a(b) for determining net income are excluded in determining share-of-cost.
 2. SSI benefits paid under 42 U.S.C. 1382(e)(1)(E) and (G) to a person who receives care in a hospital or nursing facility are not included in calculating the share-of-cost.
 3. The share-of-cost of a person with a spouse is calculated as follows:
 - a. If an institutionalized person has a community spouse under 42 U.S.C. 1396r-5(h), share-of-cost is calculated under R9-28-410 and 42 U.S.C. 1396r-5(b) and (d); and
 - b. If an institutionalized person does not have a community spouse, share of cost is calculated solely on the income of the institutionalized person.
 4. Income assigned to a trust is considered in accordance with federal and state law.
 5. The following expenses are deducted from the share-of-cost of an eligible person to calculate the person's share-of-cost:
 - a. A personal-needs allowance equal to 15 percent of the FBR for a person residing in a medical institution for a full calendar month. A personal-needs allowance equal to 300 percent of the FBR for a person who receives or intends to receive HCBS or who resides in a medical institution for less than the full calendar month;
 - b. A spousal allowance, equal to the FBR minus the income of the spouse, if a spouse but no children remain at home;
 - c. A family allowance equal to the standard specified in Section 2 of the AFDC State Plan as it existed on July 16, 1996 for the number of family members minus the income of the family members if a spouse and children remain at home;
 - d. Expenses for the medical and remedial care services listed in subsection (6) if the expenses have not been paid or are not subject to payment by a third-party, the person still has the obligation to pay the expense, and one of the following conditions is met:
 - i. The expense represents a payment made and reported to the Administration during the application period or a payment reported to the Administration no later than the end of the month following the month in which the payment occurred and the expense has not previously been allowed a share-of-cost deduction; or
 - ii. The expense represents the unpaid balance of an allowed, noncovered medical or remedial expense, and the expense has not been previously a share-of-cost deduction;
 - e. An amount determined by the Director for the maintenance of a single person's home for not longer than six months if a physician certifies that the person is likely to return home within that period; or
 - f. An amount for Medicare and other health insurance premiums, deductibles, or coinsurance not subject to third-party reimbursement; and
 6. In the post-eligibility calculation of income;
 - a. The Administration recognizes that the following medical and remedial care services are not covered under the Title XIX State Plan, nor covered by a program contractor for a person determined to need institutional services under this Article when the medical or remedial care services are medically necessary for the person:
 - i. Nonemergency dental services for a person who is age 21 or older;

- ii. Hearing aids and hearing aid batteries for a person who is age 21 or older;
 - iii. Nonemergency eye care and prescriptive lenses for a person who is age 21 or older;
 - iv. Chiropractic services, including treatment for subluxation of the spine, demonstrated by x-ray;
 - v. Orthognathic surgery for a person who is age 21 or older; or
 - b. On a case-by-case basis, other noncovered medically necessary services that a person petitions the Administration for and the Director approves.
- G.** A person shall provide information and verification of income under A.R.S. § 36-2934(G) and 20 CFR 416.203.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1). Amended by exempt rulemaking at 7 A.A.R. 4691, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 14 A.A.R. 2090, effective July 5, 2008 (Supp. 08-2).

R9-28-409. Transfer of Assets

- A.** The provisions in this Section apply to an institutionalized person who has, or whose spouse has, transferred assets and received less than the fair market value (uncompensated value) specified in A.R.S. § 36-2934(B) and 42 U.S.C. 1396p(c)(1)(A), August 10, 1993, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.
- B.** A person shall report transfer of assets. The Administration shall evaluate all transfers occurring during or after the look-back period under 42 U.S.C. 1396p(c)(1)(B), August 10, 1993, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments. The person shall provide verification of any transfer.
- C.** Certain transfers are permitted under 42 U.S.C. 1396p(c)(2), August 10, 1993, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.
- D.** If the Administration determines a disqualification period applies due to a transfer, and the person is otherwise eligible, the person may remain eligible for ALTCS acute care services but shall be disqualified for receiving ALTCS coverage under 42 U.S.C. 1396p(c)(1)(C), August 10, 1993, which is incorporated by reference and on file with the Administration and the Secretary of State. This incorporation contains no future editions or amendments.
- E.** The period of disqualification for transfers shall be computed by dividing the cumulative uncompensated value of the transferred assets by the average cost for a private pay patient for nursing care services at the time of application.
1. For single or multiple transfers occurring in the same calendar month, the sum of all uncompensated value shall be divided by the monthly private pay rate. Disregarding fractions, the result of this calculation equals the number of months of ineligibility.
 2. For multiple transfers occurring in different calendar months, the total uncompensated value for each transfer of assets shall be determined under subsection (E)(1) but, if the periods of ineligibility overlap, the period of ineligibility shall run consecutively. Fractions are disregarded at the end of the entire period.
 3. For multiple transfers occurring in different months, the total uncompensated value for each transfer shall be

determined under subsection (E)(1), but if the periods of ineligibility do not overlap, each period of ineligibility shall be treated under subsection (E)(1).

- F.** Transfers of assets for less than fair market value are presumed to have been made to establish eligibility for ALTCS services.
- G.** Rebuttal of disqualification.
1. A person found ineligible for ALTCS services by reason of a transfer of assets for uncompensated value shall have the right to rebut the disqualification under 42 U.S.C. 1936p(c)(2)(C), August 10, 1993, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.
 2. The person shall have the burden of rebutting the presumption.
 3. If a person rebuts a transfer on the basis of debt repayment, the Administration shall determine the validity of the debt under A.R.S. § 44-101.
- H.** Undue hardship. A period of disqualification for ALTCS services due to a transfer may be waived by the Director if the person is otherwise eligible and a substantial showing is made by clear and convincing evidence that:
1. The person is unable to obtain necessary medical care without ALTCS eligibility, and
 2. Is in imminent danger of death.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1).

R9-28-410. Community Spouse

- A.** The methodology in this Section applies to an institutionalized person who has a community spouse.
- B.** If the institutionalized person's most current period of continuous institutionalization began on or after September 30, 1989, the Administration shall use the methodology for the treatment of resources under 42 U.S.C. 1396r-5(c).
1. The following resource criteria shall be used in addition to the criteria specified in R9-28-407 to be eligible:
 - a. Resources owned by a couple at the beginning of the first continuous period of institutionalization from and after September 30, 1989, shall be computed from the first day of institutionalization. The total value of resources owned by the institutionalized spouse and the community spouse, and a spousal share equal to one-half of the total value, are computed under 42 U.S.C. 1396r-5(c)(1).
 - b. The Community Spouse Resource Reduction (CSRDR) is calculated under 42 U.S.C. 1396r-5(f)(2).
 - c. The CSRDR is subtracted from the total resources of the couple to determine the amount of the couple's resources considered available to the institutionalized spouse at the time of application under 42 U.S.C. 1396r-5(c)(2).
 - i. Resources in excess of the CSRDR must be equal to or less than the standard for a person specified in R9-28-407.
 - ii. The CSRDR is allowed as a deduction for 12 consecutive months beginning with the first month in which the institutionalized spouse is eligible for ALTCS benefits. Beginning with the 13th month, the separate property of the institutionalized spouse must be within the resource standard for a person specified in R9-28-407.
 - iii. If a person who was previously eligible for ALTCS as an institutionalized person with a

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- community spouse reapplies for ALTCS after a break in institutionalization of more than 30 days, the CSRSD will be allowed as a deduction from resources for a 12-month period in addition to the period in subsection (c)(ii).
2. Resources are excluded as specified in R9-28-407, except that one vehicle is totally excluded regardless of its value, and any additional vehicles are included using equity value.
 3. The Director may grant eligibility if the Administration determines that a denial of eligibility would create an undue hardship for the institutionalized spouse.
- C.** This Section applies to the income eligibility and post-eligibility treatment of income beginning September 30, 1989, regardless of when the first period of institutionalization began.
1. Income payments are attributed to the institutionalized person and the community spouse under 42 U.S.C. 1396r-5(b)(2).
 2. Income is excluded as specified in R9-28-408.
 3. The institutionalized spouse's income eligibility is determined by combining the income of the institutionalized person and the community spouse and dividing by two. If the institutionalized person is not eligible using this method, the income eligibility shall be based on the income received in the person's name.
 4. The following allowances described in 42 U.S.C. 1396r-5(d)(1) and (2) are allowed as deductions from the institutionalized spouse's income in determining share-of-cost:
 - a. A personal-needs allowance specified in R9-28-408(f)(5)(a);
 - b. A community spouse monthly income allowance, but only to the extent that the institutionalized spouse's income is made available to or for the benefit of the community spouse;
 - c. A family allowance for each family member equal to one-third of the amount remaining after deducting the countable income of the family member from a minimum monthly-needs allowance (MMMNA);
 - d. An amount for medical or remedial services as specified in R9-28-408; and
 - e. An amount for Medicare and other health insurance premiums, deductibles, or coinsurance not subject to third-party reimbursement.
- D.** Transfers.
1. The institutionalized spouse may transfer to any of the following an amount of resources equal to the CSRSD without affecting eligibility under 42 U.S.C. 1396r-5(f). The institutionalized spouse may transfer resources to:
 - a. The community spouse; or
 - b. Someone other than the community spouse if the resources are for the sole benefit of the community spouse.
 2. The institutionalized spouse is allowed a period of 12 consecutive months, beginning with the first month of eligibility, to transfer resources in excess of the resource standard in R9-28-407(E)(2) to the persons listed in subsection (D)(1).
 3. All other transfers by the institutionalized person or transfers by the community spouse are treated under the provisions in R9-28-409.
- E.** Specific hearing rights as described under 9 A.A.C. 34 apply to a person whose eligibility is determined under this Section.
1. The institutionalized spouse or the community spouse is entitled to a fair hearing if dissatisfied with the determination of any of the following:
 - a. The community spouse monthly income allowance,
 - b. The amount of monthly income allocated to the community spouse,
 - c. The computation of the spousal share of resources,
 - d. The attribution of resources, or
 - e. The CSRSD.
 2. The hearing officer may increase the amount of the MMMNA if either the community spouse or institutionalized spouse establishes that the community spouse needs income above the established MMMNA due to exceptional circumstances.
 3. The hearing officer may increase the amount of the CSRSD to allow the community spouse to retain enough resources to generate income to meet the MMMNA. The hearing officer may allow the community spouse to retain an amount of resources necessary to purchase a single premium life annuity that would furnish monthly income sufficient to bring the community spouse's total monthly income up to the MMMNA.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1). Amended by final rulemaking at 14 A.A.R. 2090, effective July 5, 2008 (Supp. 08-2).

R9-28-411. Changes, Redeterminations, and Notices

- A.** Reporting and verifying changes.
1. A person shall report to the ALTCS eligibility office the following changes for a person, a person's spouse, or a person's dependent children under 42 CFR 435.916:
 - a. A change of address;
 - b. An admission to or discharge from a medical facility, public institution, or private institution;
 - c. A change in the household's composition;
 - d. A change in income;
 - e. A change in resources;
 - f. A determination of eligibility for other benefits;
 - g. A death;
 - h. A change in marital status;
 - i. An improvement in the person's medical condition;
 - j. A change in school attendance;
 - k. A change in Arizona state residency;
 - l. A change in citizenship or alien status;
 - m. Receipt of an SSN under R9-28-405;
 - n. A transfer of assets under R9-28-409;
 - o. A change in trust income and disbursements in accordance with state and federal law;
 - p. A change in first- or third-party liability that may be responsible for payment of all or a portion of the person's medical costs;
 - q. A change in first-party medical insurance premiums;
 - r. A change in the household expenses used to calculate the community spouse monthly income allowance described in R9-28-410;
 - s. A change in the amount of the community spouse monthly income allowance that is provided to the community spouse by the institutionalized spouse under R9-28-410; and
 - t. Any other change that may affect the person's eligibility or share-of-cost.
 2. A change shall be reported either orally or in writing and shall include:
 - a. The name of the affected person;
 - b. The change;
 - c. The date the change happened;
 - d. The name of the person reporting the change; and

- e. The person's Social Security or case number, if known, under A.R.S. § 36-2934.
- 3. A person shall provide verification of changes upon request, under A.R.S. § 36-2934, if needed to redetermine eligibility or to re-calculate post-eligibility computation of income.
- 4. A person shall report anticipated changes in advance, as soon as the future event becomes known.
- 5. A person shall report other changes events within 10 days of the date the change occurred.
- B.** Processing of changes and redeterminations. A person's eligibility shall be redetermined at least one time every 12 months and when changes occur, under 42 CFR 435.916. A person's share-of-cost, specified in R9-28-408, shall be redetermined whenever a change occurs that may affect the post-eligibility computation of income.
- C.** Actions that may result from a redetermination or change. Processing a redetermination or change shall result in one of the following findings:
 - 1. No change in eligibility or the post-eligibility computation of income;
 - 2. Discontinuance of eligibility if a condition of eligibility is no longer met;
 - 3. Suspension of eligibility if a condition of eligibility is temporarily not met;
 - 4. A change in the post-eligibility computation of income and the person's share-of-cost; or
 - 5. A change in service from ALTCS to ALTCS acute care services, or from ALTCS acute care services to ALTCS, caused by changes in a person's living arrangement, specified in R9-28-406, or a transfer of assets specified in R9-28-409.
- D.** Notices.
 - 1. Contents of notice. The Administration shall issue a notice when an action is taken regarding a person's eligibility or computation of share-of-cost. The notice shall contain the following information:
 - a. A statement of the action being taken;
 - b. The effective date of the action;
 - c. The specific reason for the intended action;
 - d. The actual figures used in the eligibility determination and specify the amount by which the person exceeds income standards if eligibility is being discontinued because either a person's resources exceed the resource limit specified in R9-28-407(E), or a person's income exceeds the income limit specified in R9-28-408(E);
 - e. The specific law or regulation that supports the action, or a change in federal or state law that requires an action;
 - f. An explanation of a person's right to request an evidentiary hearing; and
 - g. An explanation of the date by which a request for hearing must be received so that eligibility or the current share-of-cost may be continued.
 - 2. Advance notice of changes in eligibility or share-of-cost. "Advance notice" means a notice that is issued to a person at least 10 days before the effective date of change, under 42 CFR 435.919. Except as specified in subsection (D)(3), advance notice shall be issued whenever the following adverse action is taken:
 - a. To discontinue or suspend eligibility if an eligible person no longer meets a condition of eligibility, either ongoing or temporarily;
 - b. To affect post-eligibility computation of income and increase a person's share-of-cost; or
 - c. To reduce benefits from ALTCS to ALTCS acute care services due to a change from a long-term care living arrangement to an acute care living arrangement, specified in R9-28-406(B), or due to a transfer with uncompensated value, specified in R9-28-409.
- 3. Under 42 CFR 431.213, notice shall be issued to a person to discontinue eligibility or to increase the share-of-cost, no later than the effective date of action if:
 - a. A person provides a clear, written statement, signed by the person, that a person no longer desires services;
 - b. A person provides information that requires termination of eligibility or an increase in the share-of-cost and the person signs a clear written statement waiving advance notice;
 - c. A person cannot be located and mail sent to that person has been returned as undeliverable;
 - d. A person has been admitted to a public institution where the person is ineligible for ALTCS under R9-28-406; or
 - e. A person has been approved for Medicaid in another state;
 - f. The Administration has information that confirms the death of the person;
 - g. The person's primary care provider has prescribed a change in the level of medical care; or
 - h. The notice involves an adverse determination regarding the PAS, specified in A.R.S. § 36-2536.
- E.** Transitional. HCBS services may be provided to a person who is no longer at risk of institutionalization but who continues to require significant long-term care services under A.R.S. § 36-2936(D).

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1).

R9-28-412. General Enrollment

- A.** Program contractors. The Administration shall enroll each ALTCS member with:
 - 1. An elderly and physically disabled (EPD) program contractor,
 - 2. The developmentally disabled (DD) program contractor,
 - 3. A tribal program contractor, or
 - 4. The AHCCCS fee-for-service program.
- B.** Enrollment choice. An ALTCS member may choose a program contractor:
 - 1. At the time of application, or
 - 2. If the ALTCS member establishes a home outside of the GSA.
- C.** Annual enrollment. If an ALTCS member is elderly or physically disabled and lives in a GSA served by more than one program contractor, a member may change to an available program contractor during the annual enrollment choice period.
- D.** A program contractor is responsible for the enrolled ALTCS member as described in R9-28-712, County-of-Fiscal Responsibility.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Amended by final rulemaking at 14 A.A.R. 2090, effective July 5, 2008 (Supp. 08-2).

R9-28-413. Enrollment with an EPD Program Contractor

- A.** A member's enrollment with one EPD program contractor. The Administration shall enroll an ALTCS elderly or physically disabled member with the one EPD program contractor assigned to that GSA.
- B.** New member makes a choice of an EPD program contractor on or after October 1, 2000. The Administration shall provide a new member an opportunity to choose an EPD program contractor, if an ALTCS member is elderly or physically disabled, and lives in a GSA served by more than one EPD program contractor.
- C.** New member who makes no choice of an EPD program contractor on or after October 1, 2000. The Administration shall enroll an elderly or physically disabled new member that lives in a GSA with more than one EPD program contractor and who makes no choice of an EPD program contractor under the following:
 - 1. Criteria. The Administration will prioritize enrollment based on continuity of care and enroll a member with an EPD program contractor chosen under the following criteria, including but not limited to:
 - a. A member's living arrangement, and
 - b. A member's primary care practitioner.
 - 2. Algorithm. The Administration shall enroll a member through an algorithm as specified in contract, when a member has a choice of more than one EPD program contractor and the criteria in subsection (C)(1) does not apply.
- D.** A member enrolled with an EPD program contractor prior to October 1, 2000, and is enrolled in the system after October 1, 2000.
 - 1. Choice. The Administration shall request an existing member residing in a GSA with more than one EPD program contractor to choose an EPD program contractor.
 - 2. A member makes no choice. If a member makes no choice, the Administration will continue enrollment with a member's existing EPD program contractor. If that existing EPD program contractor is not awarded a bid, the member will be enrolled with an EPD program contractor as specified in Section (C).

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1).

R9-28-414. Enrollment with the DD Program Contractor

- A.** A member's DD program contractor. The Administration shall enroll a member with the DES Division of Developmental Disabilities as specified in A.R.S. § 36-2940, if the ALTCS member is eligible for services for the developmentally disabled services.
- B.** Indian on and off reservation. The Administration shall enroll an Indian ALTCS member who is developmentally disabled, with the DES Division of Developmental Disabilities. This enrollment shall be made whether the member is considered to be residing on or off reservation.

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1).

R9-28-415. Enrollment with a Tribal Program Contractor

- A.** On-reservation. Notwithstanding R9-28-412, the Administration shall enroll a Native American ALTCS member who is elderly or physically disabled with the ALTCS tribal program contractor as specified in A.R.S. § 36-2932 if the person:
 - 1. Lives on-reservation of a tribe participating as an ALTCS tribal program contractor, or

- 2. Lived on-reservation of a tribe participating as an ALTCS tribal program contractor immediately prior to placement in an off-reservation NF or alternative HCBS setting.
- B.** Off-reservation. The Administration shall enroll a Native American ALTCS member who is elderly or physically disabled with an EPD program contractor under R9-28-413, if the member lives off-reservation, and does not have on-reservation status as specified in subsection (A)(2).

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Amended by final rulemaking at 14 A.A.R. 2090, effective July 5, 2008 (Supp. 08-2).

R9-28-416. Enrollment with the FFS Program

- A.** No tribal or EPD program contractor in GSA. The Administration shall enroll an ALTCS elderly or physically disabled member who resides in an area with no ALTCS tribal program contractor or EPD program contractor in the AHCCCS FFS program under A.R.S. § 36-2945.
- B.** Prior period coverage. The Administration shall enroll a member in AHCCCS fee-for-service program if a member is eligible for ALTCS services only during prior period coverage.

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Amended by exempt rulemaking at 7 A.A.R. 4691, effective October 1, 2001 (Supp. 01-3).

R9-28-417. Notification Requirements

- A.** Administration responsibilities. The Administration shall notify a member's program contractor when a member is enrolled or disenrolled from the ALTCS program. The Administration shall include the following in the notification:
 - 1. The member's name,
 - 2. The member's identification number,
 - 3. The member's effective date of enrollment or disenrollment, and
 - 4. The member's share-of-cost on a monthly enrollment roster.
- B.** Program contractor's responsibilities. The program contractor shall notify the Administration if an ALTCS member has any change that may affect eligibility including but not limited to:
 - 1. A change in residential address,
 - 2. A change in medical or functional condition,
 - 3. A change in living arrangement including:
 - a. Alternative HCBS setting,
 - b. Home,
 - c. Nursing facility, or
 - d. Other living arrangement not specified in this subsection,
 - 4. Change in resource or income, or
 - 5. Death.

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1).

R9-28-418. Disenrollment

The Administration shall disenroll an ALTCS member on the last day of the month following receipt of appropriate notification under R9-28-411 except:

- 1. The Administration shall disenroll an ALTCS member who dies. A member's last day of enrollment shall be the date of death.
- 2. The Administration may disenroll a member immediately if requested.

3. If ALTCS benefits have been continued pending an eligibility appeal decision and the discontinuance is upheld as specified in 9 A.A.C. 34, the Administration shall disenroll a member effective on the date of the hearing decision.

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Amended by final rulemaking at 14 A.A.R. 2090, effective July 5, 2008 (Supp. 08-2).

ARTICLE 5. PROGRAM CONTRACTOR AND PROVIDER STANDARDS

R9-28-501. Program Contractor and Provider Standards – Related Definitions

Definitions. The following words and phrases, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, and 9 A.A.C. 22, Article 1, have the following meanings unless the context of the Chapter explicitly requires another meaning:

“Certification” means a voluntary process by which a federal or state regulatory entity grants recognition to a person, facility, or organization that has met certain qualifications specified by the regulatory entity, allowing the person, facility, or organization to use the word “certified” in a title or designation.

“Therapeutic leave” means that a member leaves an institutional facility for a period that does not exceed nine days per contract year.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). New Section made by final rulemaking at 11 A.A.R. 4286, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4406, effective January 3, 2009 (Supp. 08-4).

R9-28-501.01. Pre-Existing Conditions

A program contractor shall comply with the pre-existing condition requirements in A.A.C. R9-22-502.

Historical Note

New Section made by final rulemaking at 14 A.A.R. 4406, effective January 3, 2009 (Supp. 08-4).

R9-28-502. Long-term Care Provider Requirements

- A. A provider shall obtain any necessary authorization from the program contractor or the Administration for services provided to a member.
- B. A provider shall maintain and make available to a program contractor and to the Administration, financial, and medical records for not less than five years from the date of final payment, or for records relating to costs and expenses to which the Administration has taken exception, five years after the date of final disposition or resolution of the exception. The provider shall maintain records that meet uniform accounting standards and generally accepted practices for maintenance of medical records, including detailed specification of all patient services delivered, the rationale for delivery, and the service date.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended subsection (E) effective June 6, 1989 (Supp. 89-2). Amended effective December

8, 1997 (Supp. 97-4). Amended by final rulemaking at 11 A.A.R. 4286, effective December 5, 2005 (Supp. 05-4).

R9-28-503. Licensure and Certification for Long-term Care Institutional Facilities

- A. A nursing facility shall not provide services to a member unless the facility is licensed by Arizona Department of Health Services, Medicare- and Medicaid-certified, and meets the requirements in 42 CFR 442, as of October 1, 2004, and 42 CFR 483, as of October 1, 2004, incorporated by reference, on file with the Administration, and available from the U.S. Government Printing Office, 732 N. Capitol St., N.W., Washington, D.C. 20401. This incorporation by reference contains no future editions or amendments.
- B. An ICF-MR shall not provide services to a member unless the ICF-MR is Medicaid-certified and meets the requirements in A.R.S. § 36-2939(B)(1) and 42 CFR 442, Subpart C, as of October 1, 2004, and 42 CFR 483, as of October 1, 2004, incorporated by reference, on file with the Administration and available from the U.S. Government Printing Office, 732 N. Capitol St., N.W., Washington, D.C. 20401. This incorporation by reference contains no future editions or amendments.
- C. A nursing facility or ICF-MR that provides services to a member shall register as a provider with the Administration to receive reimbursement. The Administration shall not register a provider unless the provider meets the licensure and certification requirements of subsection (A) or (B).

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Amended effective November 5, 1993 (Supp. 93-4). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 11 A.A.R. 4286, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4406, effective January 3, 2009 (Supp. 08-4).

R9-28-504. Standards of Participation, Licensure, and Certification for HCBS Providers

- A. A noninstitutional long-term care provider shall not register with the Administration unless the provider meets the requirements of the Arizona Department of Health Services’ rules for licensure, if applicable.
- B. Additional qualifications to provide services to a member:
 1. A community residential setting and a group home for a person with developmental disabilities shall be licensed by the appropriate regulatory agency of the state as described in A.A.C. R9-33-107 and A.A.C. R6-6-714;
 2. An adult foster care home shall be certified or licensed under 9 A.A.C. 10;
 3. A home health agency shall be Medicare-certified and licensed under 9 A.A.C. 10;
 4. A person providing a homemaker service shall meet the requirements specified in the contract between the person and the Administration;
 5. A person providing a personal care service shall meet the requirements specified in the contract between the person and the Administration;
 6. An adult day health care provider shall be licensed under 9 A.A.C. 10;
 7. A therapy provider shall meet the following requirements:
 - a. A physical therapy provider shall meet the requirements in 4 A.A.C. 24;
 - b. A speech therapist provider shall meet the applicable requirements under 9 A.A.C. 16, Article 2.

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- c. An occupational therapy provider shall meet the requirements in 4 A.A.C. 43; and
- d. A respiratory therapy provider shall meet the requirements in 4 A.A.C. 45;
- 8. A respite provider shall meet the requirements specified in contract;
- 9. A hospice provider shall be Medicare-certified and licensed under 9 A.A.C. 10;
- 10. A provider of home-delivered meal service shall comply with the requirements in 9 A.A.C. 8;
- 11. A provider of non-emergency transportation shall be licensed by the Arizona Department of Transportation, Motor Vehicle Division;
- 12. A provider of emergency transportation shall meet the licensure requirements in 9 A.A.C. 13;
- 13. A day care provider for the developmentally disabled under A.R.S. § 36-2939 shall meet the licensure requirements in 6 A.A.C. 6;
- 14. A habilitation provider shall meet the requirements in A.A.C. R6-6-1523 or the therapy requirements in this Section;
- 15. A service provider, other than a provider specified in subsections (B)(1) through (B)(14), approved by the Director shall meet the requirements specified in a program contractor's contract with the Administration;
- 16. A behavioral health provider shall have all applicable state licenses or certifications and meet the service specifications in A.A.C. R9-22-1205; and
- 17. An assisted living home or a residential unit shall meet the requirements as defined in A.R.S. § 36-401 and as authorized in A.R.S. § 36-2939.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Amended effective July 13, 1992 (Supp. 92-3). Amended effective November 5, 1993 (Supp. 93-4). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 5 A.A.R. 874, effective March 4, 1999 (Supp. 99-1). Amended by final rulemaking at 11 A.A.R. 4286, effective December 5, 2005 (Supp. 05-4).

R9-28-505. Standards, Licensure, and Certification for Providers of Hospital and Medical Services

A provider shall not provide hospital services to a member unless the hospital is licensed by the Arizona Department of Health Services, and meets the requirements in 42 CFR 441 and 482, as of October 1, 2004, and 42 CFR 456, Subpart C, as of October 1, 2004, incorporated by reference, on file with the Administration and available from the U.S. Government Printing Office, 732 N. Capitol St., N.W., Washington, D.C. 20401. This incorporation contains no future editions or amendments. An Indian Health Service (IHS) hospital and a Veterans Administration hospital shall not provide services to a member unless accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 11 A.A.R. 4286, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4406, effective January 3, 2009 (Supp. 08-4).

R9-28-506. Requirements for Spouse as Paid Caregiver

A. For purposes of this Section, the following definitions apply:

- 1. "Extraordinary care" means care that exceeds the range of activities that a spouse would ordinarily perform in the household on behalf of the ALTCS member if the member did not have a disability or chronic illness, and that is necessary to ensure the health and welfare of the member and avoid institutionalization.
- 2. "Personal care or similar services" means assistance provided to an ALTCS member with a disability or chronic illness to enable the member to perform Activities of Daily Living (ADL) or Instrumental Activities of Daily Living (IADL) that the member would normally perform for himself or herself if the member did not have a disability or chronic illness. Assistance may involve performing a personal care task for the member or cuing the member so that the member performs the task for himself or herself.
- B. As authorized by the Section 1115 Waiver, a member may choose to have personal care or similar services provided by the member's spouse as a paid caregiver if the following conditions and limitations are met:
 - 1. The member resides in his or her own home;
 - 2. The Administration or a Program Contractor offers the member the choice of a provider of personal care or similar services other than the member's spouse;
 - 3. The personal care or similar services is described in the member's plan of care prepared by the member's case manager;
 - 4. The case manager records at least annually in the member's plan of care the member's choice to have personal care or similar services provided by the member's spouse as a paid caregiver;
 - 5. The personal care or similar services provided by the spouse are extraordinary care;
 - 6. The spouse is one of the following:
 - a. Employed by a provider that subcontracts with the member's Program Contractor;
 - b. If the member is developmentally disabled, the spouse is either employed by a provider that subcontracts with the member's Program Contractor, or registered with AHCCCS as an independent provider; or
 - c. If the member is a Native American enrolled in FFS, the spouse is either employed by an AHCCCS registered provider or registered with AHCCCS as an independent provider;
 - 7. The spouse meets the training and other qualifications that apply to other providers of personal care or similar services registered with AHCCCS;
 - 8. The Program Contractor does not pay a spouse providing personal care or similar services at a rate that exceeds the rate that would be paid to a provider of personal care or similar services who is not a spouse and the Administration does not pay a spouse providing personal care or similar services at a rate that exceeds the capped fee-for-service payment for personal care or similar services; and
 - 9. A spouse providing personal care or similar services as a paid caregiver is not paid for more than 40 hours of services in a seven-day period.
- C. For a member who elects to have the member's spouse provide personal care or similar services as a paid caregiver, personal care or similar services in excess of 40 hours in a seven-day period are not covered. If a spouse elects to provide less than the hours authorized by the Administration or Program Contractor, the remaining hours of medically necessary personal care or similar services may be provided by another personal caregiver, but the total hours of care provided by the spouse

and any other personal caregiver shall not exceed 40 hours in a seven-day period.

- D. By electing to have the member's spouse provide personal care and similar services as a paid caregiver, the member is not precluded from receiving medically necessary, cost effective home and community based services other than personal care or similar services.

Historical Note

New Section made by final rulemaking at 13 A.A.R. 3587, effective October 2, 2007 (Supp. 07-4).

R9-28-507. Program Contractor General Requirements

- A. To participate in the ALTCS program, through a program contractor or directly through the Administration, a provider of ALTCS-covered services shall be registered with the Administration.
- B. An ALTCS program contractor shall ensure that providers of service meet the requirements of this Article.
- C. Each ALTCS program contractor shall maintain member service records for five years, that include, at a minimum, a case management plan, medical records, encounter data, grievances, complaints, and service information for each ALTCS member.
- D. An ALTCS program contractor shall produce and distribute informational materials that are approved by the Administration to each enrolled ALTCS member or designated representative within 12 business days after the program contractor receives notification of enrollment from the Administration. The program contractor shall ensure that the informational materials include:
 1. A description of all covered services as specified in contract;
 2. An explanation of service limitations and exclusions;
 3. An explanation of the procedure for obtaining services, including a notice stating that the program contractor is liable only for those services authorized by an ALTCS member's case manager;
 4. An explanation of the procedure for obtaining emergency services;
 5. An explanation of the procedure for filing a grievance and appeal; and
 6. An explanation of when plan changes may occur as specified in contract.
- E. A subcontractor shall collect the member's share of cost and report to the program contractor the amount collected as specified in the subcontractor contract. The program contractor shall report the share of cost collected to the Administration.
- F. An ALTCS program contractor shall monitor a trust fund account for an institutionalized ALTCS member to verify that expenditures from the member's trust fund account are in compliance with federal regulations 42 U.S.C. 1396p(d)(4) and A.R.S. § 36-2934.01.
- G. A program contractor shall ensure that an institutionalized ALTCS member transferred to an acute care facility to receive services is, whenever possible, returned to the original institution upon completion of acute care.
- H. A program contractor shall ensure that an institutionalized ALTCS member granted therapeutic leave is, whenever medically appropriate, returned to the same bed in the original institution upon completion of the therapeutic leave.
- I. A program contractor shall ensure that services are paid under A.A.C. R9-22-705.
- J. A program contractor shall comply with the marketing provisions in A.A.C. R9-22-504.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Amended by final rulemaking at 11 A.A.R. 4286, effective December 5, 2005 (Supp. 05-4).

R9-28-508. Self-directed Attendant Care (SDAC)

- A. For purposes of this Article the following terms are defined:
 - "Competent member" means a person who is oriented, exhibits evidence of logical thought, and can provide directions.
 - "Fiscal and Employer Agent" or "FEA" is a company specified by the program contractor or the Administration in contract to serve as an employment/payroll processing center for attendant care workers employed by the member to provide SDAC services.
 - "Medically stable" means the member's skilled-care medical needs are routine and not subject to frequent change because of health issues.
 - "Personal care" means activities of daily life such as dressing, bathing, eating and mobility.
- B. In lieu of receiving other attendant care services a competent member who meets the requirements of A.R.S. § 36-2951 or the member's legal guardian may choose to employ through the FEA a person to provide Self-directed Attendant Care (SDAC) services. A paid caregiver described under R9-28-506 and a parent of a minor child shall not receive reimbursement for SDAC services.
- C. The attendant care worker chosen to provide SDAC services does not need to be a registered provider. The attendant care worker shall have, at a minimum, hands-on training in First Aid, CPR, Universal Precautions, and state and federal laws regarding privacy of health information or training of similar efficacy as approved by the Administration.
- D. The Administration or Program Contractor shall cover SDAC services only if the member resides in the member's home, and shall not cover SDAC services if the member is institutionalized or residing in an alternative residential setting. If the member has a legal guardian, the legal guardian shall be present when SDAC services are provided.
- E. A member who chooses to receive SDAC services is not precluded from receiving medically necessary, cost-effective home health services from other agencies or providers if the services provided are not duplicative of the specific attendant care or skilled service already received through the program contractor.
- F. A competent member or legal guardian may employ an SDAC attendant care worker to provide personal care, homemaker and general supervision services.
- G. A competent member, who is medically stable, or the member's legal guardian may employ an attendant care worker to also provide the following skilled services:
 1. Bowel care, including suppositories, enemas, manual evacuation, and digital stimulation;
 2. Bladder catheterizations (non-indwelling) that do not require a sterile procedure;
 3. Wound care (non-sterile);
 4. Glucose monitoring;
 5. Glucagon as directed by the health care provider;
 6. Insulin by subcutaneous injection only if the member is not able to self-inject;
 7. Permanent gastrostomy tube feeding; and

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8. Additional services requested in writing with the approval of the Director and the Arizona State Board of Nursing.

H. The Administration or program contractor shall not cover services under subsection (G) unless:

1. For each SDAC attendant care worker employed by a member or legal guardian, a registered nurse licensed under A.R.S. Title 32, Chapter 15 visits the member and SDAC attendant care worker before a skilled service is provided. The registered nurse will assess, educate, and train the member and SDAC attendant care worker regarding the specific skilled service that the member requires; and
2. The registered nurse determines in writing that the attendant care worker understands how and demonstrates the skill to perform the processes or procedures required to provide the specific skilled service.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective April 25, 1990 (Supp. 90-2). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). New Section made by final rulemaking at 16 A.A.R. 2386, effective January 16, 2011 (Supp. 10-4). Amended by final rulemaking at 18 A.A.R. 2344, effective November 11, 2012 (Supp. 12-3).

R9-28-509. Agency with Choice

A. Definitions. The following words and phrases, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, and 9 A.A.C. 22, Article 1, have the following meanings specific to this Section:

“Agency” means a provider of home and community based services, other than an individual, that has a co-employment relationship with one or more members for purposes of this Section.

“Co-employment relationship” means a situation where the Agency serves as the legal employer of record and the ALTCS member or authorized representative assumes certain responsibilities related to directing and or managing care.

“Individual’s representative” means a parent, family member, guardian, advocate, or other person authorized by the member to serve as a representative in connection with the provision of services and supports. This authorization should be in writing, when feasible, or by another method that clearly indicates the individual’s free choice. An individual’s representative may not also be a paid caregiver of an individual receiving services and supports.

“Standardized training” means minimum training standards required of all paid caregivers by the Administration as specified in contract.

B. Purpose. The Agency with Choice program is an ALTCS member directed service model for the provision of home and community based services. Under this model, the ALTCS member or individual’s representative and the agency enter into a co-employment relationship.

C. In lieu of receiving HCBS services under a traditional service model, a member or the member’s individual’s representative may choose to participate in the Agency with Choice service model. Under the Agency with Choice service model, the

agency shall maintain the authority to hire and fire paid caregivers and provide standardized training to the caregiver, and the member or individual representative may elect to recruit, select, dismiss, determine duties, schedule, specify training to meet the unique needs of the member, and supervise the paid caregivers on a day-to-day basis.

D. Setting. This program is applicable to ALTCS members who reside in their own home.

E. A member who chooses to receive services under the Agency with Choice service model is not precluded from receiving medically necessary, cost-effective services and supports from other agencies or providers if the services provided are not duplicative of the specific attendant care or skilled service already received through the contractor.

Historical Note

Section made by final rulemaking at 18 A.A.R. 3380, effective January 1, 2013 (Supp. 12-4).

R9-28-510. Case Management

A. A program contractor shall assign to each member a case manager to identify, plan, coordinate, monitor, and reassess the need for and provision of long-term care services.

B. A case manager shall:

1. Ensure that appropriate ALTCS placement and services are provided for a member within 30 days of enrollment;
2. Develop a service plan by:
 - a. Completing a case management plan when a member is enrolled in ALTCS and authorizing services for a member who continues to be financially and medically eligible for services;
 - b. Ensuring that a member participates in the preparation of the member’s case management plan;
 - c. Specifying the paid and natural support services to be received by the member, including the duration, scope of services, units of service, frequency of service delivery, provider of services, and effective time period; and
 - d. Coordinating with the primary care provider in determining the necessary services for the member, including hospital and medical services;
3. Submit a written justification to the case manager’s supervisor to include HCBS in the case management plan if the services exceed 80 percent of the institutional cost;
4. Manage a case management plan by:
 - a. Re-evaluating and revising the case management plan when the member transfers to another facility, transfers to a hospital, has a change in level of care; and
 - b. Monitoring receipt of services by a member;
5. Assist the member to maintain or progress toward the highest level of functioning;
6. Ensure that records are transferred when the member is transferred from a facility or provider to a new facility or provider;
7. Perform additional monitoring of a member with rehabilitation potential and whose condition is fragile or unstable, whose case management plan is marginally cost effective, or whose use of medical and hospital services is unusual;
8. Arrange behavioral health services, if necessary. The case manager shall have initial and quarterly consultation and collaboration with a behavioral health professional to review the treatment plan, unless the case manager meets the definition of a behavioral health professional under A.A.C. R9-20-101.

- C. A program contractor shall submit a service plan and other information related to the case management plan upon request to the Administration.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Amended effective July 13, 1992 (Supp. 92-3). Amended effective November 5, 1993 (Supp. 93-4). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 11 A.A.R. 4286, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 18 A.A.R. 3380, effective January 1, 2013 (Supp. 12-4).

R9-28-511. Quality Management/Utilization Management (QM/UM) Requirements

A program contractor shall:

1. Comply with all requirements specified in A.A.C. R9-22-522; and
2. Submit a quarterly utilization control report within time lines specified in contract, and meet the requirements in 42 CFR 456 Subparts C, D, and F, October 1, 2004, incorporated by reference in R9-28-505.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Amended under an exemption from the provisions of the Administrative Procedure Act effective March 1, 1993 (Supp. 93-1). Amended effective November 5, 1993 (Supp. 93-4). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 5 A.A.R. 874, effective March 4, 1999 (Supp. 99-1). Amended by final rulemaking at 11 A.A.R. 4286, effective December 5, 2005 (Supp. 05-4).

R9-28-512. Expired

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective December 8, 1997 (Supp. 97-4). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 4851, effective October 9, 2002 (Supp. 02-4).

R9-28-513. Program Compliance Audits

The Administration shall meet the requirements specified under A.A.C. R9-22-521 for a program contractor.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 11 A.A.R. 4286, effective December 5, 2005 (Supp. 05-4).

R9-28-514. Release of Safeguarded Information by the Administration and Contractors

The Administration, program contractors, providers, and noncontracting providers shall meet the requirements specified under A.A.C. R9-22-512 for an ALTCS applicant, or member.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 11 A.A.R. 4286, effective December 5, 2005 (Supp. 05-4).

R9-28-515. Repealed

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Section repealed by final rulemaking at 11 A.A.R. 4286, effective December 5, 2005 (Supp. 05-4).

ARTICLE 6. RFP AND CONTRACT PROCESS

Article 6, consisting of Sections R9-28-601 through R9-28-610, repealed; new Article 6, consisting of Sections R9-28-601 through R9-28-608, adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1).

R9-28-601. General Provisions

- A. The Director has full operational authority to adopt rules for the RFP process and the award of contract under A.R.S. § 36-2944.
- B. The Administration shall follow the provisions under 9 A.A.C. 22, Article 6 for members, subject to limitations and exclusions under that Article, unless otherwise specified in this Chapter.
- C. The Administration shall award contracts under A.R.S. § 36-2932 to provide services under A.R.S. § 36-2939.
- D. The Administration is exempt from the procurement code under A.R.S. § 41-2501.
- E. The Administration and contractors shall retain all records relating to contract compliance for five years under A.R.S. § 36-2932 and dispose of the records under A.R.S. § 41-2550.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective August 11, 1997 (Supp. 97-3). Amended by final rulemaking at 5 A.A.R. 874, effective March 4, 1999 (Supp. 99-1). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Amended by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1).

R9-28-602. RFP

The ALTCS RFP for a program contractor serving members who are EPD shall meet the requirements of A.R.S. §§ 36-2944, A.R.S. § 36-2939, A.A.C. R9-22-602, and Articles 2 and 11 of this Chapter.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Amended effective August 11, 1997 (Supp. 97-3). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Amended by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1).

R9-28-603. Contract Award

The Administration shall award a contract under A.R.S. § 36-2944 and A.A.C. R9-22-603.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective August 11, 1997 (Supp. 97-3). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1).

R9-28-604. Contract or Proposal Protests; Appeals

Contract or proposal protests or appeals shall be under A.A.C. R9-22-604 and 9 A.A.C. 34.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective August 11, 1997 (Supp. 97-3). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 18 A.A.R. 2502, effective November 13, 2012 (Supp. 12-3).

R9-28-605. Waiver of Contractor's Subcontract with Hospitals

A contractor's subcontract with hospitals may be waived under A.A.C. R9-22-605.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective August 11, 1997 (Supp. 97-3). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1).

R9-28-606. Contract Compliance Sanction

- A. The Administration shall follow sanction provisions under A.A.C. R9-22-606.
- B. The Administration shall apply remedies found in 42 CFR 488, Subpart F, effective January 1, 2012, incorporated by reference and on file with the Administration and the Office of the Secretary of State, for a nursing facility that does not meet requirements of participation under 42 U.S.C. 1396r. This incorporation by reference contains no future editions or amendments.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective August 11, 1997 (Supp. 97-3). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 18 A.A.R. 2502, effective November 13, 2012 (Supp. 12-3).

R9-28-607. Repealed**Historical Note**

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective November 5, 1993 (Supp. 93-4). Amended effective August 11, 1997 (Supp. 97-3). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Section repealed by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1).

R9-28-608. Repealed**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Section repealed by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1).

R9-28-609. Repealed**Historical Note**

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Section repealed by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1).

R9-28-610. Repealed**Historical Note**

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended under an exemption from the provisions of the Administrative Procedure Act effective March 1, 1993 (Supp. 93-1). Section repealed by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1).

ARTICLE 7. STANDARDS FOR PAYMENTS**R9-28-701. Standards for Payment Related Definitions**

Definitions. In this Article, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, and 9 A.A.C. 22, Article 1, the following phrase has the following meaning unless the context of the Article explicitly requires another meaning:

"County of fiscal responsibility" means the county that is financially responsible for the state's share of ALTCS funding.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1). Section repealed; new Section made by final rulemaking at 11 A.A.R. 3165, effective October 1, 2005 (Supp. 05-3).

R9-28-701.10. General Requirements

The following Sections of A.A.C. Chapter 22, Articles 2 and 7, are applicable to reimbursement for services provided under the ALTCS program, except that the term "program contractor" shall be substituted for "contractor."

1. Scope of the Administration's and Contractor's Liability, R9-22-701.10;
2. Charges to Members, R9-22-702;
3. Payments by the Administration or by a program contractor, R9-22-703 and R9-22-705;
4. Contractor's Liability to Hospitals for the Provision of Emergency and Post-stabilization Care, R9-22-709;
5. Payment for Non-hospital services, R9-22-710;
6. Specialty Contracts, R9-22-712(G)(3), R9-22-712.01 (10) and Article 2;
7. Payments by the Administration for Hospital Services Provided to an Eligible Person, R9-22-712; R9-22-712.01 and R9-22-712.10;
8. Overpayment and Recovery of Indebtedness, R9-22-713;
9. Payments to Providers, R9-22-714;
10. Hospital Rate Negotiations, R9-22-715; and
11. Reinsurance, R9-22-720.

Historical Note

New Section made by final rulemaking at 13 A.A.R. 458, effective April 7, 2007 (Supp. 07-1).

R9-28-702. Repealed**Historical Note**

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 3340, effective July 15, 2002 (Supp. 02-3). Amended by final rulemaking at 11 A.A.R. 3244, effective October 1, 2005 (Supp. 05-3). Section repealed by

final rulemaking at 13 A.A.R. 458, effective April 7, 2007 (Supp. 07-1).

R9-28-703. Repealed

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective November 5, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 3340, effective July 15, 2002 (Supp. 02-3). Section repealed by final rulemaking at 13 A.A.R. 458, effective April 7, 2007 (Supp. 07-1).

R9-28-704. Repealed

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 3340, effective July 15, 2002 (Supp. 02-3). Section repealed by final rulemaking at 13 A.A.R. 458, effective April 7, 2007 (Supp. 07-1).

R9-28-705. Repealed

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective April 25, 1990 (Supp. 90-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective November 5, 1993 (Supp. 93-4). Amended by final rulemaking at 5 A.A.R. 874, effective March 4, 1999 (Supp. 99-1). Amended by final rulemaking at 11 A.A.R. 3165, effective October 1, 2005 (Supp. 05-3). Section repealed by final rulemaking at 13 A.A.R. 458, effective April 7, 2007 (Supp. 07-1).

R9-28-706. Repealed

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended subsections (A) and (B) effective June 6, 1989 (Supp. 89-2). Amended effective April 25, 1990 (Supp. 90-2). Amended effective November 5, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 10 A.A.R. 4658, effective January 1, 2005 (Supp. 04-4). Amended by final rulemaking at 11 A.A.R. 3852, effective November 12, 2005 (Supp. 05-3). Section repealed by final rulemaking at 13 A.A.R. 458, effective April 7, 2007 (Supp. 07-1).

R9-28-707. Repealed

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1). Section repealed by final rulemaking at 13 A.A.R. 458, effective April 7, 2007 (Supp. 07-1).

Editor's Note: *The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that the amendment was not reviewed by the Governor's Regulatory Review Council; the agency did not submit a notice of proposed rulemaking for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rulemaking; and the Attorney General has not certified the rule. This Section was subsequently amended through the regular rulemaking process.*

Arizona Administrative Register; the agency was not required to hold public hearings on the rulemaking; and the Attorney General has not certified the rule. This Section was subsequently amended through the regular rulemaking process.

R9-28-708. Repealed

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective April 26, 1989 (Supp. 89-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective November 5, 1993 (Supp. 93-4). Amended by final rulemaking at 11 A.A.R. 3852, effective November 12, 2005 (Supp. 05-3). Section repealed by final rulemaking at 13 A.A.R. 458, effective April 7, 2007 (Supp. 07-1).

R9-28-709. Repealed

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended subsection (B) effective June 6, 1989 (Supp. 89-2). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 3340, effective July 15, 2002 (Supp. 02-3). Section repealed by final rulemaking at 13 A.A.R. 458, effective April 7, 2007 (Supp. 07-1).

R9-28-710. Repealed

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended subsections (C) and (D) effective June 6, 1989 (Supp. 89-2). Amended effective September 22, 1997 (Supp. 97-3). Section repealed by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1).

R9-28-711. Repealed

Historical Note

Adopted effective November 5, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 3340, effective July 15, 2002 (Supp. 02-3). Amended by final rulemaking at 11 A.A.R. 3165, effective October 1, 2005 (Supp. 05-3). Section repealed by final rulemaking at 13 A.A.R. 458, effective April 7, 2007 (Supp. 07-1).

R9-28-712. County of Fiscal Responsibility

A. General requirements.

1. The Administration shall determine the county of fiscal responsibility under A.R.S. § 36-2913 for an applicant or member who is elderly or physically disabled.
2. A program contractor shall cover services and provisions specified in 9 A.A.C. 22, Articles 2 and 7 and Article 11 of this Chapter.

B. Criteria for determining county of fiscal responsibility for an applicant.

1. If the applicant resides in the applicant's own home, the county of fiscal responsibility is the county where the applicant currently resides.
2. This applies only if subsection (B)(3) does not apply. If the applicant is residing in a NF or alternative HCBS setting, the county of fiscal responsibility is the county in which the applicant last resided in the applicant's own home.
3. If the applicant moves from another state directly into a NF or alternative HCBS setting in this state, the county of

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fiscal responsibility is the county in which the person currently resides.

4. If the applicant moves from the Arizona State Hospital (ASH) into a NF or alternative HCBS setting, or is an inmate of a public institution moving from the public institution into a NF or alternative HCBS setting, the county of fiscal responsibility is the county in which the applicant resided in the applicant's own home prior to admission to ASH or the public institution.
- C. Criteria for determining if there is a change in county of fiscal responsibility for a member moving from one county to another county.
 1. No change in the county of fiscal responsibility. There is no change in the county of fiscal responsibility for a member if:
 - a. The member moves from a NF to another NF in a different county,
 - b. The member moves from a NF to an alternative HCBS setting in a different county,
 - c. The member moves from an alternative HCBS setting to another alternative HCBS setting in a different county,
 - d. The member moves from an alternative HCBS setting to a NF in a different county,
 - e. The member moves from the member's own home to an alternative HCBS setting in a different county,
 - f. The member moves from the member's own home to a NF in a different county,
 - g. The member moves from a NF or alternative HCBS setting into ASH, or
 - h. The member moves from ASH to a NF or alternative HCBS setting.
 2. Change in the county of fiscal responsibility. If a member moves from one county to another, the county of fiscal responsibility changes to the new county if the member moves from:
 - a. An alternative HCBS setting to the member's own home in a different county,
 - b. A NF to the member's own home in a different county,
 - c. The member's own home to the member's own home in a different county, or
 - d. ASH to the member's own home.
 3. Transfers between program contractors. The county of fiscal responsibility changes if the Administration transfers a member from one program contractor to a different program contractor and if:
 - a. Both program contractors agree, or
 - b. The Administration determines that it is in the best interest of the member.

Historical Note

Adopted effective November 4, 1998 (Supp. 98-4).
Amended by final rulemaking at 8 A.A.R. 3340, effective July 15, 2002 (Supp. 02-3).

R9-28-713. Repealed**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Amended by final rulemaking at 11 A.A.R. 3165, effective October 1, 2005 (Supp. 05-3). Section repealed by final rulemaking at 13 A.A.R. 458, effective April 7, 2007 (Supp. 07-1).

R9-28-714. Repealed**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1). Section repealed by final rulemaking at 13 A.A.R. 458, effective April 7, 2007 (Supp. 07-1).

R9-28-715. Repealed**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1). Section repealed by final rulemaking at 13 A.A.R. 458, effective April 7, 2007 (Supp. 07-1).

ARTICLE 8. TEFRA LIENS AND RECOVERIES**R9-28-801. Definitions Related to TEFRA Liens**

In addition to the definitions in A.R.S. §§ 36-2901 and 36-2931, 9 A.A.C. 22, Article 1, and 9 A.A.C. 28, Article 1, the following definitions apply to this Article:

"Consecutive days" means days following one after the other without an interruption resulting from a discharge.

"File" means the date that AHCCCS receives a request for a State Fair Hearing under R9-28-805, as established by a date stamp on the request or other record of receipt.

"Home" means property in which a member has an ownership interest and that serves as the member's principal place of residence. This property includes the shelter in which a member resides, the land on which the shelter is located, and related outbuildings.

"Recover" means that AHCCCS takes action to collect from a claim.

"TEFRA lien" means a lien under 42 U.S.C. 1396p of the Tax Equity and Fiscal Responsibility Act of 1982.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective November 5, 1993 (Supp. 93-4). Section repealed; new Section adopted effective August 11, 1997 (Supp. 97-3). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 3365, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 820, effective April 3, 2004 (Supp. 04-1). New Section made by final rulemaking at 14 A.A.R. 3791, effective November 8, 2008 (Supp. 08-3).

R9-28-801.01. TEFRA Liens – General

Purpose. The purpose of TEFRA is to allow AHCCCS to file a lien on an AHCCCS member's interest in any real property before the member is deceased, including but not limited to life estates and beneficiary deeds.

Historical Note

New Section made by final rulemaking at 14 A.A.R. 3791, effective November 8, 2008 (Supp. 08-3).

R9-28-802. TEFRA Liens – Affected Members

- A. Except for members under R9-28-803, AHCCCS shall file a TEFRA lien against the real property of all members who are:
 1. Receiving ALTCS services,
 2. 55 years of age or older, and
 3. Permanently institutionalized.
- B. A rebuttable presumption exists that a member is permanently institutionalized if the member has continually resided in a nursing facility, ICF/MR, or other medical institution defined

in 42 CFR 435.1010 for 90 or more consecutive days. A member may rebut the presumption by providing a written opinion from a treating physician, rendered to a reasonable degree of medical certainty, that the member's condition is likely to improve to the point that the member will be discharged from the medical institution and will be capable of returning home by a date certain.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective November 5, 1993 (Supp. 93-4). Section repealed; new Section adopted effective August 11, 1997 (Supp. 97-3). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 3365, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 820, effective April 3, 2004 (Supp. 04-1). New Section made by final rulemaking at 14 A.A.R. 3791, effective November 8, 2008 (Supp. 08-3).

R9-28-803. TEFRA Liens – Prohibitions

AHCCCS shall not file a TEFRA lien against a member's home if one of the following individuals is lawfully residing in the member's home:

1. Member's spouse;
2. Member's child who is under the age of 21;
3. Member's child who is blind or disabled under 42 U.S.C. 1382c; or
4. Member's sibling who has an equity interest in the home and who was residing in the member's home for at least one year immediately before the date the member was admitted to a nursing facility, ICF/MR, or other medical institution as defined under 42 CFR 435.1010.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Section repealed; new Section adopted effective August 11, 1997 (Supp. 97-3). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 3365, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 820, effective April 3, 2004 (Supp. 04-1). New Section made by final rulemaking at 14 A.A.R. 3791, effective November 8, 2008 (Supp. 08-3).

R9-28-804. TEFRA Liens – AHCCCS Notice of Intent

- A. Time-frame. At least 30 days before filing a TEFRA lien, AHCCCS shall send the member or member's representative a Notice of Intent.
- B. Content of the Notice of Intent. The Notice of Intent shall include the following information:
 1. A description of a TEFRA lien and the action that AHCCCS intends to take,
 2. How a TEFRA lien affects a member's property,
 3. The legal authority for filing a TEFRA lien,
 4. The time-frames and procedures involved in filing a TEFRA lien, and
 5. The member's right to request an exemption.
- C. Request for exemption. A member or a member's representative may request an exemption. To request an exemption the member or the member's representative shall submit a written statement to AHCCCS within 30 days from the receipt of the Notice of Intent describing the factual basis for a claim that the property should be exempt from placement of a TEFRA lien or from recovery of lien based on R9-28-802, R9-28-803, or R9-28-806. AHCCCS shall respond to the member or member's representative in writing within 30 days of receiving a request

for exemption, unless the parties mutually agree to a longer period of time.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective April 25, 1990 (Supp. 90-2). Section repealed effective August 11, 1997 (Supp. 97-3). New Section made by final rulemaking at 14 A.A.R. 3791, effective November 8, 2008 (Supp. 08-3).

R9-28-805. TEFRA Liens and Estate Recovery – Member's Request for a State Fair Hearing

- A. If the member or member's representative does not request an exemption under R9-28-804(C), the Administration shall send the member or representative a Notice of TEFRA Lien. The member or representative may file a request for a State Fair Hearing within 30 days of the receipt of the Notice of TEFRA Lien.
- B. If the member requests an exemption and the request is denied, the Administration shall send the member or representative a Denial of a Request for Exemption. The member or representative may file a request for a State Fair Hearing within 30 days of the receipt of the Denial of Request for Exemption. After the 30-day time-frame to file a State Fair Hearing, the member or representative is sent a Notice of a TEFRA Lien.
- C. Hearings regarding TEFRA liens shall be conducted under 9 A.A.C. 34.

Historical Note

New Section made by final rulemaking at 14 A.A.R. 3791, effective November 8, 2008 (Supp. 08-3).

R9-28-806. TEFRA Liens – Recovery

- A. AHCCCS shall seek to recover a TEFRA lien upon the sale or transfer of the real property subject to the lien. However, AHCCCS shall not seek to recover the TEFRA lien or attempt recovery against any real property subject to the TEFRA lien so long as the member is survived by the member's:
 1. Spouse;
 2. Child under the age of 21; or
 3. Child who receives benefits under either Title II or Title XVI of the Social Security Act as blind or disabled, as defined under 42 U.S.C. 1382c.
- B. AHCCCS shall not seek to recover a TEFRA lien on an individual's home if the member is survived by:
 1. A sibling of the member who currently resides in the deceased member's home and who was residing in the member's home for a period of at least one year immediately before the date of the member's admission to the nursing facility, ICF/MR, or other medical institution as defined under 42 CFR 435.1010; or
 2. A child of the member who resides in the deceased member's home and who:
 - a. Was residing in the member's home for a period of at least two years immediately before the date of the member's admission to the nursing facility, ICF/MR, or other medical institution as defined under 42 CFR 435.1010; and
 - b. Provided care to the member that allowed the member to reside at home rather than in an institution.
- C. To determine whether a child of the member provided care under subsection (B)(2), AHCCCS shall require the following information:
 1. A physician's written statement that describes the member's physical condition and service needs for the previous two years before the member's death;

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2. Verification that the child actually lived in the member's home;
3. A written statement from the child providing the services that describes and attests to the services provided;
4. A written statement, if any, made by the member prior to death regarding the services received; and
5. A written statement from physician, friend, or relative as witness to the care provided.

Historical Note

New Section made by final rulemaking at 14 A.A.R. 3791, effective November 8, 2008 (Supp. 08-3).

R9-28-807. TEFRA Liens – Release

AHCCCS shall issue a release of a TEFRA lien within 30 days of:

1. Satisfaction of the lien;
2. Notice that the member has been discharged from the nursing facility, ICF/MR, or other medical institution, defined under 42 CFR 435.1010, and the member has returned home and is physically residing in the home with the intention of remaining in the home. Discharge to an alternative HCBS setting defined at R9-28-101 does not constitute a return to the home; or
3. Notice of the member's death, if a lien has been filed on a life estate.

Historical Note

New Section made by final rulemaking at 14 A.A.R. 3791, effective November 8, 2008 (Supp. 08-3).

ARTICLE 9. FIRST- AND THIRD-PARTY LIABILITY AND RECOVERIES**R9-28-901. Definitions**

In addition to the definitions in A.R.S. §§ 36-2901 and 36-2931, 9 A.A.C. 22, Article 1, and 9 A.A.C. 28, Article 1, the following definitions apply to this Article:

"Estate" has the meaning in A.R.S. § 14-1201.

"Member" means a person eligible for AHCCCS-covered services under A.R.S. Title 36, Chapter 29, Article 2.

"Recover" means that AHCCCS takes action to collect from a claim.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective November 7, 1997 (Supp. 97-4). Section repealed; new Section made by final rulemaking at 10 A.A.R. 1308, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 10 A.A.R. 3013, effective September 11, 2004 (Supp. 04-3). Amended by final rulemaking at 14 A.A.R. 3791, effective November 8, 2008 (Supp. 08-3).

R9-28-902. General Provisions

The provisions in A.A.C. R9-22-1002 apply to this Section.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective July 1, 1993 (Supp. 93-3). Amended effective November 7, 1997 (Supp. 97-4). Amended by final rulemaking at 10 A.A.R. 1308, effective May 1, 2004 (Supp. 04-1).

R9-28-903. Cost Avoidance

The provisions in A.A.C. R9-22-1003 apply to this Section.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1308, effective May 1, 2004 (Supp. 04-1).

R9-28-904. Member Participation

The provisions in A.A.C. R9-22-1004 apply to this Section.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1308, effective May 1, 2004 (Supp. 04-1).

R9-28-905. Collections

The provisions in A.A.C. R9-22-1005 apply to this Section.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1308, effective May 1, 2004 (Supp. 04-1).

R9-28-906. AHCCCS Monitoring Responsibilities

The provisions in A.A.C. R9-22-1006 apply to this Section.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective November 7, 1997 (Supp. 97-4). Section repealed; new Section made by final rulemaking at 10 A.A.R. 1308, effective May 1, 2004 (Supp. 04-1).

R9-28-907. Notification for Perfection, Recording, and Assignment of AHCCCS Liens

The provisions in A.A.C. R9-22-1007 apply to this Section.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1308, effective May 1, 2004 (Supp. 04-1).

R9-28-908. Notification Information for Liens

The provisions in A.A.C. R9-22-1008 apply to this Section.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1308, effective May 1, 2004 (Supp. 04-1).

R9-28-909. Notification of Health Insurance Information

The provisions in A.A.C. R9-22-1009 apply to this Section.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1308, effective May 1, 2004 (Supp. 04-1).

R9-28-910. Recoveries

AHCCCS shall recover funds paid before or after the death of a member for ALTCS benefits including: capitation payments, Medicare Parts A and B premium payments, coinsurance and deductibles paid by AHCCCS, fee-for-service payments, and reinsurance payments from:

1. The estate of a member who was 55 years of age or older when the member received benefits; or
2. The estate or the property of a member under A.R.S. §§ 36-2935, 36-2956, and 42 U.S.C. 1396p.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1308, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 14 A.A.R. 3791, effective November 8, 2008 (Supp. 08-3).

R9-28-911. Estate Recovery and Undue Hardship

A. Any recovery of a claim by AHCCCS against a member's estate shall be made only after the death of the member's surviving spouse and only at a time:

1. When there exists no surviving minor child under age 21; and

2. When there exists no surviving child who receives benefits under either Title II or Title XVI of the Social Security Act because the child is blind or disabled as defined in 42 U.S.C. 1382c.
- B.** Undue hardship exemption request. A member's representative may request an undue hardship exemption. If the member's representative wishes to request an undue hardship exemption, the member's representative shall submit the request within 30 days from the receipt of the notification of the AHCCCS claim against the estate. The member's representative shall submit a written statement to AHCCCS describing the factual basis for a claim that the property should be exempt from estate recovery as provided under this Section. AHCCCS shall respond to the member or member's representative in writing within 30 days of receiving an undue hardship exemption request, unless the parties mutually agree to a longer period of time.
- C.** AHCCCS shall waive a claim against a member's estate because of undue hardship if any of the following situations exist:
 1. The estate consists only of real property that is listed as residential property by the Arizona Department of Revenue or County Assessor's Office, and the heir or devisee:
 - a. Owns a business that is located at the residential property and:
 - i. The business was in operation at the residential property for at least 12 months preceding the death of the member,
 - ii. The business provides more than 50 percent of the heir's or devisee's livelihood, and
 - iii. The recovery of the property would result in the heir or devisee losing the heir's or devisee's means of livelihood; or
 - b. Currently resides in the residence and:
 - i. Resided there at the time of the member's death,
 - ii. Made the residence his or her primary residence for the 12 months immediately before the death of the member, and
 - iii. Owns no other residence; or
 2. The estate consists only of personal property and:
 - a. The heir's or devisee's gross annual income for the household size is less than 100 percent of the Federal Poverty Level (FPL). New sources of income such as employment or Social Security that may not have yet been received are included in determining the household's annual gross income; and
 - b. The heir or devisee does not own a home, land, or other real property.
- D.** When the estate consists of both personal property and real property that qualify for the undue hardship exemption criteria under subsections (B) and (C), AHCCCS shall not grant an undue hardship waiver; however, AHCCCS shall adjust its claim to the value of the personal property.
- E.** AHCCCS shall exempt the following income, resources, and property of Native Americans (NA) and Alaska Natives (AN) from estate recovery:
 1. Income and resources from tribal land and other resources currently held in trust and judgment funds from the Indian Claims Commission or U.S. Claims Court;
 2. Ownership interest in trust or non-trust property;
 3. Ownership interests left as a remainder in an estate in rents, leases, royalties, or usage rights related to natural resources;
 4. Any other ownership interests or rights in a property that has unique religious, spiritual, traditional, or cultural sig-

nificance or rights that support subsistence or a traditional life style according to applicable Tribal law or custom; and

5. Income left as a remainder in an estate derived from any property listed in subsection (E)(1) through (4), that was either collected by a NA, or by a Tribe or Tribal organization and distributed to a NA.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1308, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 10 A.A.R. 3013, effective September 11, 2004 (Supp. 04-3). Amended by final rulemaking at 14 A.A.R. 3791, effective November 8, 2008 (Supp. 08-3).

R9-28-912. Partial Recovery

AHCCCS shall use the following factors in determining whether to seek a partial recovery of funds when an heir or devisee does not meet the requirements of R9-28-911 and requests a partial recovery:

1. Financial and medical hardship to the heir or devisee;
2. Income of the heir or devisee and whether the heir or devisee's household gross annual income is less than 100 percent of the FPL;
3. Resources of the heir or devisee;
4. Value and type of assets;
5. Amount of AHCCCS' claim against the estate; and
6. Whether other creditors have filed claims against the estate or have foreclosed on the property.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1308, effective May 1, 2004 (Supp. 04-1).

R9-28-913. Repealed

Historical Note

New Section made by final rulemaking at 10 A.A.R. 3013, effective September 11, 2004 (Supp. 04-3). Repealed by final rulemaking at 14 A.A.R. 3791, effective November 8, 2008 (Supp. 08-3).

R9-28-914. Repealed

Historical Note

New Section made by final rulemaking at 10 A.A.R. 3013, effective September 11, 2004 (Supp. 04-3). Repealed by final rulemaking at 14 A.A.R. 3791, effective November 8, 2008 (Supp. 08-3).

R9-28-915. Repealed

Historical Note

New Section made by final rulemaking at 10 A.A.R. 3013, effective September 11, 2004 (Supp. 04-3). Repealed by final rulemaking at 14 A.A.R. 3791, effective November 8, 2008 (Supp. 08-3).

R9-28-916. Repealed

Historical Note

New Section made by final rulemaking at 10 A.A.R. 3013, effective September 11, 2004 (Supp. 04-3). Repealed by final rulemaking at 14 A.A.R. 3791, effective November 8, 2008 (Supp. 08-3).

R9-28-917. Repealed

Historical Note

New Section made by final rulemaking at 10 A.A.R. 3013, effective September 11, 2004 (Supp. 04-3).

Repealed by final rulemaking at 14 A.A.R. 3791, effective November 8, 2008 (Supp. 08-3).

R9-28-918. Repealed

Historical Note

New Section made by final rulemaking at 10 A.A.R. 3013, effective September 11, 2004 (Supp. 04-3).

Repealed by final rulemaking at 14 A.A.R. 3791, effective November 8, 2008 (Supp. 08-3).

R9-28-919. Repealed

Historical Note

New Section made by final rulemaking at 10 A.A.R. 3013, effective September 11, 2004 (Supp. 04-3).

Repealed by final rulemaking at 14 A.A.R. 3791, effective November 8, 2008 (Supp. 08-3).

ARTICLE 10. CIVIL MONETARY PENALTIES AND ASSESSMENTS

R9-28-1001. Basis for Civil Monetary Penalties and Assessments for Fraudulent Claims

AHCCCS shall use the provisions in 9 A.A.C. 22, Article 11 for the determination and collection of penalties, assessments, and penalties and assessments.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Amended effective June 9, 1998 (Supp. 98-2).

Amended by final rulemaking at 10 A.A.R. 3065, effective September 11, 2004 (Supp. 04-3).

R9-28-1002. Repealed

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective November 5, 1993 (Supp. 93-4). Repealed effective June 9, 1998 (Supp. 98-2).

R9-28-1003. Repealed

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective November 5, 1993 (Supp. 93-4). Repealed effective June 9, 1998 (Supp. 98-2).

R9-28-1004. Repealed

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Repealed effective June 9, 1998 (Supp. 98-2).

ARTICLE 11. BEHAVIORAL HEALTH SERVICES

R9-28-1101. General Requirements

General requirements. The following general requirements apply to behavioral health services provided under this Article, subject to all exclusions and limitations.

1. Administration. The program shall be administered under A.R.S. § 36-2932.
2. Provision of services. Behavioral health services shall be provided under A.R.S. § 36-2939, this Chapter and 9 A.A.C. 22, Article 12, as applicable.
3. Definitions. The definitions in A.A.C. R9-22-1201 and R9-22-102 apply to this Article, in addition to the following definitions:

“Case management” means the activities described in R9-28-510.

“Cost avoid” means the same as in A.A.C. R9-22-1201.

“Intergovernmental agreement” or “IGA” means an agreement for services or joint or cooperative action between the Administration and a tribal contractor.

“Qualified behavioral health service provider” means a behavioral health service provider that meets the requirements of R9-28-1106.

“Tribal contractor” means a tribal organization (The Tribe) or urban Indian organization defined in 25 U.S.C. 1603 and recognized by CMS as meeting the requirements of 42 U.S.C. 1396d(b), that provides or is accountable for providing the services or delivering the items described in the intergovernmental agreement.

4. Enrollment of Native American member. The Administration shall enroll an EPD Native American member with a tribal contractor on a FFS basis if:
 - a. The member lives on-reservation of a Native American tribal organization that is an ALTCS tribal contractor, or
 - b. The member lived on-reservation of a Native American tribal organization that is an ALTCS tribal contractor immediately before placement in an off-reservation Nursing Facility or an alternative HCBS setting.
5. Case management. A tribal contractor shall provide case management services to FFS Native American members living on or off-reservation as delineated in the IGA.
6. Services. A tribal contractor or the Administration may authorize behavioral health services for FFS Native American members enrolled with a tribal contractor as delineated in the intergovernmental agreement.
7. Enrollment of Native American members off-reservation. Except as provided in R9-28-1101(4)(b), an EPD Native American who resides off-reservation shall be enrolled with an ALTCS program contractor to receive behavioral health services, including case management, under R9-28-415.
8. Enrollment of developmentally disabled Native American member. A developmentally disabled Native American member who resides on or off-reservation shall be enrolled with the Department of Economic Security's Division of Developmental Disabilities under R9-28-414 and shall receive behavioral health services from the Department of Economic Security's Division of Developmental Disabilities.
9. Reimbursement. For FFS Native Americans, the Administration is exclusively responsible for providing reimbursement for covered behavioral health services that are authorized by a tribal contractor or the Administration under the intergovernmental agreement as specified in this Article. A program contractor is exclusively responsible for providing reimbursement for covered behavioral health services that are authorized by a program contractor as specified in this Article.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 200, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4691, effective October 1, 2001 (Supp. 01-3). Amended by final

rulemaking at 13 A.A.R. 1090, effective May 5, 2007
(Supp. 07-1).

R9-28-1102. Program or Tribal Contractor Responsibilities

- A.** Program contractor. A program contractor shall provide behavioral health services to all enrolled members, including Native American members who are not enrolled with a tribal contractor under R9-28-1101.
- B.** Tribal contractor. A tribal contractor shall provide behavioral health services to a Native American member who is enrolled with a tribal contractor as prescribed in R9-28-1101. When a tribal contractor determines that an EPD Native American member residing on a reservation needs behavioral health services under R9-28-415, the member shall receive services as authorized by the Administration or a tribal contractor under A.A.C. R9-22-1205 from any AHCCCS-registered provider.
- C.** A program or tribal contractor shall cooperate when a transition of care occurs and ensure that medical records are transferred in accordance with A.R.S. §§ 36-2932, 36-509, and R9-28-514 when a member transitions from:
 - 1. A behavioral health provider to another behavioral health provider,
 - 2. A RBHA or TRBHA to a program contractor,
 - 3. A program or tribal contractor to a RBHA or TRBHA, or
 - 4. A program contractor to a tribal contractor or vice versa.
- D.** The Administration, a tribal contractor, or a program contractor, as appropriate, shall authorize behavioral health services for Native American members.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Office of the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 200, effective December 13, 1999 (Supp. 99-4). Amended by final rulemaking at 13 A.A.R. 1090, effective May 5, 2007 (Supp. 07-1).

R9-28-1103. Eligibility for Covered Services

- A.** Eligibility for covered services. A member determined eligible under A.R.S. § 36-2934 shall receive medically necessary covered services specified in A.A.C. R9-22-1205 and R9-28-202.
- B.** Limitations. Behavioral health services are covered as specified in A.A.C. R9-22-201 and R9-22-1205.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Office of the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 200, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4691, effective October 1, 2001 (Supp. 01-3). Amended by final

rulemaking at 13 A.A.R. 1090, effective May 5, 2007
(Supp. 07-1).

R9-28-1104. General Service Requirements

- A.** Services. Behavioral health services include both mental health and substance abuse services.
- B.** Prior authorization for emergency behavioral health services. A provider is not required to obtain prior authorization for emergency behavioral health services.
- C.** Prohibition against denial of payment. A program contractor, tribal contractor, or the Administration shall not limit or deny payment to an emergency behavioral health provider for emergency behavioral health services to a member for the following reasons:
 - 1. On the basis of lists of diagnoses or symptoms,
 - 2. Prior authorization was not obtained, or
 - 3. The provider does not have a contract.
- D.** A program contractor or the Administration shall not limit or deny payment to an emergency behavioral health provider for emergency behavioral health services provided to a member if the member received those services as directed by an employee of the program contractor or the Administration.
- E.** Grounds for denial for persons enrolled with a program or tribal contractor. A program contractor or the Administration may deny payment to an emergency behavioral health provider for emergency behavioral health services for reasons including but not limited to the following:
 - 1. The claim was not a clean claim,
 - 2. The claim was not submitted timely, or
 - 3. The provider failed to provide timely notification to the Administration or the program contractor, as applicable.
- F.** Notification to program contractor for persons enrolled with a program contractor. A hospital, emergency room provider, or fiscal agent shall notify a program contractor no later than the 11th day from presentation of the member enrolled with a program contractor for emergency inpatient behavioral health services.
- G.** Notification to Administration for Native Americans enrolled with a tribal contractor. A provider shall notify the Administration no later than 72 hours after a Native American member enrolled with a tribal contractor presents to a hospital for inpatient emergency behavioral health services.
- H.** Behavioral health evaluation. Subject to A.R.S. § 36-545.06 and R9-28-903, an emergency behavioral health evaluation is covered as an emergency service for a member under this Section if:
 - 1. Required to evaluate or stabilize an acute episode of mental disorder or substance abuse; and
 - 2. Provided by a qualified provider who is a behavioral health medical practitioner as defined in A.A.C. R9-22-1201, including a licensed psychologist, a licensed clinical social worker, a licensed professional counselor, or a licensed marriage and family therapist.
- I.** Post-stabilization requirements for members enrolled with a program contractor.
 - 1. A program contractor is financially responsible for behavioral health post-stabilization services obtained within or outside the network that have received prior authorization from the program contractor.
 - 2. The program contractor is financially responsible for behavioral health post-stabilization services obtained within or outside the network that have not received prior authorization from the program contractor, but are administered to maintain the member's stabilized condition within one hour of a request to the program contractor for prior authorization of further post-stabilization services;

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3. The program contractor is financially responsible for behavioral health post-stabilization services obtained within or outside the network that have not received prior authorization from the program contractor, but are administered to maintain, improve, or resolve the member's stabilized condition if:
 - a. The program contractor does not respond to a request for prior authorization within one hour;
 - b. The program contractor authorized to give the prior authorization cannot be contacted; or
 - c. The representative of the program contractor and the treating physician cannot reach an agreement concerning the member's care and the program contractor's physician is not available for consultation. The treating physician may continue with care of the member until the program contractor's physician is reached, or:
 - i. A program contractor's physician with privileges at the treating hospital assumes responsibility for the member's care;
 - ii. A program contractor's physician assumes responsibility for the member's care through transfer;
 - iii. A representative of the program contractor and the treating physician reach agreement concerning the member's care; or
 - iv. The member is discharged.
 4. Transfer or discharge. The attending physician or the provider actually treating the member for the emergency behavioral health condition shall determine when the member is sufficiently stabilized for transfer or discharge and that decision shall be binding on the program contractor.
- J.** Prior authorization for non-emergency behavioral health services. When a member's behavioral health condition is determined by the provider not to require emergency behavioral health services, the provider shall follow the program contractor's or the Administration's prior authorization requirements.
- K.** E.P.S.D.T. services. For Title XIX members under age 21, E.P.S.D.T. services shall include all medically necessary Title XIX-covered behavioral health services to a member.
- L.** Experimental services. Experimental services and services that are provided primarily for the purpose of research are not covered.
- M.** Gratuities. A service or an item, if furnished gratuitously to a member by a provider, is not covered and payment to a provider shall be denied.
- N.** GSA. Behavioral health services rendered to a member enrolled with a program contractor shall be provided within the program contractor's GSA except when:
 1. A primary care provider refers a member to another area for medical specialty care;
 2. A member's medically necessary covered service is not available within the GSA;
 3. A net savings in behavioral health service delivery costs can be documented by the program contractor for a member. Undue travel time or hardship shall be considered for a member or a member's family; or
 4. A member is placed by the program contractor in a NF or an Alternative HCBS setting located out of the program contractor's GSA, but remains enrolled with that program contractor.
- O.** Travel. If a member travels or temporarily resides outside of a program contractor's GSA, covered services are restricted to emergency behavioral health care, unless authorized by the member's program contractor.
- P.** Non-covered services. If a member requests a behavioral health service that is not covered or is not authorized by a program contractor, the tribal contractor, or the Administration, the behavioral health service may be provided by an AHC-CCS-registered behavioral health service provider according to A.A.C. R9-22-702.
- Q.** Restrictions and limitations.
 1. The restrictions, limitations, and exclusions in this Article do not apply to a program contractor that elects to provide a noncovered service.
 2. Room and board is not a covered service unless provided by the Administration or a program contractor in a Level 1, inpatient, sub-acute, or residential center under A.A.C. R9-22-1205.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective July 1, 1993; amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 204, § 11, effective January 1, 1996; filed with the Office of the Secretary of State December 22, 1995 (Supp. 95-4). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 200, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4691, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 13 A.A.R. 1090, effective May 5, 2007 (Supp. 07-1).

R9-28-1105. Scope of Behavioral Health Services

- A.** Scope of Services. The provisions of A.A.C. R9-22-1205 are the scope of behavioral health services for a member under this Article. A member in an institutional or Alternative HCBS setting as defined in R9-28-101 may receive covered behavioral health therapeutic home care services from a program contractor.
- B.** Applicability. References in A.A.C. R9-22-1205 to ADHS/DBHS apply to a program contractor.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Office of the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 200, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4691, effective October 1, 2001 (Supp. 01-3). Amended by exempt rulemaking at 8 A.A.R. 933, effective February 12, 2002 (Supp. 02-1). Amended by final rulemaking at 13 A.A.R. 1090, effective May 5, 2007 (Supp. 07-1).

R9-28-1106. General Provisions and Standards for Service Providers

- A. Applicability. The provisions of A.A.C. R9-22-1206 are the general provisions and standards for service providers. References in A.A.C. R9-22-1206 to ADHS/DBHS or to a RBHA apply to a program contractor.
- B. Qualified service provider. A qualified behavioral health service provider shall:
 - 1. Have all applicable state licenses or certifications, or comply with alternative requirements established by the Administration;
 - 2. Register with the Administration as a behavioral health service provider; and
 - 3. Comply with all requirements under Article 5 and this Article.
- C. Quality and utilization management.
 - 1. Service providers shall cooperate with the program contractor's quality and utilization management programs and the Administration as under R9-28-511 and in contract.
 - 2. Service providers shall comply with applicable procedures under 42 CFR 456, incorporated by reference in A.A.C. R9-22-1206.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective July 1, 1993 (Supp. 93-3). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 200, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4691, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 13 A.A.R. 1090, effective May 5, 2007 (Supp. 07-1).

R9-28-1107. General Provisions for Payment

- A. Prior authorization. For ALTCS members enrolled with a program contractor, payment to a provider for behavioral health services that require prior authorization may be denied as specified in R9-22-705. References in A.A.C. R9-22-705 to a contractor apply to a program contractor.
- B. For ALTCS FFS members, payment to a provider for behavioral health services that require prior authorization may be denied if a provider does not obtain prior authorization from a tribal contractor or the Administration, as applicable.
- C. The Administration or a program contractor shall cost avoid any behavioral health service claims if the Administration or the program contractor establishes the probable existence of first-party liability or third-party liability.

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 200, effective December 13, 1999 (Supp. 99-4). Amended by final rulemaking at 13 A.A.R. 1090, effective May 5, 2007 (Supp. 07-1).

R9-28-1108. Repealed**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 200, effective December 13, 1999 (Supp. 99-4). Amended by final rulemaking at 6 A.A.R. 3365, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 13 A.A.R. 1090, effective May 5, 2007 (Supp. 07-1).

ARTICLE 12. REPEALED

Article 12, consisting of Section R9-28-1201, repealed by final rulemaking at 10 A.A.R. 820, effective April 3, 2004. The subject matter of Article 12 is now in 9 A.A.C. 34 (Supp. 04-1).

R9-28-1201. Repealed**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 3365, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 820, effective April 3, 2004 (Supp. 04-1).

ARTICLE 13. FREEDOM TO WORK

Article 13, consisting of Sections R9-28-1301 through R9-28-1324, made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4).

R9-28-1301. General Freedom to Work Requirements

The Administration shall determine eligibility for AHCCCS medical services under Article 2 of this Chapter and A.A.C. R9-22-1901.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4). Section amended by final rulemaking at 15 A.A.R. 269, effective March 7, 2009 (Supp. 09-1).

R9-28-1302. General Administration Requirements

The Administration shall comply with the confidentiality rule under A.A.C. R9-22-512(C).

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4). Section amended by final rulemaking at 15 A.A.R. 269, effective March 7, 2009 (Supp. 09-1).

R9-28-1303. Application for Coverage

- A. A person may apply by submitting an application to an Administration office.
- B. The application date is the date the application is received at an Administration office.
- C. The provisions of A.A.C. R9-22-1406(B) and (D) apply to this Section.
- D. An applicant or representative who files an application may withdraw the application either orally or in writing. The Administration shall send an applicant withdrawing an application a denial notice under R9-28-1304.
- E. Except as provided in 42 CFR 435.911, the Administration shall determine eligibility within 45 days.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 9 A.A.R. 5138, effective January 3, 2004 (Supp. 03-4). Section amended by final rulemaking at 15 A.A.R. 269, effective March 7, 2009 (Supp. 09-1).

R9-28-1304. Notice of Approval or Denial

The Administration shall send an applicant a written notice of the decision regarding the application. This notice shall include a statement of the action and:

- 1. If approved:
 - a. The effective date of eligibility,
 - b. The amount the person shall pay, and
 - c. An explanation of the person's hearing rights specified in 9 A.A.C. 34; or

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2. If denied, the information required by R9-28-401.01(G)(2).

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4). Section amended by final rulemaking at 15 A.A.R. 269, effective March 7, 2009 (Supp. 09-1).

R9-28-1305. Reporting and Verifying Changes

An applicant or member shall report and verify changes as described under R9-28-411(A), to the Administration, including any changes in the spouse's income that may affect the share of cost.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4). Section amended by final rulemaking at 15 A.A.R. 269, effective March 7, 2009 (Supp. 09-1).

R9-28-1306. Actions that Result from a Redetermination or Change

The processing of a redetermination or change shall result in one of the following actions:

1. No change in eligibility, share-of-cost, or premium,
2. Discontinuance of eligibility if a condition of eligibility is no longer met,
3. A change in the person's share-of-cost,
4. A change in premium amount, or
5. A change in the coverage group under which a person receives AHCCCS medical coverage.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4).

R9-28-1307. Notice of Adverse Action

- A. The requirements under R9-28-411(D)(1) apply.
- B. Advance notice of a change in eligibility, share of cost, or premium amount. Advance notice means a notice of proposed action that is issued to the member at least 10 days before the effective date of the proposed action. Except under subsection (C), advance notice shall be issued whenever an adverse action is taken to:
 1. Discontinue eligibility,
 2. Increase a person's share-of-cost,
 3. Increase the premium amount, or
 4. Reduce benefits from ALTCS to acute care services.
- C. Exceptions from advance notice. A notice shall be issued to the member to discontinue eligibility no later than the effective date of action if:
 1. A member provides a clearly written statement, signed by that member, that services are no longer wanted;
 2. A member provides information that requires termination of eligibility or reduction of services, indicates that the member understands that termination of eligibility or reduction of services will be the result of supplying the information and signs a written statement waiving advance notice;
 3. A member cannot be located and mail sent to the member's last known address has been returned as undeliverable. A member whose eligibility is discontinued under this subsection is subject to reinstatement of discontinued services under 42 CFR 431.231(d);
 4. A member has been admitted to a public institution where a person is ineligible for coverage;
 5. A member has been approved for Medicaid in another state; or

6. The Administration receives information confirming the death of a member.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4). Section amended by final rulemaking at 15 A.A.R. 269, effective March 7, 2009 (Supp. 09-1).

R9-28-1308. Request for Hearing

An applicant or member may request a hearing under 9 A.A.C. 34.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4). Section amended by final rulemaking at 15 A.A.R. 269, effective March 7, 2009 (Supp. 09-1).

R9-28-1309. Conditions of Eligibility

An applicant or member shall meet the following conditions to qualify for the Freedom to Work program:

1. Furnish a valid Social Security Number (SSN);
2. Be a resident of Arizona;
3. Be a citizen of the United States, or meet requirements for a qualified alien under A.R.S. § 36-2903.03(B);
4. Be at least 16 years of age, but less than 65 years of age;
5. Have countable income that does not exceed 250 percent of FPL. The Administration shall count income under 42 U.S.C. 1382a and 20 CFR 416 Subpart K with the following exceptions:
 - a. The unearned income of the applicant or member shall be disregarded,
 - b. The income of a spouse or other family members shall be disregarded, and
 - c. The deduction for a minor child shall not apply;
6. Reside in a living arrangement specified under R9-28-406(A);
7. Be determined as physically disabled by meeting the medical criteria under Article 3 of this Chapter; and
8. Comply with the member responsibility provisions under A.A.C. R9-22-1502(D) and (F).

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4). Section repealed; new Section made by final rulemaking at 15 A.A.R. 269, effective March 7, 2009 (Supp. 09-1).

R9-28-1310. Repealed**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 269, effective March 7, 2009 (Supp. 09-1).

R9-28-1311. Repealed**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 269, effective March 7, 2009 (Supp. 09-1).

R9-28-1312. Repealed**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 269, effective March 7, 2009 (Supp. 09-1).

R9-28-1313. Premium Requirements

- A. As a condition of eligibility, an applicant or member shall:
1. Pay the premium required under subsection (B).
 2. Not have any unpaid premiums that exceed the premium amount for one month.
- B. The Administration shall process premiums under 9 A.A.C. 31, Article 14 with the following exceptions:
1. A member who has countable income:
 - a. Under \$500, the monthly premium payment shall be \$0.
 - b. Over \$500 but not greater than \$750, the monthly premium payment shall be \$10.
 2. The premium for a member shall be increased by \$5 for each \$250 increase in countable income above \$750.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4). Section amended by final rulemaking at 15 A.A.R. 269, effective March 7, 2009 (Supp. 09-1).

R9-28-1314. Repealed**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 269, effective March 7, 2009 (Supp. 09-1).

R9-28-1315. Repealed**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 269, effective March 7, 2009 (Supp. 09-1).

R9-28-1316. Institutionalized Person

A person is not eligible for AHCCCS medical coverage if the person is:

1. An inmate of a public institution and federal financial participation (FFP) is not available, or
2. Older than age 20 but younger than age 65 and is residing in an Institution for Mental Disease under 42 CFR 435.1009 except when allowed under the Administration's Section 1115 IMD waiver or allowed under a managed care contract approved by CMS.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4). Section amended by final rulemaking at 15 A.A.R. 269, effective March 7, 2009 (Supp. 09-1).

R9-28-1317. Repealed**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 269, effective March 7, 2009 (Supp. 09-1).

R9-28-1318. Repealed**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4). Section repealed

by final rulemaking at 15 A.A.R. 269, effective March 7, 2009 (Supp. 09-1).

R9-28-1319. Repealed**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 269, effective March 7, 2009 (Supp. 09-1).

R9-28-1320. Additional Eligibility Criteria for the Basic Coverage Group

As a condition of eligibility, an applicant or member shall be employed. Employed means that an applicant or member is paid for working and Social Security or Medicare taxes are paid on the applicant's or member's income.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4). Section amended by final rulemaking at 15 A.A.R. 269, effective March 7, 2009 (Supp. 09-1).

R9-28-1321. Share of Cost

The Director shall determine the amount a person shall pay for the cost of ALTCS services (share-of-cost) under A.R.S. § 36-2932(L) and 42 CFR 435.725 or 42 CFR 435.726. Share of cost shall be calculated for people who reside in a medical institution for an entire calendar month under R9-28-408(G) and R9-28-410(C) except that the personal-needs allowance shall be increased by 50 percent of the member's earned income.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4).

R9-28-1322. Repealed**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 269, effective March 7, 2009 (Supp. 09-1).

R9-28-1323. Enrollment

The Administration shall enroll members under R9-28-412 through R9-28-418.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4).

R9-28-1324. Redetermination of Eligibility

- A. Redetermination. Except as provided in subsection (B), the Administration shall complete a redetermination of eligibility at least once a year.
- B. Change in circumstance. The Administration may complete a redetermination of eligibility if there is a change in the member's circumstances, including a change in disability or employment that may affect eligibility.
- C. Medical Improvement. If a member is no longer disabled under Article 3 of this Chapter, the Administration shall determine if the member is eligible under other coverage groups.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4).

Arizona Health Care Cost Containment System – Medicare Cost Sharing Program

TITLE 9. HEALTH SERVICES

CHAPTER 29. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
MEDICARE COST SHARING PROGRAM

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R9-29-602.	Repealed

ARTICLE 1. DEFINITIONS

R9-29-101. Location of Definitions

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

Definition	Section or Citation
“Federal poverty level” or “FPL”	A.R.S. § 36-2981
“Medicare Cost Sharing”	R9-29-101
“Non-QMB Dual”	R9-29-101
“QI-1”	R9-29-101
“QMB Dual”	R9-29-101
“QMB Only”	R9-29-101
“SLMB”	R9-29-101

- B. General definitions. In addition to definitions contained in A.R.S. § 36-2971, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

“Medicare Cost Sharing” (MCS). The MCS Program is administered by the Administration and provides help to Medicare beneficiaries with costs related to Medicare services. MCS is also referred to as the “Medicare Savings Programs.”

“Non-QMB Dual” means a person who qualifies to receive both Medicare and Medicaid services, but does not qualify for the QMB program.

“QI-1” means a person who qualifies as a Medicare beneficiary and for cost sharing assistance with the person’s Part B premium known as Qualified Individual-1 (QI-1). This person does not qualify for QMB due to the person’s income exceeding the QMB and SLMB FPL level.

“QMB Dual” means a person determined eligible under Article 2 of this Chapter for Qualified Medicare Beneficiary (QMB) and eligible for Acute Care services provided for in 9 A.A.C. 22 or ALTCS services provided for in 9 A.A.C. 28. A QMB Dual person receives both Medicare and Medicaid services and cost sharing assistance. For the purpose of Article 2 of this Chapter, QMB includes members defined in A.R.S. § 36-2971(5).

“QMB Only” means a person who qualifies to receive Medicare services only and cost-sharing assistance known as Qualified Medicare Beneficiary program (QMB). For the purpose of Article 2 of this Chapter, QMB includes members defined in A.R.S. § 36-2971(5).

“SLMB” means a person who qualifies as a Medicare beneficiary and for cost sharing assistance with the person’s Part B premium known as Specified Low Income Medicare Beneficiary (SLMB). This person does not qualify for QMB due to the person’s income exceeding the QMB FPL level.

Historical Note

Adopted effective May 23, 1990 (Supp. 90-2). Amended effective June 16, 1992 (Supp. 92-2). Amended effective April 14, 1998 (Supp. 98-2). Amended by final rulemaking at 6 A.A.R. 3372, effective August 7, 2000 (Supp. 00-3). Amended by exempt rulemaking at 7 A.A.R. 4357,

effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-102. Repealed

Historical Note

New Section made by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Repealed by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

ARTICLE 2. ELIGIBILITY

R9-29-201. General

- A. Eligibility determination. AHCCCS shall determine eligibility for a QMB, SLMB, or QI-1 under this Article.
- B. Confidentiality. The Administration shall maintain the confidentiality of an applicant or member's records and limit the release of safeguarded information under A.A.C. R9-22-512.
- C. The Administration will accept applications for the QI-1 program subject to the availability of funds. If the Director determines that monies may be insufficient for the program, the Administration shall stop processing applications for the program. If the Administration stops processing an application because the monies are insufficient, the Administration shall place an applicant on a waiting list and notify the applicant. After the Administration has verified that funding is sufficient, it will resume processing applications.

Historical Note

Adopted effective May 23, 1990 (Supp. 90-2). Amended effective April 14, 1998 (Supp. 98-2). Amended by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-202. Application Process

- A. The Administration shall provide the opportunity to apply without delay.
- B. To apply for the MCS Program, a person shall submit an application form prescribed by AHCCCS unless the person's application has been referred by the Social Security Administration as part of the Extra Help program described under A.A.C. R9-30-101.
- C. An application shall be submitted by a person listed in A.A.C. R9-22-1406(B) unless the person's application has been referred by the Social Security Administration as part of the Extra Help program described under A.A.C. R9-30-101.
- D. The date of application is the date a signed application is received as described under A.A.C. R9-22-1406 or the date of an application referred by the Social Security Administration as part of the Extra Help program described under A.A.C. R9-30-101.
- E. Applicant's representative. AHCCCS shall allow a person of an applicant's choice to accompany, assist, and represent the applicant in the application process or assistance can be provided by AHCCCS. If requested, AHCCCS shall help a person complete an application.
- F. AHCCCS shall determine whether an application is complete under A.A.C. R9-22-1406.

Historical Note

Adopted effective May 23, 1990 (Supp. 90-2). Amended effective June 16, 1992 (Supp. 92-2). Section repealed; new Section adopted effective April 14, 1998 (Supp. 98-2). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4).

03-4). Amended by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-203. Assignment of Rights

A person determined eligible for QMB benefits assigns rights to medical benefits to which the person is entitled to AHCCCS, under A.R.S. §§ 36-2903 and 36-2972.

Historical Note

Adopted effective May 23, 1990 (Supp. 90-2). Section repealed; new Section adopted effective April 14, 1998 (Supp. 98-2). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Section R9-29-203 repealed; new Section R9-29-203 renumbered from R9-29-207 and amended by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-204. Eligibility Requirements

To be eligible for MCS a person shall:

1. Provide information necessary to establish paternity and enforce medical support obligations, when requested by AHCCCS for the QMB program,
2. Furnish a SSN or apply for a SSN,
3. Be a United States citizen or a qualified alien under A.R.S. § 36-2903.03,
4. Be a resident of Arizona,
5. Apply for potential benefits that may be available to the person, if requested by AHCCCS,
6. Provide verification, or authorize the release of verification, for all information necessary to complete the determination of eligibility, and
7. Receive Medicare Part A benefits or be determined conditionally entitled to Medicare Part A benefits by the Social Security Administration.

Historical Note

Adopted effective May 23, 1990 (Supp. 90-2). Repealed effective April 14, 1998 (Supp. 98-2). New Section made by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). R9-29-204 repealed; new Section R9-29-204 made by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-205. Income Standards

- A. To be eligible, a person's income shall meet the following federal poverty levels (FPL), adjusted annually:
 1. QMB. Income is equal to or less than 100 percent of the FPL.
 2. SLMB. Income is greater than 100 percent but equal to or less than 120 percent of the FPL.
 3. QI-1. Income is at least 120 percent but equal to or less than 135 percent of the FPL.
- B. AHCCCS shall calculate income under A.A.C. R9-22-1503.

Historical Note

New Section made by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Section R9-29-205 repealed; new Section R9-29-205 renumbered from R9-29-213 and amended by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-206. Institutionalized Person

The provisions in A.A.C. R9-22-1402 apply to this Article for an institutionalized person.

Historical Note

New Section made by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Section R9-29-206 repealed; new Section R9-29-206 renumbered from

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R9-29-215 by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-207. Resources

Resources such as, cash, financial accounts, real property, vehicles, trusts, and life insurance are not considered in determining a person's QMB, SLMB or QI-1 eligibility.

Historical Note

New Section made by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Section R9-29-207 renumbered to R9-29-203; new Section R9-29-207 made by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-208. Eligibility Determination

- A. AHCCCS shall make an eligibility determination within 45 days of the date of application, except when:
 1. The agency cannot reach a decision because the applicant delays or fails to take a required action, or
 2. When there is an administrative or other emergency beyond the agency's control.
- B. AHCCCS shall not use the time to determine eligibility as a waiting period before determining eligibility; or as a reason for denying eligibility when a determination has not been made within the time standards.

Historical Note

New Section made by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Section R9-29-208 repealed; new Section R9-29-208 renumbered from R9-29-219 and amended by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-209. Notice of Eligibility Determination

- A. Notice. AHCCCS shall send an applicant written notice of the eligibility decision. The notice shall include a statement of the action and an explanation of the person's hearing rights specified in Article 5.
- B. Approval. If AHCCCS determines that the applicant is eligible, the notice shall contain the effective date of eligibility.
- C. Denial. If AHCCCS determines that the applicant is not eligible, the notice shall contain:
 1. The effective date of the decision;
 2. A statement detailing the reason for the decision, including specific financial calculations and the financial eligibility standard if applicable; and
 3. The legal authority supporting the decision.

Historical Note

New Section made by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Section R9-29-209 repealed; new Section R9-29-209 renumbered from R9-29-220 by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-210. Effective Date of Eligibility

- A. QMB. The effective date of eligibility is the first day of the month following the month in which AHCCCS makes the eligibility decision.
- B. SLMB. The effective date of eligibility is the first day of the first month AHCCCS determines the person is eligible under this Article, but no earlier than the first day of the month of application.
- C. QI-1. The effective date of eligibility is the first day of the first month AHCCCS determines the person is eligible under this Article, but no earlier than the first day of the month of application. QI-1 members are entitled to receive cost sharing assistance through the end of the calendar year in which they qualified for the program.

Historical Note

New Section made by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Section R9-29-210 repealed; new Section R9-29-210 renumbered from R9-29-221 and amended by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-211. Discontinuance

- A. Discontinuance. AHCCCS shall discontinue a person's eligibility if any of the conditions of eligibility under this Article are not met.
- B. Notice. AHCCCS shall follow the discontinuance notice requirements under A.A.C. R9-22-1415, except where it states "Department" replace the term with "Administration."

Historical Note

New Section made by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Section R9-29-211 repealed; new Section R9-29-211 renumbered from R9-29-222 and amended by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-212. Renewals

- A. QMB and SLMB. AHCCCS shall renew a person's eligibility for QMB or SLMB at least one time every 12 months.
- B. QI-1. A person receiving QI-1 benefits shall reapply every 12 months.

Historical Note

New Section made by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Section R9-29-212 repealed; new Section R9-29-212 made by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-213. Reporting Changes

A person eligible under this Article shall report to an ALTCS or Social Security Insurance Medical Assistance Only (SSI-MAO) office the following changes for the person, the person's spouse, or the person's dependent children:

1. A change of address;
2. An admission to, or discharge from, a public institution, as specified in A.A.C. R9-22-1402;
3. A change in household composition;
4. A change in income;
5. A determination of eligibility for other benefits;
6. A death;
7. A change in marital status;
8. A change in Arizona state residency;
9. A change in citizenship or alien status;
10. Receipt of a SSN;
11. A change in Medicare receipt or eligibility; and
12. For QMB recipients, a change in first- or third-party liability that may be responsible for payment of all or a portion of the person's medical costs.

Historical Note

New Section made by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Section R9-29-213 renumbered to R9-29-205; new Section R9-29-213 renumbered from R9-29-224 by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-214. Repealed**Historical Note**

New Section made by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Section R9-29-214 repealed by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-215. Renumbered**Historical Note**

New Section made by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Section R9-29-215 renumbered to R9-29-206 by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-216. Repealed**Historical Note**

New Section made by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Section R9-29-216 repealed by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-217. Repealed**Historical Note**

New Section made by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Section R9-29-217 repealed by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-218. Repealed**Historical Note**

New Section made by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Section R9-29-218 repealed by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-219. Renumbered**Historical Note**

New Section made by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Section R9-29-219 renumbered to R9-29-208 by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-220. Renumbered**Historical Note**

New Section made by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Section R9-29-220 renumbered to R9-29-209 by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-221. Renumbered**Historical Note**

New Section made by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Section R9-29-221 renumbered to R9-29-210 by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-222. Renumbered**Historical Note**

New Section made by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Section R9-29-222 renumbered to R9-29-211 by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-223. Repealed**Historical Note**

New Section made by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Section R9-29-223 repealed by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-224. Renumbered**Historical Note**

New Section made by final rulemaking at 9 A.A.R. 5142,

effective January 3, 2004 (Supp. 03-4). Section R9-29-224 renumbered to R9-29-213 by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

ARTICLE 3. BENEFITS AND SERVICES**R9-29-301. QMB Only**

- A.** QMB benefits. For a person determined eligible as a QMB Only, the Administration shall provide payment of:
1. Medicare Part A premium,
 2. Medicare Part B premium, and
 3. Medicare coinsurance and Medicare deductible for Medicare services covered under Title XVIII of the Social Security Act to the provider.
- B.** Payment of QMB Only benefits. The Administration shall not pay coinsurance or deductible to a member.

Historical Note

Adopted effective May 23, 1990 (Supp. 90-2). Amended effective April 14, 1998 (Supp. 98-2). Amended by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-302. QMB Dual Member

- A.** Covered services. A person determined to be a QMB Dual eligible member shall receive medical services provided under 9 A.A.C. 22, Article 2, or services provided under 9 A.A.C. 28, Article 2, in addition to the Medicare-related payments under R9-29-301(A).
- B.** Premiums. The Administration pays Medicare part A and B premiums for a QMB Dual member enrolled with a contractor in a plan or AHCCCS Fee-For-Service.
- C.** The Administration's payment responsibilities.
1. The Administration shall pay the following costs for members not enrolled with contractors. When services are received from an AHCCCS registered provider and the service is covered:
 - a. By Medicare only, the Administration shall pay the Medicare coinsurance and deductible.
 - b. By Medicaid only, the Administration shall pay the lesser of billed charges or the Capped Fee-For-Service Schedule rate for the services covered under 9 A.A.C. 22, Article 2 and 9 A.A.C. 28, Article 2.
 - c. By both Medicare and Medicaid, the Administration shall pay Medicare coinsurance and deductible.
 2. When services are received from a non-registered provider and the service is covered, the Administration shall not pay the Medicare coinsurance and deductible.
- D.** The contractor's payment responsibilities. Unless the subcontract with the provider sets forth different terms, when the enrolled member receives services from an AHCCCS registered provider in or out of network and the service is covered:
1. By Medicare only, the contractor shall pay the Medicare coinsurance and deductible.
 2. By Medicaid only, the contractor shall pay the provider in accordance with the contract.
 3. By both Medicare and Medicaid, the contractor shall pay the lesser of:
 - a. The Medicare copay, coinsurance or deductible, or
 - b. The difference between the Health plan contracted rate and the Medicare paid amount.
- E.** Member responsibilities. A QMB Dual eligible member who receives services under 9 A.A.C. 22, Article 2 or 9 A.A.C. 28, Article 2 from a registered provider is not liable for any Medicare copay, coinsurance or deductible associated with those services and is not liable for any balance of billed charges.

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- F. Coordination of prescription drug benefit with Medicare Part D. Notwithstanding subsections (A) through (D), services do not include pharmaceutical services to the extent limited under 42 U.S.C. 1396u-5(d). A contractor is not liable for any Medicare copay, coinsurance or deductible associated with pharmaceutical services subject to the limitation under 42 U.S.C. 1396u-5(d).

Historical Note

Adopted effective May 23, 1990 (Supp. 90-2). Amended effective April 14, 1998 (Supp. 98-2). Amended by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 12 A.A.R. 864, effective March 7, 2006 (Supp. 06-1). Amended by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-303. Non-QMB Dual Member

- A. Covered services. A person determined to be a Non-QMB Dual eligible member shall receive medical services and provisions under 9 A.A.C. 22, Article 2, or services and provisions under 9 A.A.C. 28, Article 2.
- B. Premiums. The Administration pays Medicare part B premiums for a Non-QMB dual member enrolled with a contractor in a plan or AHCCCS Fee-For-Service for the following individuals:
1. An individual described in 42 CFR 431.625;
 2. An individual enrolled in ALTCS but who does not qualify as a QMB, SLMB or QI;
 3. An individual who is eligible for Medicaid under a mandatory or optional Title XIX coverage group for the aged, blind, or disabled (SSI-MAO);
 4. An individual who is eligible for continued coverage while eligibility redetermination is pending as described under 42 CFR 435.1003;
 5. An individual who is in the guaranteed enrollment period described in 42 CFR 435.212 and the state was paying the individual's Part B premium before eligibility terminated.
- C. The Administration's payment responsibilities.
1. The Administration shall pay the following costs for members not enrolled with contractors. When services are received from an AHCCCS registered provider and the service is covered up to the limitations described within 9 A.A.C. 22, Article 2:
 - a. By Medicare only, the Administration shall not pay the Medicare copay, coinsurance or deductible.
 - b. By Medicaid only, the Administration shall pay the lesser of billed charges or the Capped Fee-For-Service Schedule rate for the services covered under 9 A.A.C. 22, Article 2 and 9 A.A.C. 28, Article 2.
 - c. By both Medicare and Medicaid, the Administration shall pay the Medicare copay, coinsurance or deductible.
 2. When services are received from a non-registered provider and the service is covered, the Administration shall not pay the Medicare copay, coinsurance or deductible.
- D. The contractor's payment responsibilities.
1. When an enrolled member receives services within the network of contracted providers and the service is covered up to the limitations described within 9 A.A.C. 22, Article 2:
 - a. By Medicare only, the contractor shall not pay the Medicare copay, coinsurance or deductible.
 - b. By Medicaid only, the contractor shall pay the provider in accordance with the subcontract.
 2. When an enrolled member receives services from a non-contracting provider and the service is covered:
 - a. By Medicare only, the contractor has no responsibility for payment.
 - b. By Medicaid only, and the contractor has not referred the member to the provider or has not authorized the provider to render services and the services are not emergent, the contractor has no responsibility for payment.
 - c. By Medicaid only, and the contractor has referred the member to the provider or has authorized the provider to render services or the services are emergent, the contractor shall pay in accordance with A.A.C. R9-22-705.
 - d. By both Medicare and Medicaid, and the contractor has not referred the member to the provider or has not authorized the provider to render services and the services are not emergent, the contractor has no responsibility for payment.
 - e. By both Medicare and Medicaid, and the contractor has referred the member to the provider or has authorized the provider to render services or the services are emergent, the contractor shall pay the lesser of:
 - i. The Medicare copay, coinsurance or deductible, or
 - ii. Any amount remaining after the Medicare paid amount is deducted from the amount otherwise payable under A.A.C. R9-22-705.
- E. Member responsibilities.
1. A Non-QMB Dual eligible member who receives covered services under 9 A.A.C. 22, Article 2 or 9 A.A.C. 28, Article 2 from a provider within the contractor's network is not liable for any Medicare copay, coinsurance or deductible associated with those services and is not liable for any balance of billed charges unless services have reached the limitations described within 9 A.A.C. 22, Article 2.
 2. When an enrolled member chooses to receive services out of network that are covered by both Medicare and Medicaid, the member is responsible for any Medicare copay, coinsurance or deductible associated with those services unless the contractor is responsible as described in A.A.C. R9-22-705 and the provider has complied with A.A.C. R9-22-702.
- F. Coordination of prescription drug benefit with Medicare Part D. Notwithstanding subsections (A) through (D), services do not include pharmaceutical services to the extent limited under 42 U.S.C. 1396u-5(d). A contractor is not liable for any Medicare copay, coinsurance or deductible associated with pharmaceutical services subject to the limitation under 42 U.S.C. 1396u-5(d).

Historical Note

New Section made by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Section R9-29-303 repealed; new Section R9-29-303 made by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-304. SLMB and QI-1

AHCCCS shall pay the Medicare Part B premiums.

Historical Note

New Section made by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

ARTICLE 4. REPEALED**R9-29-401. Repealed****Historical Note**

Adopted effective May 23, 1990 (Supp. 90-2). Amended effective April 14, 1998 (Supp. 98-2). Amended by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Section R9-29-401 repealed by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-402. Repealed**Historical Note**

Adopted effective May 23, 1990 (Supp. 90-2). Repealed effective April 14, 1998 (Supp. 98-2).

R9-29-403. Repealed**Historical Note**

Adopted effective May 23, 1990 (Supp. 90-2). Repealed effective April 14, 1998 (Supp. 98-2).

R9-29-404. Repealed**Historical Note**

Adopted effective May 23, 1990 (Supp. 90-2). Repealed effective April 14, 1998 (Supp. 98-2). Repealed text removed from Section Supp. 01-2.

ARTICLE 5. GRIEVANCE SYSTEM PROCESS**R9-29-501. General Provisions for a Grievance and a Request for Hearing**

A request for hearing under this Chapter shall comply with 9 A.A.C. 34. For the purposes of this Article, “hearing” means an administrative hearing under Title 41, Chapter 6, Article 10.

Historical Note

Adopted effective May 23, 1990 (Supp. 90-2). Amended effective April 14, 1998 (Supp. 98-2). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 3372, effective August 7, 2000 (Supp. 00-3). Amended by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-502. Repealed**Historical Note**

Adopted effective May 23, 1990 (Supp. 90-2). Amended effective April 14, 1998 (Supp. 98-2). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 3372, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4).

R9-29-503. Repealed**Historical Note**

Adopted effective May 23, 1990 (Supp. 90-2). Amended effective April 14, 1998 (Supp. 98-2). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 3372, effective August 7, 2000 (Supp. 00-3). Amended by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Section R9-29-503 repealed by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-504. Repealed**Historical Note**

Adopted effective May 23, 1990 (Supp. 90-2). Repealed effective April 14, 1998 (Supp. 98-2).

ARTICLE 6. FIRST- AND THIRD-PARTY LIABILITY AND RECOVERIES**R9-29-601. First- and Third-party Liability and Recoveries**

The provisions specified in 9 A.A.C. 22, Article 10 apply to this Section. For the purposes of this Article, “third-party liability” means the resources available from a person, entity, or program that is or may be, by agreement, circumstance, or otherwise, liable to pay all or part of the medical expenses incurred by an applicant or member.

Historical Note

Adopted effective May 23, 1990 (Supp. 90-2). Amended effective April 14, 1998 (Supp. 98-2). Amended by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 18 A.A.R. 3139, effective January 6, 2013 (Supp. 12-4).

R9-29-602. Repealed**Historical Note**

Adopted effective May 23, 1990 (Supp. 90-2). Amended effective April 14, 1998 (Supp. 98-2). Section repealed by final rulemaking at 9 A.A.R. 5142, effective January 3, 2004 (Supp. 03-4).

TITLE 9. HEALTH SERVICES

CHAPTER 33. DEPARTMENT OF HEALTH SERVICES

GROUP HOMES FOR INDIVIDUALS WITH A DEVELOPMENTAL DISABILITY

Editor's Note: 9 A.A.C. 33, consisting of Articles 1 and 2, made by final rulemaking at 8 A.A.R. 910, effective February 11, 2002 (Supp. 02-1).

ARTICLE 1. LICENSURE REQUIREMENTS

Article 1, consisting of Sections R9-33-101 through R9-33-107, made by final rulemaking at 8 A.A.R. 910, effective February 11, 2002 (Supp. 02-1).

Section

R9-33-101.	Definitions
R9-33-102.	Requirement for Licensure
R9-33-103.	Individuals to Act for Applicant or Licensee
R9-33-104.	Application and Inspection
R9-33-105.	License Renewal
R9-33-106.	Changes Affecting a License
R9-33-107.	Investigation of Complaints
R9-33-108.	Time-frames
R9-33-109.	Denial, Revocation, or Suspension of a License
Table 1.1	Time-frames (in days)

ARTICLE 2. GROUP HOME REQUIREMENTS

Article 2, consisting of Sections R9-33-201 through R9-33-207, made by final rulemaking at 8 A.A.R. 910, effective February 11, 2002 (Supp. 02-1).

Section

R9-33-201.	Emergency Procedures and Evacuation Drills
R9-33-202.	Fire Safety Requirements
R9-33-203.	Physical Plant Requirements
R9-33-204.	Environmental Requirements
R9-33-205.	Vehicle Safety Requirements
R9-33-206.	Swimming Pool Requirements
R9-33-207.	Repealed

ARTICLE 1. LICENSURE REQUIREMENTS**R9-33-101. Definitions**

In addition to the definitions in A.R.S. § 36-551, the following definitions apply in this Chapter unless otherwise specified:

1. "Accreditation" means recognition as having met the operating standards and criteria of a nationally recognized accreditation organization.
2. "Administrative completeness review time-frame" means the same as in A.R.S. § 41-1072.
3. "Applicant" means an individual or business organization requesting a license under R9-33-104 to open a group home.
4. "Application packet" means the forms, documents, and additional information the Department requires to be submitted by an applicant.
5. "Business organization" means the same as "entity" in A.R.S. § 10-140.
6. "Controlling person" means a person who, with respect to a business organization:
 - a. Through ownership, has the power to vote at least 10% of the outstanding voting securities of the business organization;
 - b. If the business organization is a partnership, is a general partner or is a limited partner who holds at least 10% of the voting rights of the partnership;
 - c. If the business organization is a corporation, association, or limited liability company, is the president, the chief executive officer, the incorporator, an agent, or any person who owns or controls at least 10% of the voting securities; or
- d. Holds a beneficial interest in 10% or more of the liabilities of the business organization.
7. "Day" means a calendar day, not including the day of the act, event, or default from which a designated period of time begins to run, but including the last day of the period unless it is a Saturday, Sunday, or state holiday, in which case the period runs until the end of the next day that is not a Saturday, Sunday, or state holiday.
8. "Department" means the Arizona Department of Health Services.
9. "Documentation" means information in written, photographic, electronic, or other permanent form.
10. "Facility" means the building or buildings used for operating a group home.
11. "Fire risk prevention level" means a designation applied to a group home by the Division based on a formula aggregating safety factors existing at the group home.
12. "Hazard" means an object, equipment, situation, or condition that may result in physical injury or illness to an individual.
13. "Licensee" means the individual or business organization to which the Department has issued a license to operate a group home.
14. "Modification" means the substantial improvement, enlargement, reduction, alteration, or other substantial change in the facility or another structure on the premises at a group home.
15. "Overall time-frame" means the same as in A.R.S. § 41-1072.
16. "Plumbing system" means fixtures, pipes, and related parts, including a septic apparatus, assembled to carry clean water into a structure and to carry sewage out of a structure.
17. "Premises" means:
 - a. A facility; and
 - b. The grounds surrounding the facility that are owned, leased, or controlled by the licensee, including other structures.
18. "Private residential swimming pool" means the same as in A.A.C. R18-5-201.
19. "Resident" means an individual who is accepted by a licensee under the terms of a contract with the Division to live at the licensee's group home.
20. "Safety-approved" means tested and designated as meeting applicable safety standards by one or more of the following organizations:
 - a. Underwriters Laboratories,
 - b. Canadian Standards Association, or
 - c. Factory Mutual Insurance Company Global.
21. "Service provider contract" means the entirety of an applicant's or licensee's qualified vendor agreement with the Division.
22. "Spa" means the same as in A.A.C. R18-5-201.
23. "Staff" means the employees or volunteers who provide habilitation to residents at a group home.
24. "Substantive review time-frame" means the same as in A.R.S. § 41-1072.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 910, effective February 11, 2002 (Supp. 02-1). Amended by final rulemaking at 18 A.A.R. 3295, effective February 3, 2013 (Supp. 12-4).

R9-33-102. Requirement for Licensure

- A.** An applicant shall obtain a license to operate a group home from the Department before providing supervision or habilitation to an individual with a developmental disability in a group home.
- B.** A license to operate a group home is valid for the following, as indicated on the license:
1. Address of the group home;
 2. Name of the licensee;
 3. Name of the group home, if applicable;
 4. Fire risk prevention level; and
 5. Licensing period for the group home.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 910, effective February 11, 2002 (Supp. 02-1). Amended by final rulemaking at 18 A.A.R. 3295, effective February 3, 2013 (Supp. 12-4).

R9-33-103. Individuals to Act for Applicant or Licensee

When an applicant or licensee is required by this Chapter to provide information on or sign an application form or other document, the following shall satisfy the requirement on behalf of the applicant or licensee:

1. If the applicant or licensee is an individual, the individual; and
2. If the applicant or licensee is a business organization, the individual who the business organization has designated to act on the business organization's behalf for purposes of this Chapter and who:
 - a. Is a controlling person of the business organization,
 - b. Is a U.S. citizen or legal resident, and
 - c. Has an Arizona address.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 910, effective February 11, 2002 (Supp. 02-1). R9-33-103 renumbered to R9-33-104; new R9-33-103 made by final rulemaking at 18 A.A.R. 3295, effective February 3, 2013 (Supp. 12-4).

R9-33-104. Application and Inspection

- A.** For a license to operate a group home, an applicant shall submit to the Department a completed application packet that contains:
1. An application form provided by the Department that includes:
 - a. The applicant's name;
 - b. The proposed group home's name, if any;
 - c. The address and telephone number of the proposed group home;
 - d. The applicant's address and telephone number, if different from the address or telephone number of the proposed group home;
 - e. The applicant's e-mail address;
 - f. The name and contact information of an individual acting on behalf of the applicant according to R9-33-103, if applicable;
 - g. Whether the applicant agrees to allow the Department to submit supplemental requests for information under R9-33-108(C)(3);
 - h. Whether the applicant is a current service provider or intends to become a service provider;

- i. The fire risk prevention level at which the applicant anticipates operating the group home; and
 - j. The applicant's signature and the date signed;
2. A copy of the applicant's:
- a. U.S. passport, current or expired;
 - b. Birth certificate;
 - c. Naturalization documents; or
 - d. Documentation of legal resident alien status;
3. A copy of the applicant's:
- a. Current service provider contract with the Division indicating that services are to be provided at the address of the proposed group home; or
 - b. Documentation from the Division demonstrating that the applicant has a service provider contract pending for providing services at the address of the proposed group home; and
4. A copy of the applicant's accreditation report issued by a nationally recognized accreditation organization, if applicable.
- B.** An applicant or licensee shall allow the Department immediate access to all areas of the premises, a resident, record, or vehicle used to transport a resident, according to A.R.S. § 41-1009.
- C.** Upon receipt of the application packet in subsection (A), the Department shall issue or deny a license to an applicant as provided in R9-33-108.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 910, effective February 11, 2002 (Supp. 02-1). R9-33-104 renumbered to R9-33-105; new R9-33-104 renumbered from R9-33-103 and amended by final rulemaking at 18 A.A.R. 3295, effective February 3, 2013 (Supp. 12-4).

R9-33-105. License Renewal

- A.** At least 60 days before the expiration date indicated on a license to operate a group home, for renewal of the license to operate a group home, a licensee shall submit to the Department an application packet that contains the information and documents in R9-33-104(A)(1), R9-33-104(A)(3)(a), and R9-33-104(A)(4).
- B.** The Department shall renew a license to operate a group home:
1. If, after conducting an onsite inspection, the Department determines that the licensee is in compliance with the applicable requirements in this Chapter; and
 2. According to the time-frames in R9-33-108.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 910, effective February 11, 2002 (Supp. 02-1). R9-33-105 renumbered to R9-33-106; new R9-33-105 renumbered from R9-33-104 and amended by final rulemaking at 18 A.A.R. 3295, effective February 3, 2013 (Supp. 12-4).

R9-33-106. Changes Affecting a License

- A.** A licensee shall notify the Department in writing at least 30 days before the effective date of:
1. Termination of operation of a group home;
 2. Termination of a service provider contract with the Division;
 3. A change in the ownership of the group home;
 4. A change in the name of the group home;
 5. If the licensee is an individual, a legal change of the licensee's name;
 6. Construction or modification of the facility or another structure on the premises other than construction or modification undertaken in accordance with R9-33-203(A); or

7. If approved by the Division, a change in the group home's fire risk prevention level.
- B. If the Department receives the notification in subsection (A)(1), the Department shall void the licensee's license to operate a group home as of the termination date specified by the licensee.
- C. If the Department receives the notification in subsection (A)(2), the Department shall take the applicable action in R9-33-109.
- D. If the Department receives the notification in subsection (A)(3), the Department shall void the licensee's license to operate a group home upon issuance of a new license to operate a group home to the entity assuming ownership of the group home.
- E. If the Department receives the notification in subsection (A)(4) or (5), the Department shall issue to the licensee an amended license that incorporates the change but retains the expiration date of the existing license.
- F. If the Department receives the notification in subsection (A)(6) or (7), the Department shall conduct an inspection of the premises as indicated in R9-33-104(B) and, if the group home is in compliance with A.R.S. Title 36, Chapter 5.1 and this Chapter, if applicable, issue to the licensee an amended license that incorporates the change but retains the expiration date of the existing license.
- G. An individual or business organization planning to assume operation of an existing group home shall obtain a new license as required in R9-33-102(A) before beginning operation of the group home.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 910, effective February 11, 2002 (Supp. 02-1). R9-33-106 renumbered to R9-33-107; new R9-33-106 renumbered from R9-33-105 and amended by final rulemaking at 18 A.A.R. 3295, effective February 3, 2013 (Supp. 12-4).

R9-33-107. Investigation of Complaints

- A. Upon receipt of a complaint or information indicating that a group home may not be in compliance with A.R.S. Title 36, Chapter 5.1 or this Chapter, the Department shall:
 1. Investigate the complaint or information about noncompliance within 30 days after receipt of the complaint or information about noncompliance;
 2. Develop a written report documenting the investigation;
 3. Provide the licensee with the written report in subsection (A)(2); and
 4. If the complaint or information about noncompliance was substantiated, notify the Division of the outcome of the investigation.
- B. If the Department substantiates a complaint or information about noncompliance at a group home, the licensee of the group home shall:
 1. Establish a plan of correction, if applicable, for correction of a deficiency;
 2. Agree to carry out the plan of correction by signing the written report in subsection (A)(2); and
 3. Ensure that a deficiency listed on the plan of correction is corrected within 30 days after the date of the plan of correction or within a time period the Department and the licensee agree upon in writing.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 910, effective February 11, 2002 (Supp. 02-1). R9-33-107 renumbered to R9-33-109; new R9-33-107 renumbered from R9-33-106 and amended by final rulemaking at 18 A.A.R. 3295, effective February 3, 2013 (Supp. 12-4).

R9-33-108. Time-frames

- A. The overall time-frame described in A.R.S. § 41-1072 for a license granted by the Department under this Chapter is set forth in Table 1.1. The applicant or licensee and the Department may agree in writing to extend the substantive review time-frame and the overall time-frame. An extension of the substantive review time-frame and the overall time-frame may not exceed 25% of the overall time-frame.
- B. The administrative completeness review time-frame described in A.R.S. § 41-1072 for a license granted by the Department under this Chapter is set forth in Table 1.1 and begins on the date that the Department receives an application packet.
 1. The Department shall send a notice of administrative completeness or deficiencies to the applicant or licensee within the administrative completeness review time-frame.
 - a. A notice of deficiencies shall list each deficiency and the information or items needed to complete the application.
 - b. The administrative completeness review time-frame and the overall time-frame are suspended from the date that the notice of deficiencies is sent until the date that the Department receives all of the missing information or items from the applicant or licensee.
 - c. If an applicant or licensee fails to submit to the Department all of the information or items listed in the notice of deficiencies within 120 days after the date that the Department sent the notice of deficiencies or within a time period the applicant or licensee and the Department agree upon in writing, the Department shall consider the application withdrawn.
 2. If the Department issues a license during the administrative completeness review time-frame, the Department shall not issue a separate written notice of administrative completeness.
- C. The substantive review time-frame described in A.R.S. § 41-1072 is set forth in Table 1.1 and begins on the date of the notice of administrative completeness.
 1. As part of the substantive review of an application for a license, the Department shall conduct an inspection that may require more than one visit to the group home.
 2. The Department shall send a license or a written notice of denial of a license within the substantive review time-frame.
 3. During the substantive review time-frame, the Department may make one comprehensive written request for additional information, unless the applicant or licensee has agreed in writing to allow the Department to submit supplemental requests for information.
 - a. If the Department determines that an applicant or licensee, a group home, or the premises are not in substantial compliance with A.R.S. Title 36, Chapter 5.1 and this Chapter, the Department shall send a comprehensive written request for additional information that includes a written statement of deficiencies stating each statute and rule upon which noncompliance is based.
 - b. An applicant or licensee shall submit to the Department all of the information requested in a comprehensive written request for additional information or a supplemental request for information, including, if applicable, documentation of the corrections required in a statement of deficiencies, within 30 days after the date of the comprehensive written request for additional information or the supplement-

tal request for information or within a time period the applicant or licensee and the Department agree upon in writing.

- c. The substantive review time-frame and the overall time-frame are suspended from the date that the Department sends a comprehensive written request for additional information or a supplemental request for information until the date that the Department receives all of the information requested, including, if applicable, documentation of corrections required in a statement of deficiencies.
 - d. If an applicant or licensee fails to submit to the Department all of the information requested in a comprehensive written request for additional information or a supplemental request for information, including, if applicable, documentation of corrections required in a statement of deficiencies, within the time prescribed in subsection (C)(3)(b), the Department shall deny the application.
4. The Department shall issue a license if the Department determines that the applicant or licensee and the group home, including the premises, are in substantial compliance with A.R.S. Title 36, Chapter 5.1 and this Chapter.
 5. If the Department denies a license, the Department shall send to the applicant or licensee a written notice of denial setting forth the reasons for denial and all other information required by A.R.S. § 41-1076.

Historical Note

New Section made by final rulemaking at 18 A.A.R. 3295, effective February 3, 2013 (Supp. 12-4).

R9-33-109. Denial, Revocation, or Suspension of a License

- A. The Department may deny an application or suspend or revoke a license to operate a group home if:
 1. An applicant or licensee does not meet the application requirements contained in R9-33-104 or R9-33-105(A);
 2. A licensee is not a service provider for the duration of one licensure period;
 3. A licensee does not correct the deficiencies according to the plan of correction contained in R9-33-107 by the time stated in the plan of correction; or
 4. The nature or number of violations revealed by any type of inspection or investigation of a group home poses a direct risk to the life, health, or safety of a resident.
- B. An applicant or licensee may appeal the Department's determination in subsection (A) according to A.R.S. Title 41, Chapter 6, Article 10.
- C. The Department shall immediately notify the Division when an application is denied and when a license to operate a group home is suspended or revoked.

Historical Note

New Section renumbered from R9-33-107 and amended by final rulemaking at 18 A.A.R. 3295, effective February 3, 2013 (Supp. 12-4).

Table 1.1 Time-frames (in days)

Type of approval	Statutory authority	Overall time-frame	Administrative completeness review time-frame	Substantive review time-frame
Application for a license under R9-33-104	A.R.S. § 36-132(A)(21)	120	60	60
Renewal of a license under R9-33-105	A.R.S. § 36-132(A)(21)	60	30	30

Historical Note

Table 1.1 made by final rulemaking at 18 A.A.R. 3295, effective February 3, 2013 (Supp. 12-4).

ARTICLE 2. GROUP HOME REQUIREMENTS

R9-33-201. Emergency Procedures and Evacuation Drills

- A. A licensee shall ensure that a written plan for emergencies:
 1. Is developed and implemented;
 2. Is available and accessible to staff and each resident at the facility;
 3. Contains procedures for responding to fire, emergency, severe weather conditions, and other disasters, including:
 - a. Routes of evacuation, location of firefighting equipment, and evacuation devices identified on a floor plan of the facility;
 - b. Instructions on the use of fire alarm systems, firefighting equipment, and evacuation devices;
 - c. Procedures for evacuating each resident, including a resident who is not capable of self-preservation or who has a mobility, sensory, or other physical impairment; and
 - d. Procedures for notifying an emergency response team, law enforcement, and the licensee or the licensee's designee; and
 4. Includes procedures for when a resident is missing from the premises.
- B. A licensee shall ensure that:

1. The facility's street address is painted or posted against a contrasting background so that the group home's street address is visible from the street; or
2. The local emergency response team, such as the local fire department, is notified of the location of the facility in writing at least once every 12 months. The licensee shall make the written notification available for review at the facility for at least two years from the date of the notification.
- C. A licensee shall ensure that:
 1. Except as described in subsection (D), an evacuation drill that includes all residents, except any residents otherwise specifically excluded from evacuation drills as indicated on documentation provided by the Division for the resident, is conducted at least once every six months on each shift; and
 2. Documentation of an evacuation drill is available for review at the facility for at least two years after the date of the evacuation drill that includes:
 - a. The date and time of the evacuation drill;
 - b. The length of time to evacuate or simulate the evacuation of all residents from the facility;
 - c. A summary of the evacuation drill, including a list of the residents and staff who were present at the time of the drill, how the drill was performed, how

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long the drill took to complete, and, if applicable, a list of residents for whom evacuation was simulated; and

- d. Except as provided in subsection (D)(2), if the length of time to evacuate all residents from the facility exceeds three minutes, a plan of correction to bring the evacuation time to three minutes or less in case of an actual emergency requiring evacuation.

D. If a group home provides services to a resident whom the Division has identified, through the assessment process used to determine the group home's fire risk prevention level, as having a condition that could cause a resident to be harmed if the resident participated in an evacuation drill, a licensee shall ensure that:

1. An evacuation drill:
 - a. Does not include the resident, and
 - b. Simulates the evacuation of the resident according to the plan required in subsection (A)(3)(c), and
2. The documentation of an evacuation drill required in subsection (C)(2) also includes, if the length of time to evacuate or simulate the evacuation of all residents exceeds five minutes, a plan of correction to bring the evacuation time to five minutes or less in case of an actual emergency requiring evacuation.

E. A licensee shall ensure that:

1. A first aid kit is available in the facility that has the following items in a quantity sufficient to meet the needs of residents and staff:
 - a. Adhesive sterile bandages of assorted sizes,
 - b. Sterile gauze pads,
 - c. Sterile gauze rolls,
 - d. Adhesive or self-adhering tape,
 - e. Antiseptic solution or sealed antiseptic wipes,
 - f. Re-closable plastic bags of at least one-gallon size,
 - g. Single-use non-porous gloves,
 - h. Scissors,
 - i. Tweezers, and
 - j. A cardiopulmonary resuscitation mouth guard or mouth shield;
2. All stairways, hallways, walkways, and other routes of evacuation are free of any obstacle that may prevent evacuation of a resident in an emergency;
3. If a window or door contains locks, bars, grills, or other devices that obstruct evacuation, each device contains a release mechanism that is operable from the inside of a facility and that does not require the use of a key, special knowledge, or special effort;
4. Each facility contains a working non-cellular telephone that is available and accessible to staff and each resident at all times; and
5. The following are posted at the location of a facility's telephone:
 - a. Instructions to dial 911 or the telephone number of another local emergency response team, and
 - b. The address and telephone number of the group home.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 910, effective February 11, 2002 (Supp. 02-1). Amended by final rulemaking at 18 A.A.R. 3295, effective February 3, 2013 (Supp. 12-4).

R9-33-202. Fire Safety Requirements

A. The Department shall issue to an applicant or licensee:

1. A fire risk prevention level 1 group home license if the group home meets the requirements in subsections (B) through (G); and
2. A fire risk prevention level 2 group home license if the group home meets the requirements in subsections (B) through (H).

B. A licensee shall ensure that the premises are in compliance with all applicable state and local fire safety regulations and that:

1. Before a license is issued or renewed, a fire inspection is conducted by the local fire department, the Department, or an entity authorized by the Department;
2. Any repair or correction stated in a fire inspection report is made or corrected according to the requirements and time in the fire inspection report; and
3. A current fire inspection report is available for review at the group home.

C. A licensee shall ensure that the facility has at least one working, portable, all-purpose fire extinguisher labeled as rated at least 2A-10-BC by Underwriters Laboratories, or two co-located working, portable, all-purpose fire extinguishers labeled as rated at least 1A-10-BC by Underwriters Laboratories, installed and maintained in the facility as prescribed by the manufacturer or the fire authority having jurisdiction.

D. A licensee shall ensure that a fire extinguisher:

1. Is either:
 - a. Disposable and has a charge indicator showing green or "ready" status; or
 - b. Serviced at least once every 12 months by a fire extinguisher technician certified by the National Fire Protection Agency, the International Code Council, or Compliance Services and Assessments; and
2. If serviced, is tagged specifying:
 - a. The date of purchase or the date of recharging, whichever is more recent; and
 - b. The name of the organization performing the service, if applicable.

E. A licensee shall ensure that smoke detectors are:

1. Working and audible at a level of 75db from the location of each bed used by a resident in the facility;
2. Capable of alerting all residents in the facility, including a resident with a mobility or sensory impairment;
3. Installed according to the manufacturer's instructions;
4. Located in at least the following areas:
 - a. Each bedroom;
 - b. Each room or hallway adjacent to a bedroom, except a bathroom or a laundry room; and
 - c. Each room or hallway adjacent to the kitchen, except a bathroom, a pantry, or a laundry room; and
5. If the licensee has been cited more than once in the previous four years under subsections (E)(1) through (4), either:
 - a. Hard-wired to the electrical system of the group home with a battery backup; or
 - b. Connected to an early-warning fire detection system required in subsection (H)(2), if applicable.

F. A licensee shall ensure that each bedroom has at least one openable window or door to the outside for use as an emergency exit.

G. A licensee shall ensure that:

1. A usable fireplace is covered by a protective screen or covering at all times; and
2. Combustible or flammable materials are not stored within three feet of a furnace, heater, water heater, or usable fireplace.

H. A licensee of a fire risk prevention level 2 group home shall ensure that:

1. The facility contains an emergency lighting system that:
 - a. Works without in-house electrical power,
 - b. Illuminates the path of evacuation, and
 - c. Is inspected at least once every 12 months by the manufacturer or an entity that installs and repairs emergency lighting systems;
2. The facility has an early-warning fire detection system that:
 - a. Is safety-approved;
 - b. Is hard-wired or connected wirelessly, with battery back-up;
 - c. Sounds every alarm in the facility when smoke is detected;
 - d. Is installed in each bedroom, each room or each hallway adjacent to a bedroom, and each room or each hallway adjacent to a kitchen; and
 - e. Is inspected at least once every 12 months by the manufacturer or by an entity that installs and repairs early-warning fire detection systems;
3. The facility has one of the following:
 - a. Sufficient staff on duty to evacuate all residents present at the facility within three minutes or, if applicable under R9-33-201(D), within five minutes; or
 - b. An automatic sprinkler system installed according to the applicable standard incorporated by reference in A.A.C. R9-1-412 and installed according to NFPA 13, NFPA 13R, or NFPA 13D, as applicable, that:
 - i. Covers every room in the facility; and
 - ii. Is inspected at least once every 12 months by the manufacturer or by an entity that installs and repairs automatic sprinkler systems; and
4. Documentation is available at the facility for two years after the date of an inspection:
 - a. For:
 - i. The emergency lighting system inspection required in subsection (H)(1)(c);
 - ii. The early-warning fire detection system inspection required in subsection (H)(2)(e); and
 - iii. If applicable, the automatic sprinkler system required in subsection (H)(3)(b)(ii); and
 - b. That includes:
 - i. The date of the inspection,
 - ii. The name of the entity performing the inspection,
 - iii. A tag on the system or a written report of the results of the inspection, and
 - iv. A description of any repairs made to the system as a result of the inspection.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 910, effective February 11, 2002 (Supp. 02-1). Amended by final rulemaking at 18 A.A.R. 3295, effective February 3, 2013 (Supp. 12-4).

R9-33-203. Physical Plant Requirements**A.** A licensee shall ensure that:

1. A group home is in compliance with applicable federal and state disability laws;
2. If a group home has a resident with a mobility, sensory, or other physical impairment, documentation is available for review at the group home that:
 - a. Is provided by the Division; and

- b. Identifies modifications, if any, needed to the premises to ensure that the premises are accessible to and usable by the resident;

3. The premises have been modified as identified by the Division in subsection (A)(2)(b);
4. Ramps, stairs, or steps on the premises are secured firmly to the ground or a permanent structure and have slip-resistant surfaces; and
5. If handrails and grab bars are installed in a facility, handrails and grab bars are securely attached and stationary.

B. A licensee shall ensure that:

1. A method of heating and cooling maintains the facility between 65° F and 85° F in areas of the facility occupied by residents;
2. Ventilation is provided by an openable window, air conditioning, or other mechanical device;
3. Working, safe appliances for cooling and cooking food are provided in the facility that:
 - a. Are safety-approved;
 - b. If used to refrigerate food, maintain the food at a temperature of 40° F or below at all times; and
 - c. If used to freeze food, maintain the food at a temperature of 0° F or below at all times;
4. Hot water temperatures in the facility are maintained between 95° F and 120° F; and
5. Bathtubs and showers contain slip-resistant strips, rubber bath mats, or slip-resistant surfaces.

C. A licensee shall ensure that:

1. Electrical lighting is contained in each room in the facility;
2. Electrical devices and equipment on the premises are safety-approved, safe, and in working order;
3. Electrical outlets on the premises are safe, covered with a faceplate, and installed in accordance with the requirements of the local jurisdiction;
4. If the facility was built or modified on or after the effective date of this Chapter, any electrical outlet located within 3 feet of a water source includes a ground fault circuit interrupt (GFCI);
5. An appliance, light, or other device with a frayed or spliced electrical cord is not used on the premises; and
6. An electrical cord, including an extension cord, on the premises is not:
 - a. Used as a substitute for permanent wiring,
 - b. Run under a rug or carpeting,
 - c. Run over a nail, or
 - d. Run from one room to another.

D. A licensee shall ensure that:

1. A facility contains a safe, working plumbing system;
2. If a facility's plumbing system is connected to a non-municipal sewage disposal system, the plumbing system and connective piping are free of visible leakage; and
3. The premises do not contain unfenced or uncovered wells, ditches, or holes into which an individual may step or fall.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 910, effective February 11, 2002 (Supp. 02-1). Amended by final rulemaking at 18 A.A.R. 3295, effective February 3, 2013 (Supp. 12-4).

R9-33-204. Environmental Requirements**A.** A licensee shall ensure that:

1. The premises are free of accumulations of garbage or refuse;
2. Garbage and refuse in the facility are:

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- a. Stored in cleanable containers or in sealable plastic bags; and
 - b. Removed from the facility at least once every seven days;
- 3. Cleaning compounds and toxic substances are maintained in labeled containers that:
 - a. Are stored to prevent a hazard;
 - b. Are appropriate to the contents of each container;
 - c. If appropriate based on a resident's disability, are locked; and
 - d. Are stored in a separate location from food or medicine;
- 4. Unused furniture, equipment, fabrics, or devices are removed from the facility or maintained in a covered area on the premises that is designated by the licensee for storage in a manner that does not create a hazard; and
- 5. There are no firearms or ammunition on the premises;
- B.** A licensee shall ensure that:
 - 1. The facility is maintained free of insects and vermin;
 - 2. The premises and its structures and furnishings are:
 - a. In a clean condition,
 - b. Free of odors, such as urine or rotting food; and
 - c. In sufficiently good repair that no object, equipment, or condition present constitutes a hazard; and
 - 3. Standing water is not allowed to accumulate on the premises, except in an area or vessel the purpose of which is to hold standing water.
- C.** A licensee shall ensure that:
 - 1. An unvented space heater or open-flame space heater is not used on the premises;
 - 2. An electric portable heater or electric radiant heater is not used on the premises unless the electric portable heater or electric radiant heater:
 - a. Has:
 - i. Either a non-porous casing or a grill with a mesh small enough to prevent cloth or a child's finger from entering the casing,
 - ii. A tilt switch that shuts off power to the electric portable heater if the electric portable heater tips over,
 - iii. An automatic shutoff control to prevent overheating, and
 - iv. A thermostat control; and
 - b. Is plugged directly into a wall outlet; and
 - 3. A vented space heater used on the premises is:
 - a. Safety-approved;
 - b. Professionally installed in accordance with the requirements of the local jurisdiction; and
 - c. Mounted as a permanent fixture in a wall, floor, or ceiling.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 910, effective February 11, 2002 (Supp. 02-1). Section repealed; new Section renumbered from R9-33-205 and amended by final rulemaking at 18 A.A.R. 3295, effective February 3, 2013 (Supp. 12-4).

R9-33-205. Vehicle Safety Requirements

- A.** A licensee shall ensure that a vehicle used to transport a resident:
 - 1. Is maintained in safe and working order; and
 - 2. Is equipped with:
 - a. A working heating and air conditioning system;
 - b. A first aid kit that meets the requirements in R9-33-201(E)(1);

- c. Working seat belts for the driver and each passenger; and
 - d. Floor mounted seat belts and wheel chair lock-down devices for each wheel chair passenger transported, if the vehicle is used to transport a passenger in a wheelchair.

- B.** A licensee shall ensure that documentation of each maintenance or repair of a vehicle used to transport a resident is available for review at the facility for at least two years after the date of the maintenance or repair.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 910, effective February 11, 2002 (Supp. 02-1). Section renumbered to R9-33-204; new Section renumbered from R-33-206 and amended by final rulemaking at 18 A.A.R. 3295, effective February 3, 2013 (Supp. 12-4).

R9-33-206. Swimming Pool Requirements

- A.** Except as provided in subsection (B), a licensee shall ensure that a private residential swimming pool on the premises:
 - 1. If filled with water, is surrounded by a fence or enclosure constructed of rigid material that:
 - a. Is at least 5 feet high;
 - b. Is free of an opening that exceeds 4 inches or, if a wire mesh fence, is free of an opening that exceeds 1 3/4 inches;
 - c. Is free of openings for handholds or footholds on the exterior of the fence or enclosure;
 - d. Is at least 20 inches from the edge of the private residential swimming pool;
 - e. Is clear of objects out to a distance of 30 inches on either side of the fence or enclosure from the level of the ground to a height of 5 feet above the fence or enclosure;
 - f. Has at least one gate that:
 - i. Opens outward from the private residential swimming pool,
 - ii. Has a self-closing latch attached no less than 54 inches above ground level as measured from the exterior side of the fence or enclosure, and
 - iii. Is locked when the private residential swimming pool is not in use;
 - g. Is secured perpendicular to level ground; and
 - h. Is located at least 54 inches from the exterior wall of the facility to allow evacuation without entering the private residential swimming pool area;
 - 2. Is not located in the path of an emergency exit;
 - 3. If filled with water, is equipped with the following:
 - a. An operational water circulation system that clarifies the swimming pool water,
 - b. An operational vacuum cleaning system that maintains the sides and bottom of the pool free of dirt and debris,
 - c. A shepherd's crook that is attached to its own pole, and
 - d. A ring buoy with an attached rope that is at least 10 feet long plus the distance from the edge to the middle of the private residential swimming pool; and
 - 4. If not filled with water, is covered completely by a covering that:
 - a. Is permitted by the local jurisdiction,
 - b. Is free of an opening that exceeds 1 inch,
 - c. Withstands weight of at least 495 pounds per square foot on all parts of the covering without any distortion or compression, and

- d. Has at least one access hatch that is locked so that a resident cannot open it.
- B. The requirements in subsection (A) do not apply to a group home if the Division provides to the Department written documentation indicating that the Division has determined that the private residential swimming pool is safe, based upon the functional level of the residents:
 - 1. At the time of initial licensure,
 - 2. At the time of license renewal, and
 - 3. Upon the placement of a resident at the group home.
- C. A licensee shall ensure that a spa:
 - 1. Except as specified in subsection (C)(2), is covered and locked when not in use, with a mechanism that a resident cannot open; and

- 2. If a resident is under 6 years of age, is enclosed by a fence specified in subsection (A)(1).

Historical Note

New Section made by final rulemaking at 8 A.A.R. 910, effective February 11, 2002 (Supp. 02-1). Section renumbered to R9-33-205; new Section made by final rulemaking at 18 A.A.R. 3295, effective February 3, 2013 (Supp. 12-4).

R9-33-207. Repealed**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 910, effective February 11, 2002 (Supp. 02-1). Repealed by final rulemaking at 18 A.A.R. 3295, effective February 3, 2013 (Supp. 12-4).

Supplement to the

Arizona Administrative Code

The official compilation of Arizona Rules

Arizona Secretary of State's Office

Public Services Division

1700 W. Washington Street, Fl 7.

Phoenix, AZ 85007

Replacement Check List

For rules filed within the

4th Calendar Quarter

October 1 - December 31, 2012

Code Release Number: Supp. 12-4

Within the stated calendar quarter, this Title contains all rules made, amended, repealed, renumbered, and recodified, or rules that have expired or were terminated due to an agency being eliminated under sunset law. These rules were either certified by the Governor's Regulatory Review Council or the Attorney General's Office, or exempt from the rulemaking process, and filed with the Office of the Secretary of State. Refer to the historical notes for more information. Please note that some rules you are about to remove may still be in effect after the publication date of this Supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

Follow the instructions to replace the updated Chapters.

TITLE 10. LAW

Chapter 4. Arizona Criminal Justice Commission

Sections, Parts, Exhibits, Tables or Appendices modified

R10-4-101 through R10-4-111, R10-4-201 through R10-4-204

REMOVE Supp. 11-3

Pages: 1 - 14

REPLACE with Supp. 12-4

Pages: 1 - 15

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TITLE 10. LAW

CHAPTER 4. ARIZONA CRIMINAL JUSTICE COMMISSION

(Authority: A.R.S. §§ 41-1308 and 41-1309)

ARTICLE 1. CRIME VICTIM COMPENSATION PROGRAM

(Authority: A.R.S. §§ 41-2407 and 41-2402)

Article 1, consisting of Sections R10-4-101 through R10-4-111, adopted effective December 31, 1986.

Section

- R10-4-101. Definitions
- R10-4-102. Administration of the Fund
- R10-4-103. Statewide Operation
- R10-4-104. Operational Unit Requirements
- R10-4-105. Crime Victim Compensation Board
- R10-4-106. Prerequisites for a Compensation Award
- R10-4-107. Submitting a Claim
- R10-4-108. Compensation Award Criteria
- R10-4-109. Hearing; Request for Rehearing
- R10-4-110. State-level Claim Review
- R10-4-111. Emergency Compensation Award

ARTICLE 2. CRIME VICTIM ASSISTANCE PROGRAM

(Authority: A.R.S. §§ 41-2408 and 41-2402)

Article 2, consisting of Sections R10-4-201 through R10-4-207, adopted effective December 22, 1986.

Section

- R10-4-201. Definitions
- R10-4-202. Administration of the Fund
- R10-4-203. Grant Eligibility Requirements
- R10-4-204. Services
- R10-4-205. Renumbered
- R10-4-206. Renumbered
- R10-4-207. Repealed

ARTICLE 3. CRIMINAL JUSTICE ENHANCEMENT FUND

Article 3, consisting of R10-4-301 through R10-4-305, made by final rulemaking at 17 A.A.R. 1469, effective September 10, 2011 (Supp. 11-3).

Article 3, consisting of R10-4-301 through R10-4-305, adopted summary rules filed March 16, 1998; interim effective date of November 28, 1997, now the permanent effective date (Supp. 98-1).

Article 3, consisting of R10-4-301 through R10-4-305, repealed by summary action with an interim effective date of November 28, 1997; filed in the Office of the Secretary of State November 3, 1997 (Supp. 97-4).

Article 3, consisting of Sections R10-4-301 through R10-4-305, adopted effective September 11, 1986.

Section

- R10-4-301. Definitions
- R10-4-302. Contact Information Required
- R10-4-303. Fund Guidelines Required
- R10-4-304. Records Required
- R10-4-305. Complaints

ARTICLE 4. DRUG AND GANG ENFORCEMENT ACCOUNT GRANTS

Article 4 consisting of Sections R10-4-401 through R10-4-404 adopted as permanent rules effective July 18, 1988.

Article 4 consisting of Sections R10-4-401 through R10-4-404 adopted as an emergency effective February 22, 1988 pursuant to A.R.S. § 41-1026, valid for only 90 days. Emergency expired.

Section

- R10-4-401. Definitions
- R10-4-402. General Information Regarding Grants
- R10-4-403. Grant Application
- R10-4-404. Application Evaluation; Standards for Award
- R10-4-405. Request for Modification of Recommended Allocation Plan
- R10-4-406. Required Reports

ARTICLE 5. FULL-SERVICE FORENSIC CRIME LABORATORY ACCOUNT

Article 5, consisting of Sections R10-4-501 through R10-4-504, made by final rulemaking at 7 A.A.R. 2217, effective May 11, 2001 (Supp. 01-2).

Section

- R10-4-501. Definitions
- R10-4-502. Grant Solicitation Process
- R10-4-503. Grant Application Evaluation; Decision of the Commission
- R10-4-504. Reports

ARTICLE 1. CRIME VICTIM COMPENSATION PROGRAM

R10-4-101. Definitions

In this Article:

1. "Board" means the Crime Victim Compensation Board of an operational unit.
2. "Claim" means an application for compensation submitted under this Article.
3. "Claimant" means a natural person who files a claim.
4. "Collateral source" means a source of compensation for economic loss that a claimant received or is accessible to and obtainable by the claimant or that is payable to or on behalf of the victim. Collateral source includes the following sources of compensation:
 - a. The perpetrator or a third party responsible for the perpetrator's actions;
 - b. The United States government or any of its agencies, a state or any of its political subdivisions, or an instrumentality of two or more states, unless:
 - i. The law providing for the compensation makes the compensation excess or secondary to benefits under this Article, or
 - ii. The compensation is made with federal funds granted under 42 U.S.C. 10602;
 - c. Social Security, Medicare, or Arizona Health Care Cost Containment System payments;
 - d. State-required, insurance for a temporary, non-occupational disability;
 - e. Worker's compensation insurance;
 - f. Wage continuation program of any employer;
 - g. Insurance proceeds payable to cover a specific compensable cost due to criminally injurious conduct or an act of international terrorism;
 - h. A contract providing for prepaid hospital and other health care services or disability benefits; and

- i. A gift, devise, or bequest to cover a specific compensable cost.
5. "Commission" means the Arizona Criminal Justice Commission, as established by A.R.S. § 41-2404.
6. "Compensable cost" means an economic loss for which a compensation award is allowed under this Article.
7. "Compensation award" means a payment made to a claimant under the standards at R10-4-108.
8. "Crime scene cleanup expense" means the reasonable and customary cost for:
 - a. Removing or attempting to remove bodily fluids, dirt, stains, and other debris that result from criminally injurious conduct or act of international terrorism occurring within a residence or the surrounding curtilage;
 - b. Repairing or replacing exterior doors, locks, or windows damaged as a direct result of criminally injurious conduct or act of international terrorism occurring within a residence or the surrounding curtilage.
9. "Criminally injurious conduct" means conduct that:
 - a. Constitutes a crime as defined by state or federal law regardless of whether the perpetrator of the conduct is apprehended, charged, or convicted;
 - b. Poses a substantial threat of physical injury, mental distress, or death; and
 - c. Is punishable by fine, imprisonment, or death, or would be punishable but the perpetrator of the conduct lacked the capacity to commit the crime under applicable laws.
10. "Derivative victim" means:
 - a. The spouse, child, parent, stepparent, stepchild, sibling, grandparent, grandchild, or guardian of a victim who died as a result of criminally injurious conduct or an act of international terrorism;
 - b. A child born to a victim after the victim's death;
 - c. A person living in the household of a victim who died as a result of criminally injurious conduct or act of international terrorism, in a relationship determined by the Board to be substantially similar to a relationship listed in subsection (10)(a);
 - d. A member of the victim's family who witnessed the criminally injurious conduct or act of international terrorism or who discovered the scene of the criminally injurious conduct or act of international terrorism;
 - e. A natural person who is not related to the victim but who witnessed the criminally injurious conduct or act of international terrorism or discovered the scene of the criminally injurious conduct or act of international terrorism; or
 - f. A natural person whose own mental health counseling and care or presence during the victim's mental health counseling and care is required for the successful treatment of the victim.
11. "Durable medical equipment" means an appliance, apparatus, device, or product that:
 - a. Is medically necessary to treat an injury or condition resulting from criminally injurious conduct or an act of international terrorism;
 - b. Improves the function of an injured body part or delays deterioration of a patient's physical condition;
 - c. Is primarily and customarily used to serve a medical purpose rather than primarily for transportation, comfort, or convenience; and
 - d. Provides the medically appropriate level of performance and quality for the medical injury or condition present.
12. "Economic loss" means financial detriment resulting from medical expense, mental health counseling and care expense, crime scene cleanup expense, funeral expense, or work loss.
13. "Fund" means the Victim Compensation and Assistance Fund established by A.R.S. § 41-2407.
14. "Funeral expense" means a reasonable and customary cost, such as those listed on the Statement of Funeral Goods and Services Selected required under A.A.C. R4-12-307, incurred as a direct result of a victim's funeral, cremation, Native American ceremony, or burial.
15. "Good cause" means a reason that the Board determines is substantial enough to afford a legal excuse.
16. "Inactive claim" means a claim for which no compensation award is made for 12 consecutive months.
17. "Incident of criminally injurious conduct" means all criminal actions that are related to or dependent upon each other regardless of the time involved in perpetrating the actions, number of persons perpetrating the actions, or the number of crimes with which the perpetrator is or could be charged.
18. "International terrorism" has the meaning prescribed in 18 U.S.C. 2331.
19. "Jurisdiction" means any county in this state.
20. "Medical expense" means a reasonable and customary cost for medical care provided to a victim due to a physical injury or medical condition that is a direct result of criminally injurious conduct or an act of international terrorism.
21. "Mental distress" means a substantial disorder of emotional processes, thought, or cognition that impairs judgment, behavior, or ability to cope with the ordinary demands of life.
22. "Mental health counseling and care expense" means a reasonable and customary cost to assess, diagnose, and treat a victim's or derivative victim's mental distress resulting from criminally injurious conduct or an act of international terrorism.
23. "Minimum wage standard" means the uniform minimum wage payable in Arizona under federal or state law, whichever is greater.
24. "Operational unit" means a public or private agency authorized by the Commission to receive, evaluate, and present to the Board a claim.
25. "Program" means the Crime Victim Compensation Program.
26. "Proximate cause" means an event sufficiently related to criminally injurious conduct or act of international terrorism to be held the cause of the criminally injurious conduct or act of international terrorism.
27. "Reasonable and customary" means the normal charge within a specific geographic area for a specific service by a provider of a particular level of experience or expertise.
28. "Resident" means a natural person who is domiciled in Arizona or is in Arizona for other than a temporary or transitory purpose.
29. "Subrogation" means the substitution of the state or an operational unit in place of a claimant to enforce a lawful claim against a collateral source to recover any part of a compensation award made to the claimant using funds of the state or operational unit.
30. "Total and permanent disability" means a physical or mental condition that the Board finds is a proximate

result of criminally injurious conduct or act of international terrorism and:

- a. Produces a significant and sustained reduction in the victim's former mental or physical abilities dramatically altering the victim's ability to interact with others and carry on normal functions of life;
 - b. Lessens the victim's ability to work to a material degree; or
 - c. Causes a physical or neurophysical impairment from which no fundamental or marked improvement in the victim's crime-related condition can reasonably be expected.
31. "Transportation costs" means a travel expense that may be reimbursed to a claimant as follows:
- a. Mileage, calculated at the rate established by:
 - i. The operational unit, or
 - ii. The state if the operational unit has not established a mileage rate;
 - b. Fare expenses; and
 - c. Vehicle rental at the cost specified in the rental agreement.
32. "Victim" means a natural person who suffers a physical injury or medical condition, mental distress, or death as a direct result of:
- a. Criminally injurious conduct,
 - b. An act of international terrorism,
 - c. The person's good faith effort to prevent criminally injurious conduct or an act of international terrorism, or
 - d. The person's good faith effort to apprehend a person suspected of engaging in criminally injurious conduct or an act of international terrorism.
33. "Work loss" means a reduction in income from:
- a. Work that a victim or derivative victim would have performed if the victim had not been a victim; and
 - b. Social Security or Supplemental Security Income that a victim would have received or from which a derivative victim would have benefitted if the victim had not been killed.

Historical Note

Adopted effective December 31, 1986 (Supp. 86-6). Section repealed; new Section R10-4-101 renumbered from R10-4-103 and amended by final rulemaking at 6 A.A.R. 4727, effective November 20, 2000 (Supp. 00-4).

Amended by final rulemaking at 13 A.A.R. 4124, effective January 5, 2008 (Supp. 07-4). Amended by final rulemaking at 18 A.A.R. 3309, effective February 3, 2013 (Supp. 12-4).

R10-4-102. Administration of the Fund

- A. The Commission shall deposit in the Fund all funds received under A.R.S. § 12-116.01 and any other funds received for compensating a claimant.
- B. The Commission shall designate one operational unit for a jurisdiction or jurisdictions to receive an allocation from the Fund each state fiscal year.
- C. The Commission shall distribute a portion of the Fund to each operational unit for expenditure by the Board. The Commission shall distribute the funds using a formula that the Commission determines annually using:
 1. A base amount for each operational unit,
 2. An analysis of the prior year's claim activity,
 3. The share of population of each jurisdiction, and
 4. The share of crime of each jurisdiction.
- D. The Commission shall reserve the lesser of \$50,000 or 10 percent of the Fund to be used in the event of an unforeseen

increase of victimization that causes an operational unit for a particular jurisdiction to lack the funds needed to provide compensation.

- E. If there is an unforeseen increase in victimization in a particular jurisdiction, the Commission shall designate an additional operational unit to accept claims from that jurisdiction or make a compensation award based on the criteria established by R10-4-108.
- F. If, at the end of a fiscal year, an operational unit has unexpended funds received from the Commission, the operational unit shall return the funds to the Commission within 90 days after the end of the fiscal year. The Commission shall deposit the returned funds in the Fund for use in the next fiscal year.
- G. Funds collected by an operational unit through subrogation or restitution may be retained by the operational unit to the extent authorized by the Commission and shall be used to pay compensation awards based on the criteria established by R10-4-108.
- H. An operational unit that receives additional funds for victim compensation shall submit a quarterly, written report to the Commission. The operational unit shall include in the report the amount of additional funds received and distributed to compensate victims or claimants. The Commission shall use the information in the written report to apply for federal matching funds. If matching funds are received, the Commission shall forward the matching funds to the appropriate operational unit.
- I. An operational unit shall use funds to pay administrative costs only to the extent authorized by the Commission.

Historical Note

Adopted effective December 31, 1986 (Supp. 86-6). Amended effective October 28, 1994 (Supp. 94-4). Section repealed; new Section R10-4-102 renumbered from R10-4-104 and amended by final rulemaking at 6 A.A.R. 4727, effective November 20, 2000 (Supp. 00-4). Amended by final rulemaking at 13 A.A.R. 4124, effective January 5, 2008 (Supp. 07-4). Amended by final rulemaking at 18 A.A.R. 3309, effective February 3, 2013 (Supp. 12-4).

R10-4-103. Statewide Operation

For any jurisdiction not served by an operational unit, the Commission shall operate a program in accordance with this Article or provide for a program by contract.

Historical Note

Adopted effective December 31, 1986 (Supp. 86-6). Amended effective October 28, 1994 (Supp. 94-4). Amended effective June 12, 1997 (Supp. 97-2). Former Section R10-4-103 renumbered to R10-4-101; new Section R10-4-103 renumbered from R10-4-105 and amended by final rulemaking at 6 A.A.R. 4727, effective November 20, 2000 (Supp. 00-4). Amended by final rulemaking at 13 A.A.R. 4124, effective January 5, 2008 (Supp. 07-4). Amended by final rulemaking at 18 A.A.R. 3309, effective February 3, 2013 (Supp. 12-4).

R10-4-104. Operational Unit Requirements

- A. To be designated by the Commission as an operational unit for a jurisdiction, a public or private agency shall submit to the Commission a written request for designation.
- B. The Commission shall designate a public or private agency as the operational unit for a jurisdiction or jurisdictions:
 1. Only if the public or private agency agrees not to:
 - a. Use Commission funds or federal funds to supplant funds otherwise available to compensate a victim or claimant;

- b. Make a distinction between a resident and a non-resident in evaluating a claim; and
 - c. Make a distinction in evaluating a claim relating to a federal crime that occurs in Arizona and one relating to a state crime; and
2. Only if the public or private agency agrees to:
- a. Forward to the Board a claim relating to an incident of criminally injurious conduct or an act of international terrorism occurring in the public or private agency's jurisdiction or jurisdictions;
 - b. Forward to the Board a claim made by or on behalf of a resident of the public or private agency's jurisdiction or jurisdictions who is a victim or derivative victim of an incident of criminally injurious conduct or an act of international terrorism occurring in another state, the District of Columbia, Puerto Rico, or any other possession or territory of the United States that does not have a crime victim compensation program that meets the requirements of 42 U.S.C. 10602(b);
 - c. Forward to the Board a claim made by or on behalf of a resident of the public or private agency's jurisdiction or jurisdictions who is a victim or derivative victim of an incident of criminally injurious conduct or an act of international terrorism occurring outside of the United States in an area without a crime compensation program;
 - d. Notify the Commission of any change in the public or private agency's program procedures before the change takes effect and if the change is material, obtain written approval from the Commission before instituting the change;
 - e. Submit a written quarterly financial report to the Commission, on a form provided by the Commission, and provide detailed information regarding the expenditure of funds received from the Commission and those required as a match for funds received from the Commission;
 - f. Provide an application form to a claimant;
 - g. Comply with all civil rights requirements;
 - h. Ensure that each claim is investigated and substantiated before forwarding the claim to the Board for a compensation award; and
 - i. Monitor a compensation award to ensure that amounts paid are consistent with this Article.
- C. If more than one agency requests to be designated by the Commission as an operational unit for a jurisdiction, the Commission shall designate the agency that it determines is better able to evaluate claims and manage the expenditure of public funds. The Commission shall give preference to a public agency if both a public and private agency request designation.

Historical Note

Adopted effective December 31, 1986 (Supp. 86-6).
 Amended effective October 28, 1994 (Supp. 94-4).
 Amended effective June 12, 1997 (Supp. 97-2). Former Section R10-4-104 renumbered to R10-4-102; new Section R10-4-104 renumbered from R10-4-106 and amended by final rulemaking at 6 A.A.R. 4727, effective November 20, 2000 (Supp. 00-4). Amended by final rulemaking at 13 A.A.R. 4124, effective January 5, 2008 (Supp. 07-4). Amended by final rulemaking at 18 A.A.R. 3309, effective February 3, 2013 (Supp. 12-4).

R10-4-105. Crime Victim Compensation Board

- A. Each operational unit shall establish a Crime Victim Compensation Board that consists of an odd number of members with

at least three members. Members of the Board shall not receive compensation for their services but are eligible for travel reimbursement under A.R.S. § 38-621.

- B. Board members serve a three-year term and are eligible for reappointment.
- C. When a Board is first established, approximately one-third of the members shall be appointed for a three-year term, one-third for a two-year term, and one-third for a one-year term. If a Board member is unable to complete the term of the Board member's appointment, the Commission Chairman shall appoint a new Board member for the unexpired term only.
- D. When a Board is first established and when a new member is appointed to an existing Board, the Commission Chairman shall choose the individual to be appointed from a list submitted by the operational unit.
- E. A majority of the Board membership constitutes a quorum that may transact the business of the Board.
- F. The Board shall elect from its membership a chairman and other necessary officers to serve terms determined by the Board.
- G. The Board shall make a compensation award according to this Article and perform other acts necessary for operation of the program.
- H. As required by A.R.S. Title 38, Chapter 3, Article 8, a Board member shall not participate in making any decision regarding a claim or compensation award if the Board member or a relative of the Board member, as defined at A.R.S. § 38-502, has a substantial interest in the decision.
- I. An employee of an operational unit shall not serve as a Board member.
- J. A newly appointed Board member shall meet all training requirements established by the Commission for new Board members within six months of the Board member's date of appointment.
- K. A Board member who is reappointed shall meet all training requirements established by the Commission for reappointed Board members within six months of the Board member's date of reappointment.
- L. A Board member shall not miss more than one-third of Board meetings in a year due to unexcused absence.

Historical Note

Adopted effective December 31, 1986 (Supp. 86-6). Former Section R10-4-105 renumbered to R10-4-103; new Section R10-4-105 renumbered from R10-4-107 and amended by final rulemaking at 6 A.A.R. 4727, effective November 20, 2000 (Supp. 00-4). Amended by final rulemaking at 13 A.A.R. 4124, effective January 5, 2008 (Supp. 07-4). Amended by final rulemaking at 18 A.A.R. 3309, effective February 3, 2013 (Supp. 12-4).

R10-4-106. Prerequisites for a Compensation Award

- A. The Board shall make a compensation award only if it determines that:
- 1. Criminally injurious conduct or an act of international terrorism:
 - a. Occurred in Arizona; or
 - b. Occurred outside of Arizona in an area without a crime compensation program and affected a resident;
 - 2. The criminally injurious conduct or act of international terrorism directly resulted in the victim's physical injury, mental distress, medical condition, or death;
 - 3. The victim of the criminally injurious conduct or act of international terrorism or a person who submits a claim regarding criminally injurious conduct or an act of international terrorism was not:

- a. The perpetrator, an accomplice of the perpetrator, or a person who encouraged or in any way participated in or facilitated the criminally injurious conduct or act of international terrorism that directly resulted in the victim's physical injury, mental distress, medical condition, or death;
 - b. Serving a sentence of imprisonment in any detention facility, home arrest program, or work furlough at the time of the criminally injurious conduct or act of international terrorism that directly resulted in the victim's physical injury, mental distress, medical condition, or death;
 - c. Escaped from serving a sentence of imprisonment in any detention facility, home arrest program, or work furlough at the time of the criminally injurious conduct or act of international terrorism that directly resulted in the victim's physical injury, mental distress, medical condition, or death;
 - d. Convicted of a federal crime and delinquent in paying a fine, monetary penalty, or restitution imposed for the offense if the U.S. Attorney General and the Director of the Administrative Office of the U.S. Courts have issued a written determination that the entities administering federal victim compensation programs have access to an accurate and efficient criminal debt payment tracking system; or
 - e. Convicted of a state crime and delinquent in paying a fine, monetary penalty, or restitution imposed for the crime if the delinquency is identified by the Arizona Administrative Office of the Courts or the Clerk of the Superior Court.
4. The criminally injurious conduct or act of international terrorism was reported to an appropriate law enforcement authority within 72 hours after its discovery;
 5. The victim, derivative victim, or claimant cooperated with law enforcement agencies;
 6. The victim, derivative victim, or claimant incurred economic loss as a direct result of the criminally injurious conduct or act of international terrorism that is not compensable by a collateral source; and
 7. A claim, as described in R10-4-107, was submitted to the operational unit within two years after discovery of the criminally injurious conduct or act of international terrorism.
- B.** The Board shall extend the time limits under subsections (A)(4) and (A)(7) if the Board determines there is good cause for a delay.
- C.** If a victim died as a result of criminally injurious conduct or act of international terrorism, the requirement under subsection (A)(3)(e) is waived for the deceased victim. Expenses incurred by the deceased victim and eligible claimants may be covered.
- D.** If the Board determines that a compensation award does not solely benefit a claimant who is delinquent under subsection (A)(3)(e), the requirement under subsection (A)(3)(e) may be waived for:
1. A claimant who is the parent or legal guardian of a minor victim of criminally injurious conduct or an act of international terrorism, or
 2. A compensation award for expenses under R10-4-108(C)(3).

Historical Note

Adopted effective December 31, 1986 (Supp. 86-6).
 Amended effective December 12, 1990 (Supp. 90-4).
 Amended effective October 28, 1994 (Supp. 94-4).
 Amended effective June 12, 1997 (Supp. 97-2). Former

Section R10-4-106 renumbered to R10-4-104; new Section R10-4-106 renumbered from R10-4-108 and amended by final rulemaking at 6 A.A.R. 4727, effective November 20, 2000 (Supp. 00-4). Former R10-4-106 renumbered to R10-4-108; new R10-4-106 made by final rulemaking at 13 A.A.R. 4124, effective January 5, 2008 (Supp. 07-4). Amended by final rulemaking at 18 A.A.R. 3309, effective February 3, 2013 (Supp. 12-4).

R10-4-107. Submitting a Claim

- A.** If the prerequisites in R10-4-106 are met, a natural person is eligible to submit a claim if the person is:
1. A victim;
 2. A derivative victim;
 3. A person authorized to act on behalf of a victim or a deceased victim's dependent; or
 4. A person who assumed an obligation for or paid an expense directly related to a victim's economic loss.
- B.** If a person is eligible under subsection (A) to submit a claim regarding more than one incident of criminally injurious conduct or act of international terrorism, the person shall submit a separate claim regarding each incident of criminally injurious conduct or act of international terrorism.
- C.** If more than one person is eligible under subsection (A) to submit a claim regarding an incident of criminally injurious conduct or act of international terrorism, each person shall submit a separate claim.
- D.** To apply for a compensation award, a person who is eligible under subsection (A) shall submit a claim, using a form that is available from the Commission, to the operational unit for the jurisdiction in which the incident of criminally injurious conduct occurred or to the operational unit for the jurisdiction in which a victim lives if the incident of criminally injurious conduct is an act of international terrorism or occurred in an area without a victim compensation program. The claimant shall provide the following:
1. About the victim:
 - a. Full name,
 - b. Residential address,
 - c. Gender,
 - d. Date of birth,
 - e. Residential and work telephone numbers,
 - f. Statement of whether the victim is deceased,
 - g. Ethnicity,
 - h. Statement of whether the victim is a resident, and
 - i. Statement of whether the victim is disabled;
 2. About the claimant if the claimant is not the victim:
 - a. Full name;
 - b. Residential address;
 - c. Gender;
 - d. Date of birth;
 - e. Residential and work telephone numbers;
 - f. Relationship to the victim; and
 - g. If there are multiple victims or derivative victims of an incident of criminally injurious conduct or act of international terrorism, the name, residential address, and date of birth of each, and for derivative victims, the relationship to the victim;
 3. About the crime:
 - a. Type of crime;
 - b. Statement of whether the crime was related to domestic violence;
 - c. Statement of whether the crime was a federal crime;
 - d. Date on which crime was committed;
 - e. Date on which crime was reported to law enforcement authorities;

- f. Name of law enforcement agency to which the crime was reported;
 - g. Name of law enforcement officer to whom the crime was reported;
 - h. Law enforcement report number;
 - i. Location of crime;
 - j. Name of perpetrator, if known; and
 - k. Brief description of the crime and resulting injuries;
4. About a civil lawsuit:
 - a. Statement of whether the claimant has or will file a civil lawsuit related to the crime; and
 - b. If the answer to subsection (D)(4)(a) is yes, the name, address, and telephone number of the claimant's attorney;
 5. About benefits from collateral sources:
 - a. List of the benefits the claimant has received since the incident of criminally injurious conduct or act of international terrorism or is entitled to receive; and
 - b. For each benefit identified:
 - i. Type of benefit,
 - ii. Contact address and telephone number; and
 - iii. Claimant's identification or policy number;
 6. About the economic loss for which compensation is requested:
 - a. Medical expenses. A statement of whether the claim includes medical expenses and if so, the name, address, telephone number, account number, and date of service for each provider;
 - b. Mental health counseling and care expenses. A statement of whether the claim includes mental health counseling and care expenses and if so, the name, address, telephone number, account number, and date of service for each provider;
 - c. Work loss expenses. A statement of whether the claim includes work loss expenses and if so, the date on which the claimant was first unable to work, date on which the claimant returned to work, total time lost from work, hourly rate of pay, number of hours worked each week, number of hours worked each day, name, address, and telephone number of employer, and name of supervisor;
 - d. Funeral expenses. A statement of whether the claim includes funeral expenses and if so, the name, address, and telephone number of the provider and the amount paid; and
 - e. Crime scene cleanup expenses. A statement of whether the claim includes crime scene cleanup expenses and if so, the name, address, and telephone number of the provider and the amount paid;
 - f. Transportation costs. A statement of whether the claim includes transportation costs and if so, the reason for travel as listed under R10-4-108(C)(6) and if mileage is claimed, the date and mileage of each trip; and
 7. The claimant's dated signature:
 - a. Certifying that the claimant is eligible to submit a claim and that the information provided is true and correct to the best of the claimant's knowledge;
 - b. Subrogating to the state and operational unit the claimant's right to receive benefits from a collateral source;
 - c. Authorizing the release of confidential information necessary to administer the claim; and
 - d. Authorizing the release to the Program of protected health information that relates to care provided as a result of the criminally injurious conduct or act of international terrorism and is necessary to verify the claim.
- E. A claimant shall attach the following to the claim form submitted under subsection (D):
 1. A copy of all bills, contracts, receipts, and insurance statements relating to each expense claimed under subsection (D)(6); and
 2. If work loss expenses are claimed, a signed statement on official letterhead:
 - a. From the claimant's employer verifying the information provided under subsection (D)(6)(c); and
 - b. If applicable, from the physician or mental health care provider indicating the claimant:
 - i. Was unable to work as a result of being a victim or derivative victim, the length of time the claimant was unable to work, and the date on which the claimant was or will be able to return to work; or
 - ii. Is totally and permanently disabled.

Historical Note

Adopted effective December 31, 1986 (Supp. 86-6). Amended effective October 28, 1994 (Supp. 94-4). Former Section R10-4-107 renumbered to R10-4-105; new Section R10-4-107 renumbered from R10-4-109 and amended by final rulemaking at 6 A.A.R. 4727, effective November 20, 2000 (Supp. 00-4). Former R10-4-107 renumbered to R10-4-109; new R10-4-107 made by final rulemaking at 13 A.A.R. 4124, effective January 5, 2008 (Supp. 07-4). Amended by final rulemaking at 18 A.A.R. 3309, effective February 3, 2013 (Supp. 12-4).

R10-4-108. Compensation Award Criteria

- A. The Board shall meet at least every 60 days to decide, based on the findings made by the operational unit, whether to make a compensation award and if so, the terms and amount of the compensation award. The Board shall make a decision within 60 days after the operational unit receives a claim under R10-4-107 unless good cause exists. The Board shall inform the claimant in writing within 10 days of the Board's decision.
- B. The Board shall not make a compensation award unless it determines that the prerequisites in R10-4-106 are met.
- C. The Board shall make a compensation award only for the following:
 1. Reasonable and customary medical expenses due to the victim's physical injury, medical condition, or death.
 - a. The Board shall include the following as a medical expense:
 - i. Repair of damage to a prosthetic device, eyeglasses or other corrective lenses, or a dental device; and
 - ii. Durable medical equipment.
 - b. The Board shall not include as a medical expense a charge for a private room in a hospital, clinic, convalescent home, nursing care facility, or other institution that provides medical services unless the Board determines that the private room is medically necessary;
 2. Reasonable and customary work loss expenses for:
 - a. A victim whose ability to work is reduced due to physical injury, mental distress, or medical condition resulting from the criminally injurious conduct or act of international terrorism;
 - b. A victim or derivative victim to make a medical or mental health counseling and care visit or attend a court proceeding directly related to the criminally injurious conduct or act of international terrorism;

- c. A derivative victim listed in R10-4-101(10)(a) through (c) if the Board determines the death resulted in a loss of support from the victim to the derivative victim;
 - d. A parent or guardian of a minor victim to transport or accompany the minor victim to a medical or mental health counseling and care visit or court proceeding directly related to the criminally injurious conduct or act of international terrorism;
 - e. A derivative victim to make funeral arrangements or tend to the affairs of a deceased victim if the derivative victim made the funeral arrangements or tended to the affairs of the deceased victim; or
 - f. A family member or guardian or a person living in the victim's household in a relationship similar to those listed in R10-4-101(10)(a) to provide non-skilled nursing care for the victim that is required as a result of the criminally injurious conduct or act of international terrorism;
3. Reasonable and customary funeral expenses. Expenses for clothing, travel, lodging, food, or per diem to attend a victim's funeral, Native American ceremony, or burial are not reasonable and customary funeral expenses and shall not be included in a claim for a compensation award;
 4. Reasonable and customary mental health counseling and care expenses due to a victim's or derivative victim's mental distress resulting from the criminally injurious conduct or act of international terrorism if:
 - a. The mental health counseling and care is provided by an individual who:
 - i. Is licensed for independent practice by the Board of Behavioral Health Examiners,
 - ii. Is a behavioral health professional as defined at A.A.C. R9-20-101,
 - iii. Is a behavioral health technician as defined at A.A.C. R9-20-101 and employed by an agency licensed by the Department of Health Services, or
 - iv. Is authorized to perform mental health counseling and care by the laws of a federally recognized tribe; and
 - b. The mental health counseling and care expenses do not include a charge for a private room in a hospital, clinic, convalescent home, nursing care facility, or any other institution that provides medical services unless the Board determines that the private room is medically necessary;
 5. Reasonable and customary crime scene cleanup expenses due to a victim's homicide, aggravated assault, or sexual assault; and
 6. Reasonable and customary transportation costs related to:
 - a. Obtaining medical care as defined in subsection (C)(1),
 - b. Obtaining mental health counseling and care as defined in subsection (C)(4),
 - c. Attending a court proceeding directly related to the incident of criminally injurious conduct or act of international terrorism that is the subject of the claim,
 - d. The victim obtaining a medical forensic examination or participating in a medical forensic interview, and
 - e. Responding to a substantiated threat to the safety or well-being of the victim or a derivative victim listed in R10-4-101(10)(d).
- D.** The Board shall not make a compensation award to a claimant that exceeds:
1. Twenty-five thousand dollars for all economic loss submitted under a claim as a result of an incident of criminally injurious conduct or act of international terrorism;
 2. The amount available to the operational unit and not committed to other compensation awards at the time the Board makes the compensation award determination;
 3. For work loss expenses:
 - a. Work loss expenses under subsections (C)(2)(a) and (C)(2)(c) are limited to an amount per calendar week equal to 40 hours at the current minimum wage and the maximum amount specified in subsections (D)(1) and (D)(2),
 - b. Work loss expenses under subsections (C)(2)(b) and (C)(2)(d) are limited to an amount per calendar month equal to 40 hours at the current minimum wage and the maximum amount specified in subsections (D)(1) and (D)(2),
 - c. Work loss expenses under subsection (C)(2)(e) are limited to an amount equal to 24 hours at the current minimum wage, and
 - d. Work loss expenses under subsection (C)(2)(f) are limited to an amount equal to 160 hours at the current minimum wage;
 4. For mental health counseling and care expenses, \$5,000 per victim or derivative victim;
 5. For funeral expenses, \$10,000;
 6. For crime scene cleanup expenses, \$2,000 for cleanup provided by a professional service, of which \$500 may be for crime scene cleanup not provided by a professional service to include only repair or cleanup material costs for one-time use items; and
 7. For transportation costs, \$1,500 paid as reimbursement of actual transportation expenses.
- E.** If the Board determines a victim is totally and permanently disabled, the Board may expedite a compensation award for the victim. The Board shall determine the amount of the expedited compensation award to the maximum allowed under subsection (D) and determine whether to provide the amount awarded in a lump sum or periodic payments.
- F.** The Board shall deny or reduce a compensation award to a claimant if:
1. The victim or claimant has recouped or is eligible to recoup the economic loss from a collateral source except if the Board determines that use of a collateral source, excluding benefits from a federal or federally financed program, to pay for mental health counseling and care expenses is not in the best interest of the victim or derivative victim, the Board shall not deny or reduce a compensation award for the mental health counseling and care expenses;
 2. The Board determines that the victim or claimant earned income from substitute work or unreasonably failed to perform available substitute work; or
 3. The Board determines that the victim's physical injury, medical condition, mental distress, or death was due in substantial part to the victim's:
 - a. Negligence,
 - b. Intentional unlawful conduct that was the proximate cause of the incident of criminally injurious conduct or act of international terrorism, or
 - c. Conduct intended to provoke or aggravate that was the proximate cause of the incident of criminally injurious conduct or act of international terrorism.
- G.** The Board shall deny or reduce a compensation award under subsection (F)(3) in proportion to the degree to which the

Board determines the victim is responsible for the victim's physical injury, medical condition, mental distress, or death.

- H.** The Board shall deny a compensation award to a claimant if:
 1. The Board determines that the victim or claimant did not cooperate fully with the appropriate law enforcement agency and the failure to cooperate fully was not due to a substantial health or safety risk. The Board shall use the following criteria to determine whether failure to cooperate fully with law enforcement warrants that a claim be denied:
 - a. The victim or claimant failed to assist in the prosecution of a person who engaged in the criminally injurious conduct or act of international terrorism or failed to appear as a witness for the prosecution;
 - b. The victim or claimant delayed assisting in the prosecution of a suspect and as a result, the suspect of the criminally injurious conduct or act of international terrorism escaped prosecution or the prosecution of the suspect was negatively affected; or
 - c. A law enforcement authority indicates to the Board that the victim or claimant delayed giving information pertaining to the criminally injurious conduct or act of international terrorism, failed to appear when requested without good cause, gave false or misleading information, or attempted to avoid law enforcement authorities; or
 2. The Board determines that the victim or claimant knowingly made a false or misleading statement on the claim or in writing on supporting documents submitted to the Board or operational unit.
- I.** If there are insufficient funds to make a compensation award, the Board may:
 1. Deny the claim,
 2. Make a partial award and reconsider the claim later during the fiscal year, or
 3. Extend the claim into a subsequent fiscal year.
- J.** The Board shall not make a compensation award to pay attorney's fees incurred by a victim or claimant.
- K.** The operational unit, in its discretion, may pay a compensation award directly to a claimant or to a provider.
- L.** The operational unit may close an inactive claim:
 1. Five years after the claim is submitted for an adult victim or derivative victim except in a homicide case;
 2. Ten years after the claim is submitted for a minor victim or derivative victim except in a homicide case; and
 3. Fifteen years after the claim is submitted for a homicide victim or derivative victim.

Historical Note

Adopted effective December 31, 1986 (Supp. 86-6).
 Amended effective October 28, 1994 (Supp. 94-4).
 Amended effective June 12, 1997 (Supp. 97-2). Former Section R10-4-108 renumbered to R10-4-106; new Section R10-4-108 renumbered from R10-4-110 and amended by final rulemaking at 6 A.A.R. 4727, effective November 20, 2000 (Supp. 00-4). Former R10-4-108 renumbered to R10-4-110; new R10-4-108 renumbered from R10-4-106 and amended by final rulemaking at 13 A.A.R. 4124, effective January 5, 2008 (Supp. 07-4).
 Amended by final rulemaking at 18 A.A.R. 3309, effective February 3, 2013 (Supp. 12-4).

R10-4-109. Hearing; Request for Rehearing

- A.** If the prerequisites in R10-4-106 are met, the Board shall conduct a hearing regarding a claim submitted under this Article.
- B.** The Board shall provide a claimant with at least 10 days' notice of a hearing or rehearing.

- C.** The Board shall provide written notice of its decision to the claimant within 10 days after a hearing or rehearing.
- D.** The Board shall serve notice of a compensation-award denial or reduction by personal delivery or certified mail to the last known residence or place of business of the person being served. Service is complete upon personal delivery or five days after mailing by certified mail.
- E.** The Board may request a rehearing of a decision at any time and for any reason under this Article.
- F.** A claimant who is aggrieved by a decision of the Board made at a hearing may request a rehearing of the decision within 30 days after the Board serves notice of the decision. A claimant shall request a rehearing in writing and specify the grounds for the request.
- G.** A claimant may amend a request for a rehearing of a Board decision at any time before it is ruled on by the Board.
- H.** The Board may require additional written explanation of an issue raised in a request for rehearing of a Board decision and may provide for oral argument.
- I.** The Board shall grant a rehearing for any of the following reasons materially affecting a claimant's rights:
 1. Irregularity in the proceedings of the Board or its operational unit or any order or abuse of discretion that deprived the claimant of a fair Board decision;
 2. Misconduct of the Board, the operational unit, or staff of the operational unit;
 3. Newly discovered material evidence that could not, with reasonable diligence, have been discovered and produced at the original Board meeting;
 4. Error in the admission or rejection of evidence or other error of law occurring at the Board meeting; and
 5. The decision is not justified by the evidence or is contrary to law.
- J.** When a rehearing is granted, the Board shall ensure that the rehearing covers only the matters specified under subsection (I) that materially affect a claimant's rights.
- K.** The Board may affirm or modify a decision on all or part of the issues for any of the reasons listed in subsection (I). An order modifying a decision shall specify with particularity the grounds for the order.

Historical Note

Adopted effective December 31, 1986 (Supp. 86-6).
 Amended effective October 28, 1994 (Supp. 94-4). Former Section R10-4-109 renumbered to R10-4-107 by final rulemaking at 6 A.A.R. 4727, effective November 20, 2000 (Supp. 00-4). Section R10-4-109 renumbered from R10-4-107 and amended by final rulemaking at 13 A.A.R. 4124, effective January 5, 2008 (Supp. 07-4).
 Amended by final rulemaking at 18 A.A.R. 3309, effective February 3, 2013 (Supp. 12-4).

R10-4-110. State-level Claim Review

- A.** A claimant who is aggrieved by a decision of a Board made at a rehearing under R10-4-109 may request a state-level claim review of the decision within 30 days after the Board serves notice of the decision. The claimant shall request a state-level claim review in writing, specify the grounds for the request, and submit the request directly to the Commission.
- B.** The State Claim Review Panel shall serve as the decision-making body for state-level claim reviews. The State Claim Review Panel shall consist of the following members:
 1. The Arizona Criminal Justice Commission Crime Victim Services Program Manager,
 2. A representative of the Office of the Attorney General, and

3. A Board chair from an operational unit that is not the operational unit that originally heard the claim being reviewed.
- C. The State Claim Review Panel shall meet as needed to hear claimant requests for a state-level claim review. The State Claim Review Panel shall complete a state-level claim review within 30 days after receiving the written request required under subsection (A).
- D. A claimant may amend a request for a state-level claim review of a Board decision at any time before it is ruled on by the State Claim Review Panel.
- E. When a state-level claim review is granted, the State Claim Review Panel shall ensure that the review:
 1. Considers only evidence previously presented to the Board, and
 2. Decides only whether the Board's decision was consistent with the standards in this Article.
- F. The State Claim Review Panel may affirm or overturn a decision made by a Board.
- G. A decision by the State Claim Review Panel is final. If the Panel overturns a decision made by a Board related to:
 1. Eligibility, the operational unit where the claim originated shall proceed with any further action related to the claim; or
 2. An economic loss, the operational unit where the claim originated shall pay the economic loss using compensation funds available to the operational unit.
- H. The State Claim Review Panel shall provide written notice of the Panel's decision to the claimant and the operational unit that originally heard the claim within 10 days after the state-level claim review.

Historical Note

Adopted effective December 31, 1986 (Supp. 86-6). Amended effective October 28, 1994 (Supp. 94-4). Former Section R10-4-110 renumbered to R10-4-108 by final rulemaking at 6 A.A.R. 4727, effective November 20, 2000 (Supp. 00-4). Section R10-4-110 renumbered from R10-4-108 and amended by final rulemaking at 13 A.A.R. 4124, effective January 5, 2008 (Supp. 07-4). Section R10-4-110 renumbered to R10-4-111; new Section R10-4-110 made by final rulemaking at 18 A.A.R. 3309, effective February 3, 2013 (Supp. 12-4).

R10-4-111. Emergency Compensation Award

- A. After receiving a claim submitted under R10-4-107, an operational unit may grant one emergency compensation award for a claim if the operational unit determines there is a reasonable likelihood that:
 1. The person to whom the emergency compensation award is made is or will be an eligible claimant, and
 2. Serious hardship will result to the person if an immediate compensation award is not made.
- B. An operational unit that makes an emergency compensation award shall ensure that the emergency compensation award does not exceed \$1,000.
- C. If the Board decides under R10-4-108 to make a compensation award to the claimant, the Board shall ensure that the amount of the emergency compensation award is deducted from the final compensation award made to the claimant.

Historical Note

Adopted effective December 31, 1986 (Supp. 86-6). Amended effective October 28, 1994 (Supp. 94-4). Section repealed by final rulemaking at 6 A.A.R. 4727, effective November 20, 2000 (Supp. 00-4). New Section R10-4-111 renumbered from R10-4-110 and amended by final

rulemaking at 18 A.A.R. 3309, effective February 3, 2013 (Supp. 12-4).

ARTICLE 2. CRIME VICTIM ASSISTANCE PROGRAM

R10-4-201. Definitions

In this Article:

1. "Commission" means the Arizona Criminal Justice Commission, established by A.R.S. § 41-2404.
2. "Crime" means conduct, completed or preparatory, committed in Arizona, that is a misdemeanor or felony under state law regardless of whether the perpetrator of the conduct is convicted. Conduct arising out of owning, maintaining, or operating a motor vehicle, aircraft, or water vehicle is not a crime unless the person engaged in the conduct acts intentionally, knowingly, recklessly, or with criminal negligence, to cause physical injury, threat of physical injury, or death.
3. "Financial support from other sources" means that at least one-fourth of the budget for a victim assistance program is from sources, including in-kind contributions, other than the Fund.
4. "Fund" means the Victim Compensation and Assistance Fund established by A.R.S. § 41-2407.
5. "Immediate family" means spouse, child, stepchild, parent, stepparent, sibling, stepbrother, stepsister, grandparent, grandchild, or guardian.
6. "In-kind contribution" means a non-cash donation to which a cash value can be given.
7. "Subrogation" means the substitution of the state or a victim assistance program in the place of a victim to enforce a lawful claim against a third party to recover the cost of services to the victim paid for with financial support from the Fund or other sources.
8. "Substantial financial support from other sources" means that at least half of the financial support to a victim assistance program is from sources, not including in-kind contributions, other than the Fund.
9. "Victim" means a natural person against whom a crime is perpetrated and the victim's immediate family.

Historical Note

Adopted effective December 22, 1986 (Supp. 86-6). Section repealed; new Section R10-4-201 renumbered from R10-4-203 and amended by final rulemaking at 6 A.A.R. 4660, effective November 20, 2000 (Supp. 00-4). Amended by final rulemaking at 13 A.A.R. 4124, effective January 5, 2008 (Supp. 07-4). Amended by final rulemaking at 18 A.A.R. 3309, effective February 3, 2013 (Supp. 12-4).

R10-4-202. Administration of the Fund

- A. The Commission shall deposit in the Fund all funds received under A.R.S. §§ 31-467.06(B) and 31-411(F) and any other funds received for victim assistance.
- B. The Commission shall make distributions from the Fund through a competitive grant process that complies with A.R.S. § 41-2701 et seq. and ensures statewide distribution and effective and efficient use of the funds.
- C. At least six weeks before an application for a grant from the Fund is due, the Commission shall make a grant application form and instructions available on its web site, which is www.azcjc.gov.
- D. To apply for a grant from the Fund, an authorized official of a public agency or private nonprofit organization that operates a program that meets the standards in R10-4-203 shall complete and submit to the Commission the application form referenced in subsection (C).

- E. The Commission's grant period coincides with the state's fiscal year. If funds received from the Commission are unexpended at the end of the grant period, the public agency or private nonprofit organization that received the funds shall return them to the Commission within 30 days after receiving a written request from the Commission. The Commission shall redeposit the unexpended funds in the Fund for use in the next fiscal year.

Historical Note

Adopted effective December 22, 1986 (Supp. 86-6). Amended effective October 28, 1994 (Supp. 94-4). Section repealed; new Section R10-4-202 renumbered from R10-4-204 and amended by final rulemaking at 6 A.A.R. 4660, effective November 20, 2000 (Supp. 00-4). Amended by final rulemaking at 13 A.A.R. 4124, effective January 5, 2008 (Supp. 07-4). Amended by final rulemaking at 18 A.A.R. 3309, effective February 3, 2013 (Supp. 12-4).

R10-4-203. Grant Eligibility Requirements

- A. A non-criminal justice governmental agency or private nonprofit organization may apply for and receive a grant from the Commission only if the non-criminal justice governmental agency or private nonprofit organization is approved by a prosecuting attorney's office or law enforcement agency.
- B. A public agency or private nonprofit organization qualified under subsection (A) may apply for and receive a grant from the Commission if, in addition to the other requirements in this Section, the public agency or private nonprofit organization operates a program that:
1. Provides services described in R10-4-204 to victims;
 2. Does not use Commission funds or federal funds to supplant funds otherwise available to the program for victim assistance;
 3. Uses volunteers effectively and efficiently to provide victim services;
 4. Promotes coordinated public and private efforts to assist victims within the community served;
 5. Assists a victim in seeking available victim compensation benefits; and
 6. Complies with all applicable civil rights laws.
- C. To receive a grant from the Commission, a public agency or private nonprofit organization that operates a program that has existed for at least three years shall demonstrate to the Commission that the program:
1. Has substantial financial support from a source other than the Fund; and
 2. Has a history of providing effective services to victims. The Commission shall determine whether the program's victim services are effective based on:
 - a. The length of time the program has provided victim services, and
 - b. Whether data indicate program results are achieved in a cost-effective manner.
- D. To receive a grant from the Commission, a public agency or private nonprofit organization that operates a program that has existed for fewer than three years shall demonstrate to the Commission that the program:
1. Has financial support from a source other than the Fund; and
 2. Is designed to meet a currently unmet need for a specific victim service.
- E. To receive a grant from the Commission, a public agency or private nonprofit organization shall agree to:
1. Submit to the Commission quarterly financial reports, on a form provided by the Commission, containing detailed

expenditures of funds received from the Commission and matching funds;

2. Submit an annual report to the Commission, on a form provided by the Commission, and provide the following information:
 - a. Number of victims served during the reporting period, by type of crime;
 - b. Type of services provided;
 - c. Number of times each service was provided;
 - d. Ethnic background, age, and sex of each victim served;
 - e. Type of assistance provided to victims in obtaining victim compensation;
 - f. Number of times each type of assistance was provided; and
 - g. A narrative assessment of the impact of Commission funds on the program.

Historical Note

Adopted effective December 22, 1986 (Supp. 86-6). Amended effective October 28, 1994 (Supp. 94-4). Former Section R10-4-203 renumbered to R10-4-201; new Section R10-4-203 renumbered from R10-4-205 and amended by final rulemaking at 6 A.A.R. 4660, effective November 20, 2000 (Supp. 00-4). Amended by final rulemaking at 13 A.A.R. 4124, effective January 5, 2008 (Supp. 07-4). Amended by final rulemaking at 18 A.A.R. 3309, effective February 3, 2013 (Supp. 12-4).

R10-4-204. Services

- A. A public agency or private nonprofit organization that receives a grant from the Commission shall ensure that the funds are used to provide only the following victim services:
1. Crisis intervention services to meet the urgent emotional or physical needs of a victim. Crisis intervention services may include a 24-hour hotline for counseling or referrals for a victim;
 2. Emergency services including:
 - a. Temporary shelter for a victim who cannot safely remain in current lodgings;
 - b. Petty cash for immediate needs related to transportation, food, shelter, and other necessities; and
 - c. Temporary repairs such as locks and windows damaged as a result of a crime to prevent the home or apartment from being re-burglarized immediately;
 3. Support services, including:
 - a. Counseling dealing with the effects of victimization;
 - b. Assistance dealing with other social services and criminal justice agencies;
 - c. Assistance in obtaining the return of property kept as evidence;
 - d. Assistance in dealing with the victim's landlord or employer; and
 - e. Referral to other sources of assistance as needed;
 4. Court-related services, including:
 - a. Direct services or petty cash that helps a victim participate in criminal justice proceedings, including transportation to court, child care, meals, and parking expenses; and
 - b. Advocate services including escorting a victim to criminal justice-related interviews, court proceedings, and assistance in accessing temporary protection services; and
 5. Notification services, including notifying a victim:
 - a. Of significant developments in the investigation or adjudication of the case;

- b. That a court proceeding, for which the victim has been subpoenaed, has been canceled or rescheduled; and
 - c. Of the final disposition of the case.
- B.** A public agency or private nonprofit organization that receives a grant from the Commission may use the funds to provide:
 - 1. Training for salaried or volunteer staff of criminal justice, social services, mental health, or related agencies, who provide direct services to victims; and
 - 2. Printing and distributing brochures or similar announcements describing the direct services available, how to obtain program assistance, and volunteer opportunities.
- C.** A public agency or private nonprofit organization that receives a grant from the Commission shall ensure that funds are not used for the following:
 - 1. Crime prevention efforts, other than those aimed at providing specific emergency help after an individual is victimized;
 - 2. General public relations programs;
 - 3. Advocacy for a particular legislative or administrative reform;
 - 4. General criminal justice agency improvement;
 - 5. A program in which victims are not the primary beneficiaries;
 - 6. Management training or training for persons who do not provide direct services to a victim; or
 - 7. Victim Compensation provided under this Chapter.

Historical Note

Adopted effective December 22, 1986 (Supp. 86-6). Amended effective October 28, 1994 (Supp. 94-4). Former Section R10-4-204 renumbered to R10-4-202; new Section R10-4-204 renumbered from R10-4-206 and amended by final rulemaking at 6 A.A.R. 4660, effective November 20, 2000 (Supp. 00-4). Amended by final rulemaking at 13 A.A.R. 4124, effective January 5, 2008 (Supp. 07-4). Amended by final rulemaking at 18 A.A.R. 3309, effective February 3, 2013 (Supp. 12-4).

R10-4-205. Renumbered

Historical Note

Adopted effective December 22, 1986 (Supp. 86-6). Amended effective October 28, 1994 (Supp. 94-4). Former Section R10-4-205 renumbered to R10-4-203 by final rulemaking at 6 A.A.R. 4660, effective November 20, 2000 (Supp. 00-4).

R10-4-206. Renumbered

Historical Note

Adopted effective December 22, 1986 (Supp. 86-6). Amended effective October 28, 1994 (Supp. 94-4). Former Section R10-4-206 renumbered to R10-4-204 by final rulemaking at 6 A.A.R. 4660, effective November 20, 2000 (Supp. 00-4).

R10-4-207. Repealed

Historical Note

Adopted effective December 22, 1986 (Supp. 86-6). Amended effective October 28, 1994 (Supp. 94-4). Section repealed by final rulemaking at 6 A.A.R. 4660, effective November 20, 2000 (Supp. 00-4).

ARTICLE 3. CRIMINAL JUSTICE ENHANCEMENT FUND

R10-4-301. Definitions

In this Article:

- 1. "Commission" means the Arizona Criminal Justice Commission.
- 2. "Contact" means the individual representative of a recipient or the Arizona Sheriffs' Association, on behalf of the various county sheriffs' offices, who communicates with the Commission regarding the Fund.
- 3. "Enhance" or "enhancing," as used in A.R.S. § 41-2401(D), means to supplement rather than replace monies from other sources.
- 4. "Fund" means the Criminal Justice Enhancement Fund established by A.R.S. § 41-2401(A).
- 5. "Head" means:
 - a. The Director of the Arizona Department of Public Safety,
 - b. The Arizona Attorney General,
 - c. The Director of the Administrative Office of the Courts, and
 - d. The sheriff of each Arizona county.
- 6. "Recipient" means the Arizona Department of Public Safety, Arizona Department of Law, the Supreme Court, and each Arizona county sheriff's office.

Historical Note

Adopted effective September 11, 1986 (Supp. 86-5). R10-4-301 repealed by summary action with an interim effective date of November 28, 1997; filed in the Office of the Secretary of State November 3, 1997 (Supp. 97-4). Adopted summary rules filed March 16, 1998; interim effective date of November 28, 1997, now the permanent effective date (Supp. 98-1). New Section made by final rulemaking at 17 A.A.R. 1469, effective September 10, 2011 (Supp. 11-3).

R10-4-302. Contact Information Required

- A.** Within 60 days after this Article takes effect, each Head and the President of the Arizona Sheriffs' Association shall submit to the Commission the name, address, telephone and fax numbers, and e-mail of the contact.
- B.** If any of the information submitted under subsection (A) changes, the Head or the President of the Arizona Sheriffs' Association shall provide immediate notice of the change to the Commission.

Historical Note

Adopted effective September 11, 1986 (Supp. 86-5). R10-4-302 repealed by summary action with an interim effective date of November 28, 1997; filed in the Office of the Secretary of State November 3, 1997 (Supp. 97-4). Adopted summary rules filed March 16, 1998; interim effective date of November 28, 1997, now the permanent effective date (Supp. 98-1). New Section made by final rulemaking at 17 A.A.R. 1469, effective September 10, 2011 (Supp. 11-3).

R10-4-303. Fund Guidelines Required

- A.** Within 60 days after this Article takes effect, the contact within the Arizona Department of Public Safety, Arizona Department of Law, and the Administrative Office of the Courts shall submit to the Commission the recipient's guidelines regarding the following:
 - 1. The procedure for handling Fund monies until they are allocated for expenditure,
 - 2. The procedure used to allocate Fund monies,
 - 3. The procedure used to ensure that Fund monies are expended as specified in A.R.S. § 41-2401(D), and
 - 4. The procedure used to assess the impact of the Fund monies on enhancing criminal justice in the manner specified in A.R.S. § 41-2401(D).

- B. Within 60 days after this Article takes effect, the contact for each county Sheriff's Office or the Arizona Sheriffs' Association shall submit to the Commission guidelines that meet the standard described in subsections (A)(3) and (4);
- C. Within 60 days after the guidelines submitted under subsections (A) and (B) are received, the Commission shall review the guidelines and assist the contact to make any changes necessary to protect Fund monies and ensure that Fund monies are expended as specified in A.R.S. § 41-2401.
- D. A recipient or the Arizona Sheriffs' Association shall review and, if necessary, update the guidelines. By October 1 of each year, the contact for each recipient or the Arizona Sheriffs' Association shall provide to the Commission the guidelines as revised or inform the Commission that no revision is necessary. Within 60 days after revised guidelines submitted under this subsection are received, the Commission shall review the revised guidelines and assist the contact to make any changes necessary to protect Fund monies and ensure that Fund monies are expended as specified in A.R.S. § 41-2401.

Historical Note

Adopted effective September 11, 1986 (Supp. 86-5). R10-4-303 repealed by summary action with an interim effective date of November 28, 1997; filed in the Office of the Secretary of State November 3, 1997 (Supp. 97-4). Adopted summary rules filed March 16, 1998; interim effective date of November 28, 1997, now the permanent effective date (Supp. 98-1). New Section made by final rulemaking at 17 A.A.R. 1469, effective September 10, 2011 (Supp. 11-3).

R10-4-304. Records Required

- A. A Head shall ensure that the following records are maintained for the recipient:
 - 1. The amount of Fund monies available to the recipient,
 - 2. To whom Fund monies were disbursed and the amount of Fund monies disbursed,
 - 3. A detailed description of the manner in which the Fund monies are expended, and
 - 4. An assessment of the impact of the Fund monies on enhancing criminal justice.
- B. A Head shall ensure that the records required under subsection (A) are:
 - 1. Maintained for three years; and
 - 2. Made available, upon request, for review by the Commission and the Arizona Auditor General.
- C. All reports required of a recipient by statute to be submitted to the Commission are subject to review and verification by the Commission.

Historical Note

Adopted effective September 11, 1986 (Supp. 86-5). R10-4-304 repealed by summary action with an interim effective date of November 28, 1997; filed in the Office of the Secretary of State November 3, 1997 (Supp. 97-4). Adopted summary rules filed March 16, 1998; interim effective date of November 28, 1997, now the permanent effective date (Supp. 98-1). New Section made by final rulemaking at 17 A.A.R. 1469, effective September 10, 2011 (Supp. 11-3).

R10-4-305. Complaints

- A. An individual who believes that Fund monies are being expended in a manner that is inconsistent with A.R.S. § 41-2401(D) may:
 - 1. Submit a written complaint to the Commission; and

- 2. If the complaint relates to an expenditure by a court, shall submit the complaint to the Director of the Administrative Office of the Courts.
- B. An individual who submits a complaint shall ensure that the complaint includes sufficient information to enable the Commission to investigate the expenditure alleged to be inconsistent with A.R.S. § 41-2401(D).
- C. Except as specified in subsection (E), if the Commission determines that an expenditure about which a complaint is submitted appears to be inconsistent with A.R.S. § 41-2401(D), the Commission shall ask the Head to explain the expenditure.
- D. If the Commission determines that the expenditure is inconsistent with A.R.S. § 41-2401(D), the Commission shall take action allowed by law to remedy the expenditure.
- E. The Director of the Administrative Office of the Courts shall:
 - 1. Investigate an expenditure about which a complaint is submitted under subsection (A)(2),
 - 2. Determine whether the expenditure is inconsistent with A.R.S. § 41-2401(D), and
 - 3. Notify the Commission of the determination and any action taken to remedy the expenditure.

Historical Note

Adopted effective September 11, 1986 (Supp. 86-5). R10-4-305 repealed by summary action with an interim effective date of November 28, 1997; filed in the Office of the Secretary of State November 3, 1997 (Supp. 97-4). Adopted summary rules filed March 16, 1998; interim effective date of November 28, 1997, now the permanent effective date (Supp. 98-1). New Section made by final rulemaking at 17 A.A.R. 1469, effective September 10, 2011 (Supp. 11-3).

ARTICLE 4. DRUG AND GANG ENFORCEMENT ACCOUNT GRANTS

R10-4-401. Definitions

In this Article:

"A-133 audit report" means a report on an audit conducted in accordance with the standards for obtaining consistency and uniformity among federal agencies for the audit of non-federal entities expending federal awards established by the Office of Management and Budget in Circular A-133.

"Account" means the Drug and Gang Enforcement Account established by A.R.S. § 41-2402.

"Applicant" means an approved agency or task force that submits an application for a grant from the Account.

"Approved agency" means a unit of state, county, local, or tribal government working to accomplish one or more of the goals established at A.R.S. § 41-2402(A).

"Approved project" means a planned endeavor to accomplish one or more of the goals established at A.R.S. § 41-2402(A) for which a grant is made from the Account.

"Commission" means the Arizona Criminal Justice Commission established by A.R.S. § 41-2404.

"Committee" means the Drug, Gang, and Violent Crime Committee of the Commission.

"Host agency" means an approved agency that submits a grant application and required reports on behalf of a task force.

"Matching funds" means non-federal and non-Account money or program income that a grant recipient adds to a grant from the Account and spends to accomplish the goals of an approved project.

“Program income” means funds generated as a result of the activities funded by a grant from the Account.

“Task force” means multiple approved agencies from different jurisdictions that collaborate to accomplish multiple goals established at A.R.S. § 41-2402(A).

Historical Note

Adopted as an emergency effective February 22, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-1). Emergency expired. Adopted without change as a permanent rule effective July 18, 1988 (Supp. 88-3). Amended effective October 28, 1994 (Supp. 94-4). Amended by final rulemaking at 7 A.A.R. 1007, effective February 8, 2001 (Supp. 01-1). Amended by final rulemaking at 14 A.A.R. 4654, effective January 31, 2009 (Supp. 08-4).

R10-4-402. General Information Regarding Grants

- A. The Commission shall annually request grant applications and make grant awards of Account funds.
- B. The Commission’s ability to make grant awards is contingent upon the availability of Account funds.
- C. The Commission shall publish its priorities for grant awards in a report of the state’s strategy for combating drugs, gangs, and violent crime. This report also includes the plan approved by the federal government and referenced under A.R.S. § 41-2402(F).
- D. The Commission shall make all information regarding grants, including the request for grant applications and application and report forms, available on its web site.
- E. The Commission shall ensure that training regarding grant application procedures and grant management are made available to interested approved agencies.
- F. The Commission shall provide oversight of all grants awarded, which may include conducting a financial review or audit of a grant recipient, to ensure that Account funds are expended in compliance with all terms of the grant agreement and all applicable state and federal laws.
- G. The Commission shall require that a grant recipient provide matching funds in the amount specified in the request for grant applications.
- H. The Commission shall not require a grant recipient to provide matching funds that exceed 25% of the total project budget.

Historical Note

Adopted as an emergency effective February 22, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-1). Emergency expired. Adopted without change as a permanent rule effective July 18, 1988 (Supp. 88-3). Amended effective October 28, 1994 (Supp. 94-4). Amended by final rulemaking at 7 A.A.R. 1007, effective February 8, 2001 (Supp. 01-1). Former Section R10-4-402 renumbered to R10-4-403; new Section made by final rulemaking 14 A.A.R. 4654, effective January 31, 2009 (Supp. 08-4).

R10-4-403. Grant Application

- A. An approved agency or task force may submit an application for a grant from the Account. If application is made by a task force, members of the task force shall identify a host agency.
- B. An applicant shall access, complete, and submit to the Commission the application form that is available on the Commission’s web site. The applicant shall provide the following information:
 1. Title of the application and proposed project;
 2. Purpose specified in A.R.S. § 41-2402(A) that the proposed project will address;

3. Statement of whether the application is a request to continue a previously approved project;
 4. Name and address of the applicant;
 5. List of member agencies of the task force if the applicant is a task force;
 6. Name of the individual authorized to submit the application;
 7. Name of the individual responsible for administering and supervising the proposed project;
 8. Statement of the mission of the proposed project;
 9. Statement of the problem addressed by the proposed project including data reflecting:
 - a. The scope of the problem, and
 - b. The absence or inadequacy of current resources to address the problem;
 10. Summary of the proposed project that explains how the proposed project seeks to address the problem identified;
 11. Description of collaborative efforts among law enforcement, prosecution, community organizations, social service agencies, and others that will be involved with the proposed project;
 12. Description of the methodology that will be used to evaluate the effectiveness of the proposed project;
 13. Goals of the proposed project stating what the proposed project is intended to accomplish;
 14. Objectives that are specific, measurable, and directly correlated to the goals of the proposed project;
 15. Detailed budget that includes:
 - a. Total amount to be expended on the proposed project including both Account and matching funds;
 - b. Estimated amount to be expended for various allowable expenses and the manner in which the estimate was determined;
 - c. Sources of the required matching funds; and
 - d. Statement of whether Account funds received will be used as matching funds for another grant program and if so, the name of the grant program and funding agency;
 16. Date of the jurisdiction’s current A-133 audit report;
 17. Description of the internal controls the applicant will use to ensure compliance with all terms of the grant agreement;
 18. Description of plan to sustain the project if Account funds are no longer available; and
 19. Signature of the individual identified in subsection (B)(6) certifying that the information presented is correct and that if a grant is received, the applicant will comply with the terms of the grant agreement and all applicable state and federal laws.
- C. In addition to submitting the application form required under subsection (B), an applicant shall submit to the Commission:
1. A copy of the jurisdiction’s current A-133 audit report or if the jurisdiction does not have a current A-133 audit report, a copy of all correspondence relating to an extension of time to have an audit completed;
 2. If the applicant is a task force, a letter on agency letterhead or another document from each member agency of the task force describing the manner in which the member intends to contribute to the proposed project; and
 3. If the applicant’s jurisdiction applied directly for federal criminal justice grant funding, a copy of the application.

Historical Note

Adopted as an emergency effective February 22, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-1). Emergency expired. Adopted without change as a permanent rule effective July 18, 1988 (Supp.

88-3). Amended by final rulemaking at 7 A.A.R. 1007, effective February 8, 2001 (Supp. 01-1). Former Section R10-4-403 renumbered to R10-4-404; new Section R10-4-403 renumbered from R10-4-402 and amended by final rulemaking at 14 A.A.C. 4654, effective January 31, 2009 (Supp. 08-4).

R10-4-404. Application Evaluation; Standards for Award

- A.** The Commission shall ensure that each application that is submitted timely and proposes a project eligible for funding from the Account is evaluated. After the applications are evaluated, the Committee shall forward a recommended allocation plan to the Commission. The Commission shall grant or deny funding within 90 days after the application deadline.
- B.** If the Commission determines that it needs additional information to facilitate its review of an application, the Commission shall:
 1. Request the additional information from the applicant, or
 2. Request the applicant to amend the application.
- C.** The Commission shall approve grant funding, in whole or in part, or deny funding using standards in the plan approved by the federal government and referenced under A.R.S. § 41-2402(F).
- D.** The standards referenced in subsection (C) include an assessment of whether the proposed project:
 1. Is directed toward a problem that is demonstrated by statistical data;
 2. Is designed to address the identified problem;
 3. Is a coordinated effort among multiple approved agencies;
 4. Has specific goals;
 5. Has measurable objectives that relate to the goals;
 6. Has appropriate methods for evaluating achievement of objectives;
 7. Has a reasonable budget of allowable expenses;
 8. Has identified the required matching funds;
 9. Has internal controls to monitor expenditure of Account funds; and
 10. If the program was previously funded, all grant requirements were met timely and there were no reportable deficiencies during monitoring reviews.

Historical Note

Adopted as an emergency effective February 22, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-1). Emergency expired. Adopted without change as a permanent rule effective July 18, 1988 (Supp. 88-3). Amended effective October 28, 1994 (Supp. 94-4). Amended by final rulemaking at 7 A.A.R. 1007, effective February 8, 2001 (Supp. 01-1). Former Section 10-4-404 renumbered to R10-4-406; new Section R10-4-404 renumbered from R10-4-403 and amended by final rulemaking 14 A.A.R. 4654, effective January 31, 2009 (Supp. 08-4).

R10-4-405. Request for Modification of Recommended Allocation Plan

- A.** Commission staff shall provide an applicant with at least five days' notice of the Committee's recommended allocation plan and the date, time, and location of the meeting at which the Committee will make a decision about forwarding the recommended allocation plan to the Commission for its action.
- B.** If an applicant disagrees with the recommended allocation plan, the applicant may verbally request that the Committee modify the recommended allocation plan. The Committee shall consider the request for modification before forwarding the recommended allocation plan to the Commission.

- C.** Commission staff shall provide an applicant with at least five days' notice of the date, time, and location of the meeting at which the Commission will consider the recommended allocation plan.
- D.** If an applicant disagrees with the recommendation of the Committee, the applicant may verbally request that the Commission modify the recommended allocation plan. The Commission shall consider the request for modification when making a final decision to award or deny a grant of Account funds to the applicant. The Commission's decision is final.

Historical Note

New Section made by final rulemaking at 14 A.A.R. 4654, effective January 31, 2009 (Supp. 08-4).

R10-4-406. Required Reports

- A.** The Commission shall annually prepare and submit the report required under A.R.S. § 41-2405(A)(11) and the report required by the federal government regarding the current criminal justice grant program. The Commission shall use data submitted by grant recipients as specified in the recipient's grant agreement to prepare these reports.
- B.** A grant recipient shall submit to the Commission financial, activity, and progress reports documenting the activities supported by the Account funds. The grant recipient shall submit the reports as specified in the grant agreement. The specific reports required are determined by the nature of the proposed project. A grant recipient shall submit a required report by the 25th day following the end of the month or quarter in which the report is due.
- C.** The Commission shall not distribute Account funds to a grant recipient that fails to submit a required report within 60 days of its due date.
- D.** A grant recipient shall cooperate with and participate in all assessment, evaluation, or data collection efforts authorized by the Commission.
- E.** The Commission has the right to obtain, reproduce, publish, or use information provided in the required reports or assessment, evaluation, or data collection efforts. When in the best interest of the state, the Commission may authorize others to receive and use the information.

Historical Note

New Section R10-4-406 renumbered from R10-4-404 and amended by final rulemaking 14 A.A.R. 4654, effective January 31, 2009 (Supp. 08-4).

ARTICLE 5. FULL-SERVICE FORENSIC CRIME LABORATORY ACCOUNT

R10-4-501. Definitions

In this Article:

1. "Account" means the Full-service Forensic Crime Laboratories Account established by A.R.S. § 41-2421(J)(5).
2. "Commission" means the Arizona Criminal Justice Commission established by A.R.S. § 41-2404.
3. "Full-service forensic crime laboratory" means a facility that:
 - a. Is operated by a criminal justice agency that is a political subdivision of the state;
 - b. Employs at least one full-time forensic scientist who holds a minimum of a bachelor's degree in a physical or natural science;
 - c. Is registered as an analytical laboratory with the Drug Enforcement Administration of the United States Department of Justice for possession of all scheduled, controlled substances;

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- d. Is accredited by the American Society of Crime Laboratory Directors/Laboratory Accreditation Board; and
- e. Provides, at a minimum, services in the areas of controlled substances, forensic biology, DNA, blood and breath alcohol, firearms, and toolmarks.

Historical Note

New Section made by final rulemaking at 7 A.A.R. 2217, effective May 11, 2001 (Supp. 01-2). Amended by final rulemaking at 12 A.A.R. 2294, effective August 5, 2006 (Supp. 06-2).

R10-4-502. Grant Solicitation Process

- A. The Commission shall annually publish and post on the Commission's internet site, which is www.azacjc.gov, a grant solicitation for distribution of Account monies. When the grant solicitation is posted, the Commission shall send an electronic notice of the posting to all Arizona criminal justice agencies that operate a full-service forensic crime laboratory.
- B. The Commission shall ensure that the grant solicitation contains:
 - 1. The Commission's goals for the grant program for the allocation year,
 - 2. Applicant eligibility criteria,
 - 3. The format in which a grant application is to be submitted,
 - 4. The date by which a grant application is to be submitted,
 - 5. Grant application evaluation criteria,
 - 6. Project expenses for which Account monies may be used,
 - 7. The period in which all Account monies must be expended,
 - 8. Account money reversion criteria and process, and
 - 9. The award denial appeal process.

Historical Note

New Section made by final rulemaking at 7 A.A.R. 2217, effective May 11, 2001 (Supp. 01-2). Amended by final rulemaking at 12 A.A.R. 2294, effective August 5, 2006 (Supp. 06-2).

R10-4-503. Grant Application Evaluation; Decision of the Commission

- A. The Commission shall evaluate each grant application and make a decision to award or deny a grant within 120 days of the date by which grant applications are due.
- B. If the Commission determines additional information is needed to facilitate its evaluation of an application, the Commission shall request from the applicant:
 - 1. Additional information, or
 - 2. Application modification.

- C. An applicant from whom additional information or application modification is requested shall submit the information or modification to the Commission within 10 business days from the date of the request.
- D. After completing its evaluation of an application, the Commission shall vote to award, in whole or in part, or deny a grant based on:
 - 1. The grant criteria published in the grant solicitation;
 - 2. The amount of funds available for allocation; and
 - 3. Compliance with the application format.

Historical Note

New Section made by final rulemaking at 7 A.A.R. 2217, effective May 11, 2001 (Supp. 01-2). Amended by final rulemaking at 12 A.A.R. 2294, effective August 5, 2006 (Supp. 06-2).

R10-4-504. Reports

Within 15 days after the end of each calendar quarter, a grantee shall submit a written report, on a form prescribed by the Commission, containing:

- 1. A financial report that includes itemized budget information, and
- 2. An activity report that documents activities supported by the grant funds and includes:
 - a. A narrative of activities undertaken during the reporting period;
 - b. An evaluation of progress toward achieving the goals and objectives in the grant application;
 - c. An evaluation of adherence to the time-frames in the grant application; and
 - d. A description of equipment purchased with grant funds during the reporting period, how the equipment is related to achieving the goals and objectives of the project, and the current status of the equipment, such as whether it is operational, waiting to be installed, or undergoing testing; and
- 3. A copy of any deliverable provided by a consultant paid with grant funds.

Historical Note

New Section made by final rulemaking at 7 A.A.R. 2217, effective May 11, 2001 (Supp. 01-2). Amended by final rulemaking at 12 A.A.R. 2294, effective August 5, 2006 (Supp. 06-2).

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Supplement to the

Arizona Administrative Code

The official compilation of Arizona Rules

Arizona Secretary of State's Office

Public Services Division

1700 W. Washington Street, Fl 7.

Phoenix, AZ 85007

Replacement Check List

For rules filed within the

4th Calendar Quarter

October 1 - December 31, 2012

Code Release Number: Supp. 12-4

Within the stated calendar quarter, this Title contains all rules made, amended, repealed, renumbered, and recodified, or rules that have expired or were terminated due to an agency being eliminated under sunset law. These rules were either certified by the Governor's Regulatory Review Council or the Attorney General's Office, or exempt from the rulemaking process, and filed with the Office of the Secretary of State. Refer to the historical notes for more information. Please note that some rules you are about to remove may still be in effect after the publication date of this Supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

Follow the instructions to replace the updated Chapters.

TITLE 19. ALCOHOL, DOG AND HORSE RACING, LOTTERY AND GAMING

Chapter 2. Arizona Racing Commission

Sections, Parts, Exhibits, Tables or Appendices modified

R19-2-201, R19-2-202, R19-2-203, R19-2-205

REMOVE Supp. 12-2

Pages: 1 - 86

REPLACE with Supp. 12-4

Pages: 1 - 86

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TITLE 19. ALCOHOL, HORSE AND DOG RACING, LOTTERY, AND GAMING**CHAPTER 2. ARIZONA RACING COMMISSION**

(Authority: A.R.S. § 5-101 et seq.)

Editor's Note: The Office of the Secretary of State prints all Code Chapters on white paper (Supp. 03-4).

Editor's Note: This Chapter contains rules which were adopted under an exemption from the provisions of the Administrative Procedure Act (A.R.S. Title 41, Chapter 6) pursuant to A.R.S. § 41-1005(A)(18). Exemption from A.R.S. Title 41, Chapter 6 means that the Arizona Racing Commission did not submit these rules to the Governor's Regulatory Review Council for review and approval; the Commission did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the Commission was not required to hold public hearings on these rules. Because this Chapter contains rules which are exempt from the regular rulemaking process, the Chapter is printed on blue paper.

19 A.A.C. 2, consisting of R19-2-101 through R19-2-124, R19-2-301 through R19-2-331, and R19-2-501 through R19-2-523, recodified from 4 A.A.C. 27, consisting of R4-27-101 through R4-27-124, R4-27-301 through R4-27-331, and R4-27-501 through R4-27-523, pursuant to R1-1-102 (Supp. 95-1).

Title 4, Chapter 27 consisting of Sections R4-27-101 through R4-27-124, R4-27-301 through R4-27-323 adopted effective August 5, 1983. R19-2-101 through R19-2-124 recodified from R4-27-101 through R4-27-124 (Supp. 95-1).

Former Title 4, Chapter 27 consisting of Sections R4-27-101 through R4-27-111, R4-27-201 through R4-27-211, R4-27-301 through R4-27-312 repealed effective August 5, 1983. R19-2-101 through R19-2-111, R19-2-201 through R19-2-211, R19-2-301 through R19-2-312 recodified from R4-27-101 through R4-27-111, R4-27-201 through R4-27-211, R4-27-301 through R4-27-312 (Supp. 95-1).

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R19-2-115.03.	Claiming Races: Claiming Restrictions
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R19-2-117.	Objections
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ARTICLE 2. RACING REGULATION FUND

Article 2, consisting of Sections R19-2-201 through R19-2-205, made by exempt rulemaking at 17 A.A.R. 1484, effective July 20, 2011 (Supp. 11-3).

Section

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R19-2-203.	Repealed
R19-2-204.	Regulatory Assessment for Dark Day Simulcasting
R19-2-205.	Regulatory Wagering Assessment of Pari-mutuel Pools

ARTICLE 3. GREYHOUND RACING

Section

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R19-2-304.	Permittee Responsibilities
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R19-2-324.	Greyhound Housing
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R19-2-326.	General Care of Greyhounds in a Racing Kennel, on a Breeding Farm, or Another Operation

- R19-2-327. Personnel of the Racing Kennel, Breeding Farm, or other Operation
- R19-2-328. Transportation of Greyhounds
- R19-2-329. Disposition of Greyhounds
- R19-2-330. Inspection Procedure for a Racing Kennel, Breeding Farm, or other Operation
- R19-2-331. Greyhound Adoption Grants
- R19-2-332. Certifying a Greyhound Arizona Bred

ARTICLE 4. TELETRACKING

Article 4, consisting of Sections R19-2-401 through R19-2-410, adopted effective February 26, 1996, under an exemption from the rulemaking process pursuant to A.R.S. § 41-105(A)(18) (Supp. 96-1).

Article 4, consisting of Sections R4-27-401 through R4-27-410, repealed effective December 14, 1994 (Supp. 94-4).

Article 4, consisting of Sections R4-27-401 through R4-27-410, adopted effective April 3, 1984 (Supp. 84-2). R19-2-401 through R19-2-410 recodified from R4-27-401 through R4-27-410 (Supp. 95-1).

Section

- R19-2-401. Definitions
- R19-2-402. Teletrack Wagering
- R19-2-403. General Provisions
- R19-2-404. Application for Original Teletrack Wagering Permit; Plan of Operation; Renewals of Teletrack Wagering Permit
- R19-2-405. Application for Approval of Additional Wagering Facilities; Plan of Operation; Renewal or Approval of Additional Wagering Facilities
- R19-2-406. Requisites for a Teletrack Wagering System
- R19-2-407. Transmission
- R19-2-408. Suspension of Teletrack Permit
- R19-2-409. Licensing of Employees at Teletrack Facilities
- R19-2-410. Directives

ARTICLE 5. PARI-MUTUEL WAGERING

Article 5, consisting of Sections R4-27-501 through R4-27-523, adopted effective October 21, 1993, under an exemption from the provisions of the Administrative Procedure Act (A.R.S. Title 41, Chapter 6) pursuant to A.R.S. § 41-1005(A)(18). Exemption from A.R.S. Title 41, Chapter 6 means that the Arizona Racing Commission did not submit these rules to the Governor's Regulatory Review Council for Review; the Commission did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Commission was not required to hold public hearings on these rules; and the Attorney General did not certify these rules. Because this Chapter contains rules which are exempt from the regular rulemaking process, the Chapter is being printed on blue paper. R19-2-501 through R19-2-523 recodified from R4-27-501 through R4-27-523 (Supp. 95-1).

Section

- R19-2-501. General
- R19-2-502. Records
- R19-2-503. Pari-mutuel Tickets
- R19-2-504. Pari-mutuel Ticket Sales
- R19-2-505. Advance Performance Wagering
- R19-2-506. Claims for Payment from Pari-mutuel Pool
- R19-2-507. Payment for Errors
- R19-2-508. Betting Explanation
- R19-2-509. Display of Betting Information
- R19-2-510. Cancelled Contests
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- R19-2-512. Coupled Entries and Mutuel Fields

- R19-2-513. Pools Dependent upon Betting Interests
- R19-2-514. Prior Approval Required for Betting Pools
- R19-2-515. Closing of Wagering in a Contest
- R19-2-516. Complaints Pertaining to Pari-mutuel Operations
- R19-2-517. Licensed Employees
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- R19-2-519. Mutuel Manager
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- R19-2-521. Simulcast Wagering
- R19-2-522. Interstate Common Pool Wagering
- R19-2-523. Calculation of Payoffs and Distribution of Pools

ARTICLE 6. STATE BOXING ADMINISTRATION

Article 6, consisting of Sections R19-2-601 through R19-2-610, recodified from Sections R4-3-415 through R4-3-424 at 5 A.A.R. 1175, April 23, 1999 (Supp. 99-2).

Section

- R19-2-601. Definitions
- R19-2-602. Notice to the Department
- R19-2-603. Ticket Manifest, Collection, Accounting
- R19-2-604. Annual Bond, Event Bond, Claims
- R19-2-605. License Fees
- R19-2-606. Fines
- R19-2-607. Repealed
- R19-2-608. Repealed
- R19-2-609. Renumbered
- R19-2-610. Renumbered

ARTICLE 1. HORSE RACING

R19-2-101. Power and Authority

- A. All powers of the Department and Commission not specifically defined in these rules are reserved to the Department and Commission under the law creating the Department and Commission and specifying its powers and duties.
- B. The jurisdiction of the Department and Commission over matters covered by the statutes and the rules is continuous throughout the year.
- C. The statutes of the state of Arizona and the rules and the orders of the Department and Commission take precedence over the conditions of a race or the conditions of a racing meeting.
- D. The Director may sustain, reverse, or modify any penalty or decision imposed by the stewards.
- E. The Commission may sustain, reverse, or modify any penalty or decision imposed by the Director.

Historical Note

Adopted effective August 5, 1983 (Supp. 83-4). Editor spelling correction to subsection (C) (Supp. 88-4). R19-2-101 recodified from R4-27-101 (Supp. 95-1).

R19-2-102. Definitions

In these rules, unless the context otherwise requires:

1. "Added money" means the money a permittee adds to the nominating and starting fees in a race.
2. "Age" means the age of a horse as computed from the first day of January in the year in which the horse is foaled.
3. "Authorized agent" means a person appointed pursuant to R19-2-106(I) of these rules.
4. "Breeder" of a horse means the owner or lessee of its dam at the time of foaling.
5. "Breeding place" means the place of birth of a horse.
6. "Commission" means the Arizona Racing Commission.
7. "Course" means the track over which horses race.
8. "Declaration" means the act of withdrawing an entered horse from a race.
9. "Department" means the Arizona Department of Racing.

10. "Director" means the Director of the Arizona Department of Racing.
11. "Entrance fee" means a fee set by the permittee which must be paid in order to make a horse eligible for a stakes race.
12. "Entry" means, according to its context, either:
 - a. A horse eligible and entered in a race, or
 - b. Two or more horses which are entered in a race and are owned in whole or in part by the same owner or are trained by a trainer who owns any interest in any of the other horses in the race.
13. "Equipment" as applied to a horse means whips, blinkers, tongue straps, muzzles, hoods, nose bands, shadow rolls, martingales, breast plates, bandages, boots, plates (shoes), and all other paraphernalia which is or might be used on or attached to a horse while racing.
14. "Field" means:
 - a. The entire group of horses in a race.
 - b. The highest numbered horse within the capacity of the tote and all horses of a higher number grouped together in the wagering.
15. "Foreign substance" means any drug, medicine, metabolite, or any other substance which does not exist naturally in the untreated horse and which may have a pharmacological effect on the racing performance of a horse or which may affect sampling or testing procedures. Foreign substances include but are not limited to stimulants, depressants, local anesthetics, narcotics, and analgesics.
16. "Foul" means any action by a horse or jockey which interferes with another horse or jockey in the running of a race.
17. "Grounds" means the entire area used by the permittee to conduct racing meetings including, but not limited to, the track, grandstand, stables, concession areas, and parking facilities.
18. "Horse" includes filly, mare, colt, horse, gelding and ridgling.
 - a. In general when referring to sex, a horse is an entire male 5 years old or older.
 - b. Ridgling shall mean a half-castrated male horse or a horse with one or both organs of reproduction absent from the sac.
19. "Lawfully issued prescription" means a prescription-only drug, as defined in A.R.S. § 13-3401, obtained directly or pursuant to a valid prescription or order from a licensed physician acting in the course of professional practice.
20. "Lessee" or "lessor" means a person who has leased a horse for racing purposes.
21. "Maiden" means a horse which at the time of starting has never won a race on the flat in any country on a recognized track or which has been disqualified after finishing first.
22. "Meeting" means the entire period for which a permit to conduct racing has been granted to any permittee by the Commission.
23. "Nominating fee" means a fee set by the permittee which must be paid in order to make a horse eligible for a stakes race.
24. "Nomination" means the naming of a horse or its foal in utero to compete in a specific race or series of races, eligibility for which may be conditional upon the payment of a fee at the time of naming.
25. "Nominator" means the person in whose name a horse is nominated for a stakes or handicap race.
26. "Off time" means the moment at which, on signal of the starter, the horses break and run.
27. "Overpayment" means the amount by which purses paid exceeds the amount due horsemen based upon the net take and break calculation.
28. "Owner" means any person possessing all or part of the legal title to a horse.
29. "Place" means the position in which a horse finishes in a race, and more specifically win-first, place-second, and show-third.
30. "Post position" means the position assigned to a horse for the start of a race.
31. "Post time" means the time set for the arrival at the starting point of the horses in a race.
32. "Prohibited substance" means any substance regulated by A.R.S. Title 13, Chapter 34.
33. "Race" means a contest among horses for purse, stakes, premium, or wager for money, run in the presence of the racing officials of the track and of the Department.
 - a. "Claiming race" means a race in which any horse entered may be claimed in conformity with these rules.
 - b. "Graded quarter race" means a quarter race for which horses are classified by the racing secretary on the basis of prior racing times and past performances.
 - c. "Handicap" means a race in which weights to be carried by the entered horses are adjusted by a handicapper for the purpose of equalizing their respective chances of winning.
 - d. "Hurdle race" means a race over a course in which jumps or hurdles are used.
 - e. "Match race" means a race between two or more horses, each the property of different owners, on terms agreed upon by the owners and approved by the Department.
 - f. "Overnight race" means a race for which entries close 96 hours or less before the time set for the first race of the day on which such race is to be run.
 - g. "Purse race" means a race for money or other prize to which the owners of the horses engaged in the race do not contribute an entry fee.
 - h. "Quarter race" means a race on the flat at 870 yards or less.
 - i. "Race on the flat" means a race over a course in which no jumps or other obstacles are placed.
 - j. "Stakes race" means a race in which any monies are to be deposited by the owners of the horses engaged in the race, including a race in which money or other prize is added, and in which nominations must close more than 72 hours before the time for the first race of the day on which such stakes race is to be run.
34. "Racing Regulation Fund" is a fund established by A.R.S. § 5-113.01 and administered by the Department, to receive funding for regulation from various pari-mutuel racing industry sources.
35. "Recognized track" means a track where pari-mutuel wagering is authorized by law or which is recognized by the American Quarter Horse Association.
36. "Ruled off" means the act of barring from the grounds of a permittee and denying all racing privileges.
37. "Scratch" means the act of withdrawing an entered horse from a race after the closing of overnight entries.
38. "Scratch time" means the time set by the permittee for the withdrawing of entries from the races of that day.
39. "Starting fee" means a fee, specified by the conditions of the race and set by the permittee, which must be paid in order to start in a race.

40. "Starting horse" means a horse which leaves the paddock for the post, excluding:
 - a. A horse subsequently excused by the stewards, or
 - b. A horse whose starting gate stall doors do not open in front of it at the time the starter dispatches the field.
41. "Subscription" means the act of nominating to a stakes race.
42. "Supplemental fee" means a fee set by the permittee that must be paid at a time prescribed by the permittee to make a horse eligible for a stakes race.
43. "Suspended" means that any privilege granted by the officials of a racing meeting or by the Commission or the Department has been temporarily withdrawn.
44. "Sustaining fees" mean fees which must be paid periodically, as prescribed by the conditions of the race, in order to keep a horse eligible for that race.
45. "Tote/totalizator" means the machines which sell mutuel tickets and the board on which the approximate odds are posted.
46. "Track" means the course over which races take place.
47. "Trainer" means the person employed by an owner or lessee to condition horses for racing.
48. "Underpayment" means the amount by which the amount due horsemen based upon the net take and break calculation exceeds the amount of purses paid.
49. "Walkover" means a race in which there are not two or more horses of separate interest sent postward.
50. "Weight" means the standard weight according to the scale set forth in R19-2-118.

Historical Note

Adopted effective August 5, 1983 (Supp. 83-4). Amended paragraph (15), added new paragraphs (26) and (45) and renumbering accordingly effective June 6, 1986 (Supp. 86-3). Amended by adding paragraphs (19) and (32) and renumbering accordingly effective November 30, 1988 (Supp. 88-4). Amended effective March 20, 1990 (Supp. 90-1). R19-2-102 recodified from R4-27-102 (Supp. 95-1). Amended by exempt rulemaking at 17 A.A.R. 1484, effective July 20, 2011 (Supp. 11-3).

R19-2-103. Permit Applications

- A. A person or persons, associations, or corporations desiring to hold or conduct a horse racing meeting within the state of Arizona shall file with the Commission its permit application that contains the information required in A.R.S. § 5-107 in paper copy and in an electronic medium. All electronic media submissions shall be compatible with the Department's computer system and software. If any addendum to the permit application cannot be submitted in an electronic medium, the applicant shall submit the addendum in a paper copy.
- B. The Department shall not issue a permit until the applicant has furnished evidence of compliance with A.R.S. § 23-901 et seq. (Workers' Compensation).
- C. Permit applicants shall submit to the Commission the names of the proposed track officials at least 60 days prior to the beginning of their meet, along with a short biographical sketch of each official not previously licensed in the same capacity by the Department.
- D. A permit application shall specify the number of races to be run on a daily basis.
- E. Racing shall be conducted only on those days granted by permit.
- F. Permit Application Time-frames.
 1. Administrative completeness review time-frame.

- a. Within 728 days after receiving an application package, the Department shall determine whether the application package contains the information required by subsections (A), (B), (C), and (D).
 - b. If the application package is incomplete, the Department shall issue a written notice that specifies what information is required and return the application. If the application package is complete, the Department shall provide a written notice of administrative completeness.
 - c. The Department shall deem an application package withdrawn if the applicant fails to file a complete application package within 180 days of being notified that the application package is incomplete.
2. Substantive review time-frame. Within 30 days after receipt of a complete application package, the Commission, with the recommendation of the Department, shall determine whether the applicant meets all substantive requirements and issue a written notice granting or denying the permit.
3. Overall time-frame. For the purpose of A.R.S. § 41-1073, the Department establishes the following time-frames for issuing a permit.
 - a. Administrative completeness review time-frame: 728 days;
 - b. Substantive review time-frame: 30 days;
 - c. Overall time-frame: 758 days.
4. Renewal and temporary permit time-frames. The administrative completeness review time-frame is 30 days, the substantive review time-frame is 30 days, and the overall time-frame is 60 days, excluding time for mailing. The renewal or temporary permit is considered administratively complete unless the Department issues a written notice of deficiencies to the applicant. Temporary permits are valid until a full permit is awarded or until the Commission revokes the temporary permit.

Historical Note

Adopted effective August 5, 1983 (Supp. 83-4). Amended effective March 20, 1990 (Supp. 90-1). R19-2-103 recodified from R4-27-103 (Supp. 95-1). Amended effective January 6, 1998 (Supp. 98-1). Amended by final rulemaking at 11 A.A.R. 5534, effective February 4, 2006 (Supp. 05-4).

R19-2-104. Permittee Responsibilities

- A. A permittee shall maintain the grounds in a neat, clean, and safe condition. If a steward determines that a permittee is not in compliance with this Section, the steward shall require that the permittee immediately bring the grounds into compliance.
- B. The permittee shall prevent any person, corporation, firm, or association not licensed by the Department from performing any act at its track which requires a license under A.R.S. Title 5, Chapter 1, or this Article.
- C. Each permittee department head shall see that the permittee department head's employees are licensed and furnish a list of the employees upon request.
- D. A permittee shall take all steps necessary to deny the privileges of a license to anyone whose license has been revoked or suspended and to keep such a person off the grounds of the permittee and to prevent a person who has been ruled off from entering the grounds of the permittee.
- E. A permittee or its employees shall not obstruct a representative of the Department performing the representative's duties.
- F. A permittee shall not knowingly allow on its grounds any betting or other operations in contravention of any law of the state of Arizona or of the United States.

- G.** The permittee shall immediately report all observed violations of any racing regulation or statute to the Department and shall cooperate with the Department and with state, federal, and local authorities in investigations of alleged violations.
- H.** A permittee shall provide the following services at the track:
1. A horse ambulance, approved by the Department, for the removal of crippled animals from the track.
 2. A physician or emergency paramedic certified under A.R.S. § 36-2205 on duty during racing hours.
 3. An ambulance, available during morning works and racing hours.
 4. First aid quarters, available during morning works and racing hours.
 5. A detention paddock (test barn) where all winners and other horses selected by the stewards are taken and kept under the supervision of the Department veterinarian until saliva, urine, blood, and other samples have been obtained.
 6. An adequate security force whose duties include:
 - a. Maintaining order.
 - b. Excluding from the grounds all handbooks, touts, and operators of gambling devices.
 - c. Excluding from the grounds all persons ruled off by the stewards or the Department.
 - d. Excluding from the grounds all persons not eligible for a license under A.R.S. § 5-108.
 - e. Immediately reporting to the stewards any licensee who, while on the premises of the permittee, creates a disturbance, is intoxicated, interferes with any racing operation, or acts in an abusive or threatening manner to any racing official or other person.
 7. A security guard stationed at the stable area entrance whose duties include:
 - a. Denying entrance to all persons not holding a license or credentials issued by the Department or a Departmental pass issued by the permittee.
 - b. Allowing any person seeking employment within the stable area to have access to that area for a period of one day, provided that:
 - i. The person is given a numbered card.
 - ii. A list of recipients of the numbered cards is provided to the track office of the Department upon request.
 - iii. The numbered card is retrieved by the security guard when the person leaves the stable area.
 - iv. The track office of the Department is notified of the retrieval.
 8. A furnished office, including utilities and necessary office equipment, for the exclusive use of Department employees and officials.
 9. A uniformed security official approved by the Department, on duty in the Department test barn during its regular business hours. The official shall provide security and monitor the collection procedure and sealing of samples taken from the horses.
 10. A copy of all tip sheets offered for sale in the parking area or elsewhere on the grounds of the permittee, furnished daily to the stewards not later than three hours before first post.
- I.** A person shall not sell tip sheets, pamphlets, or other printed matter purporting to predict the outcome of a race other than official programs, the Daily Racing Form, and newspapers in the betting area.
- J.** Wagering shall be conducted upon the grounds of a permittee only under the pari-mutuel method as provided by statute and this Article and by the use of such mechanical or other equipment as the Department may require. Bookmaking or betting other than by the pari-mutuel method is prohibited.
- K.** A permittee shall not allow the official racing of horses on any track under its control except as provided by subsection (P) below unless:
1. The conditions of the race have been written by the racing secretary at the meeting.
 2. The entries have been made in accordance with the requirements set forth in R19-2-113.
 3. The race programmed as a part of a regular racing card conducted under the pari-mutuel system.
- L.** On a daily basis, and as soon as the entries have been closed and compiled and the declarations have been made, the permittee posts a list of the entries and declarations in a conspicuous place.
- M.** A permittee shall print on a daily racing program a list of all officials and directors of the permittee and of track and racing officials, together with such pertinent rules as the Department may designate.
- N.** A permittee shall not allow an official to act until the official's appointment has been approved by the Department; provided that, in the case of sickness or inability to act, the provisions of R19-2-121(A)(5) apply.
- O.** The permittee shall provide a photo finish and videotape device, approved by the Department, for the purpose of recording all races. The photographs and videotapes may be used to aid the stewards in determining the finishes of races. Permittees shall retain for three months all official race photographs and videotapes. The Department may require that specific photographs and videotapes be retained for a longer period of time or be transmitted to the Department for subsequent administrative or judicial proceedings.
- P.** Notwithstanding subsection (K), wagering may be conducted, by permission of the Department, on electronically televised simulcasts provided:
1. The simulcasts originate from a racing facility outside the state of Arizona.
 2. The race is televised on the grounds of the permittee.
 3. The televised race is included with the posted races for that racing day.
 4. The televised race complies with the Interstate Horseracing Act of 1978 (15 U.S.C. 3001 et seq.).
 5. Monies wagered are computed in the total daily handle.
 6. An out-of-state facility, receiving a simulcast originating from a racing facility within the state of Arizona, operates under the approval and regulation of an official agency of that state.
- Q.** Any automatic timing device installed by the permittee shall have the approval of the Department.
- R.** Each commercial horse racing permittee shall furnish the Department with annual financial statements audited and certified by a firm approved by the auditor general.
1. The firm shall conduct the audit in accordance with audit standards prescribed by the auditor general.
 2. The firm shall prepare the financial statements in accordance with generally accepted accounting practices.
 3. The firm shall use the following accounting practices:
 - a. Overpayments shall be treated as an asset to the extent that they are recoverable. Overpayments are reported as an asset titled "Purse Overpayments," immediately following current assets. If the permittee and the accountant determine that all or part of any overpayment is not recoverable, the dollar amount expensed and the basis of the determination shall be disclosed in the notes to the financial statements.

- b. Underpayments shall be reflected as an account payable.
- c. Wagering income shall be reported net of sales taxes.
- d. Amounts which a permittee is seeking to recover through litigation shall not be reported as assets.
- 4. The firm shall submit the following information with the financial statements in a form prescribed by the Department:
 - a. An analysis of the composition of and changes in accounts payable which include underpayments and asset accounts which include overpayments,
 - b. A summary of current year purse expense and over- or underpayment,
 - c. The total amount of salaries and bonuses expense,
 - d. Legal and accounting expense attributable to racing-related matters,
 - e. An explanation of the types of revenues and expenses classified in accounts titled "other," and
 - f. Other financial information requested by the Commission or Department.
- 5. Financial statements of permittees granted original permits prior to July 1, 1982, shall be on a fiscal year basis. Financial statements of permittees granted original permits after July 1, 1982, may be on a fiscal or calendar year basis at the discretion of the Director.
- 6. The firm shall submit financial statements within 120 calendar days of the end of the fiscal or calendar year.
- 7. The firm shall report overpayments and underpayments to the Department in a form prescribed by the Department within 10 working days after the end of each condition book period.
- S. Each permittee shall comply with the provisions of Article 2 of this Chapter.

Historical Note

Adopted effective August 5, 1983 (Supp. 83-4). Amended subsection (H) paragraph (9) effective August 2, 1985 (Supp. 85-4). Amended subsection (R) effective June 6, 1986 (Supp. 86-3). Amended effective March 20, 1990 (Supp. 90-1). Amended effective August 6, 1991 (Supp. 91-3). R19-2-104 recodified from R4-27-104 (Supp. 95-1). Amended effective January 6, 1998 (Supp. 98-1). Amended by exempt rulemaking at 17 A.A.R. 1484, effective July 20, 2011 (Supp. 11-3).

R19-2-105. Charity Races

- A. A permittee shall provide the Commission with:
 - 1. The name of any nonprofit organization or corporation selected by the permittee as a charity entitled to benefit from a charity racing day or race.
 - 2. A list of the names and addresses of all directors, officers, and shareholders holding 10% or more of the total number of outstanding voting shares of the charitable corporation.
 - 3. A brief description of the purposes and activities to be benefited by monies received from the charity racing day or race.
 - 4. A copy of an Internal Revenue Service letter of determination qualifying the particular charity as an exempt organization or corporation for federal income tax purposes.
- B. No permittee shall charge any expenses incurred by operation of racing against the pari-mutuel handle of a charity racing day or race except those prorated expenses incurred on the day of that particular charity racing day or race.

Historical Note

Adopted effective August 5, 1983 (Supp. 83-4). Amended effective March 20, 1990 (Supp. 90-1). R19-2-105 recodified from R4-27-105 (Supp. 95-1).

R19-2-106. Licensing

- A. A person participating in any capacity in a racing meeting, including any person who performs services in connection with the conduct of the racing meeting, shall obtain a license from the Department, except:
 - 1. A person performing services during a county fair race meet who is identified by a steward as a volunteer; or
 - 2. A person owning less than 10 percent of outstanding shares of stock, regardless of classification or type, of any permittee or licensee.
- B. Applications.
 - 1. To apply for a license, a person shall complete the license application prescribed by the Department.
 - 2. The Department may issue written instructions regarding the preparation and execution of the license application, and the instructions may be a part of or separate from the application form, or both.
 - 3. When an applicant submits a license application, the applicant shall also submit the fee established by the Department pursuant to R19-2-202(C). The Department shall ensure that a schedule of license and fingerprint processing fees is displayed prominently at each track and also on its web site.
 - 4. An applicant who is at least 18 years of age shall submit a full set of fingerprints to the Department. The fingerprints shall be taken by the Department or certified by a municipal police department, sheriff's office, or other authority acceptable to the Department.
 - 5. An applicant for a trainer license shall demonstrate knowledge and skill in protecting and promoting the safety and welfare of animals participating in racing meetings by passing an examination prescribed by the Department. An applicant who fails to pass the examination shall wait at least six months before retaking the examination.
 - 6. An applicant for a racing license shall indicate on the license application whether the applicant hires employees or independent contractors to work at an Arizona racetrack. For the purposes of this Section, "employee" has the meaning in A.R.S. § 23-902(B) and "independent contractor" has the meaning in A.R.S. § 23-902(C).
 - a. An applicant that hires employees to work at an Arizona racetrack shall provide proof of compliance with A.R.S. § 23-961(A) by providing to the Department a copy of the declaration page of the applicant's workers' compensation insurance policy.
 - b. The Department shall notify the Industrial Commission of Arizona of an applicant that fails to provide proof of workers' compensation insurance as required in this Section. The Department shall notify the Industrial Commission of Arizona of an applicant that hires independent contractors to enable the Industrial Commission of Arizona to investigate the characterization of the applicant's workers as independent contractors.
- C. Each applicant and licensee shall know and follow the rules governing racing in Arizona.
- D. License procedure.
 - 1. Under delegation from the Director, a steward shall grant or deny a temporary license and transmit the license application to the Director.

2. In considering each application for a license, a steward may require the applicant, as well as the applicant's endorsers, to appear before the steward and show that the applicant is qualified to receive the license requested. The steward shall grant a license only if the applicant meets all the requirements in A.R.S. Title 5, Chapter 1, and these rules.
 3. Licensing time-frame.
 - a. Administrative completeness review time-frame
 - i. Within 85 days after receiving a license application, the Department shall determine whether the license application contains the information required by subsection (B).
 - ii. If the license application is incomplete, the Department shall issue a written notice that specifies what information is required and return the license application. If the license application is complete, the Department shall provide a written notice of administrative completeness.
 - iii. The Department shall deem a license application withdrawn if the applicant or licensee fails to file a complete license application within 10 days of being notified that the license application is incomplete.
 - b. Substantive review time-frame: Within five days after determining that a license application is administratively complete, the Department shall determine whether the applicant or licensee meets all substantive requirements and the Director, or designee, shall issue a written notice granting or denying a license.
 - c. Overall time-frame: For the purpose of A.R.S. § 41-1073, the Department establishes the following time-frames for issuing a license:
 - i. Administrative completeness review time-frame: 85 days.
 - ii. Substantive review time-frame: five days.
 - iii. Overall time-frame: 90 days.
 4. Temporary license. All licenses are temporary for 90 days under A.R.S. § 5-108(F). Unless the Director denies a license to an applicant, a temporary license automatically becomes the license after 90 days.
 5. The Department shall perform a background investigation of an applicant including fingerprint processing through the Department of Public Safety and the FBI, and reviewing records of the Association of Racing Commissioners International, Inc., North American Pari-mutuel Regulators Association, information systems, courts, law enforcement agencies, and Department within the time-frame prescribed in subsection (D)(3).
- E. Denials.**
1. A license may be denied if the applicant:
 - a. Has been or is intoxicated or a user of a narcotic drug as defined at A.R.S. § 36-2501(A)(8) within the grounds of the permittee, or
 - b. Fails to disclose the true ownership or interest in any horse.
 2. When a license is denied, the Director shall report the reason for the denial in writing to the applicant and to the Association of Racing Commissioners International, Inc. and the North American Pari-mutuel Regulators Association.
- F. General requirements and restrictions.**
1. A licensee who is employed in more than one category or who changes from one category to another shall be licensed in each category.
 2. A licensee who is an official at different types of tracks (horse, harness, or greyhound) shall be licensed at each type of track.
 3. The Director or designee shall not license a person who is less than 16 years of age in any capacity other than as an owner, and shall not license a person who is less than 18 as an official, trainer, or assistant trainer. A person less than 18 who is licensed as an owner, shall have a parent or guardian sign the owner's license application, assuming full financial responsibility for the owner, before that owner is eligible to be licensed.
 4. When present in the barn area of a horse track, the paddock area, or any other restricted area, a person shall wear in full view a photo identification badge issued by the Department or a pass issued by the permittee.
- G. Authorized agents.**
1. A person may hold a license solely as an authorized agent or be licensed as an authorized agent and be licensed in another category.
 2. The principal shall sign the license application on behalf of an authorized agent and clearly identify the powers of the agent, including whether the agent is empowered to collect money from the permittee. The license application shall be either notarized or signed in the presence of a Department employee and a copy filed with the horsemen's bookkeeper and the Department.
 3. To change an agent's powers or revoke an agent's authority, the principal shall describe the changed powers or revoked authority in writing that is either notarized or signed in the presence of a Department official, and filed with the Department and the horsemen's bookkeeper.
- Historical Note**
- Adopted effective August 5, 1983 (Supp. 83-4).
 Amended subsections (G) and (I) effective January 25, 1985 (Supp. 85-1). Amended subsections (F) and (G) effective December 5, 1985 (Supp. 85-6). Amended subsections (F) and (G) effective February 19, 1987 (Supp. 87-1). Amended subsections (A) and (B) effective October 23, 1987 (Supp. 87-4). Amended subsections (E), (F) and (G) effective November 30, 1988 (Supp. 88-4).
 Amended effective March 20, 1990 (Supp. 90-1).
 Amended effective January 13, 1995 (Supp. 95-1). R19-2-106 recodified from R4-27-106 (Supp. 95-1). Amended effective January 6, 1998 (Supp. 98-1). Amended by final rulemaking at 10 A.A.R. 717, effective April 3, 2004 (Supp. 04-1). Amended by final rulemaking at 10 A.A.R. 4483, effective December 4, 2004 (Supp. 04-4).
 Amended by exempt rulemaking at 17 A.A.R. 1484, effective July 20, 2011 (Supp. 11-3).
- R19-2-107. Stable Names**
- A.** A licensed owner who wishes to race under a stable name shall register the stable name with the Department and pay the fee listed in R19-2-106.
1. Only an owner may register or secure a license under a stable name.
 2. A name other than the legal name of an owner is a stable name.
- B.** When registering a stable name, a licensed owner shall identify any individual or business entity operating under the stable name.
1. An individual operating under a stable name shall possess and be able to produce the individual's owner's license upon request by a racing official.
 2. An individual operating under a stable name shall sign the authorized agent's application.

3. A business entity operating under a stable name shall:
 - a. Register to do business according to the laws of the state of Arizona;
 - b. Submit a list that identifies each stockholder who owns more than 10% of the existing shares, or each partner in a partnership;
 - c. Notify the Department immediately of any change in ownership; and
 - d. Use the name under which the business entity does business in Arizona as its stable name.
- C. If consistent with other laws, a licensed owner may change a stable name by registering the new stable name and paying the applicable fee in R19-2-106.
- D. To abandon a registered stable name, a licensed owner shall provide written notice to the Department.
- E. A licensed owner shall select a stable name that is distinguishable from other registered stable names.
- F. Upon registration, the Department shall determine whether a prospective stable name will be:
 1. Misleading to the public, or
 2. Unbecoming to the sport.
- G. The Department shall not register a stable name that is misleading to the public or unbecoming to the sport.
- H. A licensed owner shall register a separate name for each of the owner's stables.
- I. A licensed owner operating under a stable name shall pay all entry fees for and penalties against the stable.
- J. At the time of entry, a licensed owner shall ensure that the applicable stable name is furnished for the official program.

Historical Note

Adopted effective August 5, 1983 (Supp. 83-4).
 Amended effective March 20, 1990 (Supp. 90-1). R19-2-107 recodified from R4-27-107 (Supp. 95-1). Amended by final rulemaking at 9 A.A.R. 4919, effective December 6, 2003 (Supp. 03-4).

R19-2-108. Leases

- A. The lessee of a horse shall file a copy of the leasing arrangement with the Department. The leasing arrangement shall include:
 1. The name of the horse,
 2. The name and address of the owner-lessor,
 3. The name and address of the lessee,
 4. The stable name, if any, of each party,
 5. The terms of the lease.
- B. No corporation having more than 10 stockholders who are the registered or beneficial owners of stock or membership in the corporation shall lease any horse owned or controlled by it to any person or partnership for racing purposes.
- C. No owner's license shall be granted to a lessee of any corporation referred to in subsection (B) of these rules.
- D. A corporation which leases horses for racing purposes in this state, its stockholders, and its members shall file with the Department, upon request, a report containing such information as the Department may specify.

Historical Note

Adopted effective August 5, 1983 (Supp. 83-4).
 Amended effective March 20, 1990 (Supp. 90-1). R19-2-108 recodified from R4-27-108 (Supp. 95-1).

R19-2-109. Jockeys

- A. Generally.
 1. A jockey shall pass a physical examination by a physician designated by a permittee. An examination is valid for a 12-month period. A steward may require that a jockey take an additional physical examination if the steward

reasonably suspects a jockey's health may endanger himself, his mount, or others. A steward may refuse to allow any jockey to ride until the jockey successfully passes another examination. A steward or a steward's designee may require that any jockey provide blood or urine samples for analysis upon request under A.R.S. § 5-104 (C).

2. A jockey who rides in a race shall report to the jockey room at the time posted in the jockey room and shall remain in the jockey room between races until all engagements for the day have been fulfilled.
3. A jockey shall wear standard jockey attire in official races.
4. Only a jockey, an attendant and a racing official are permitted in the jockey room.
5. A jockey is entitled to a mount fee when the jockey is weighed out by the clerk of scales except in the following cases:
 - a. The jockey refuses to ride a mount without proper cause.
 - b. A steward replaces a jockey with a substitute jockey, unless the jockey is being replaced because of an injury received after weighing out and before the start of a race.
6. A jockey named at the draw by lot or by a steward can be replaced by an owner or trainer without payment of a mount fee by notifying a steward or the steward's designee by 9:00 a.m. the following entry day.
7. An owner or trainer shall pay a mount fee to a replaced jockey equal to the fee of the jockey who rides the race unless:
 - a. An owner or trainer replaces a jockey by notifying a steward or the steward's designee no later than 9:00 a.m. MST on the day immediately preceding the day of the race. In such a case, an owner shall pay a losing fee for each jockey the owner replaces in a race. The Director may establish an earlier deadline for jockey changes in consultation with a permittee, steward, jockey, owner, and trainer, or their representatives at the race meeting. The Director shall not establish a deadline for jockey changes later than noon of a race day at any race meeting with an average daily handle of \$100,000.00 or less; or
 - b. A replaced jockey or jockey's agent waives the fee.
- B. Equipment.
 1. A bridle that exceeds two pounds in weight shall not be used in a race.
 2. A jockey shall use a whip in a race at least 1/4 inch in diameter but not more than one pound in weight or 29 inches in length including the popper.
 3. A jockey, apprentice jockey, exercise rider, pony person, and any other person mounted on a racing surface shall wear a properly fastened helmet.
- C. Weight; weighing.
 1. An owner shall deposit a losing mount fee with a permittee before a jockey is weighed out for a race. If an owner fails to comply with this subsection, a steward may declare the owner's horse out of the race.
 2. A jockey shall weigh out and weigh in for a race without a whip or a bridle.
 3. A jockey's weight is measured against the jockey's assigned weight as published in the official race program.
 4. A jockey shall not weigh more than one pound less than the jockey's assigned weight published in the official program.
 5. A jockey shall declare the amount of overweight at the time of weighing out.

- a. A jockey shall not ride in a race if more than two pounds overweight without the consent of the owner or trainer of the horse the jockey is to ride.
- b. A jockey shall not ride in a race if more than seven pounds overweight without the consent of a steward.
- c. A steward shall not disqualify a horse because of any overweight the horse might carry.
- d. A permittee shall publicly post any change of weight different from that published in the official program.
- 6. Immediately after pulling up, a jockey shall ride to the place of weighing in, dismount after obtaining permission from the official in charge, and wait to be weighed by the clerk of the scales.
- 7. A jockey shall not intentionally touch any person or thing other than the jockey's own equipment before weighing in.
 - a. A jockey shall unsaddle the jockey's own horse, unless the jockey has obtained permission from an official in charge.
 - b. An attendant may touch a the horse only by its bridle unless the attendant has obtained permission from an official in charge.
 - c. A person shall not touch the equipment of a jockey who has returned to the winner's circle to dismount until the jockey has been weighed in unless the person has obtained permission from the official in charge.
- 8. A jockey who is not able to ride to the place of weighing in because of an accident or illness which disables either the jockey or the horse shall walk or be assisted to the scales.

D. Apprentice jockey.

- 1. Licenses.
 - a. An applicant for an apprentice jockey license shall provide a certified copy of the applicant's birth certificate or other satisfactory evidence of date of birth.
 - b. A steward shall issue an apprentice jockey license if an applicant:
 - i. Is more than 16 years of age and, if less than age 18, a parent or guardian signs the license application assuming full financial responsibility for the applicant;
 - ii. Is approved working a horse out of the gate by the starter;
 - iii. Successfully demonstrates to a steward the ability to gallop or exercise a horse; and
 - iv. Has the necessary tack and wearing apparel.
- 2. Expiration of license; weight allowance.
 - a. An apprentice jockey license expires when the apprentice jockey can no longer claim the weight allowances under subsection (b). Upon expiration an apprentice jockey shall surrender the apprentice jockey license to the Department. If a license expires during the term of the current licensing cycle the Department shall issue a jockey license at no additional cost.
 - b. An apprentice jockey who has not been licensed previously in any country may claim an allowance in all overnight races except handicaps and stakes as follows:
 - i. Five pounds for one year from the date of the apprentice jockey's fifth winner.
 - ii. If an apprentice jockey has not ridden a total of 40 winners within one year from the date of the apprentice jockey's fifth winner, the Depart-

ment shall allow the jockey to claim the five-pound allowance for three years from the date of the apprentice jockey's first winner or until the apprentice jockey has ridden a total of 40 winners, whichever comes first.

- c. The calculation of the time for which an apprentice jockey can claim an allowance shall not include time:
 - i. In the armed forces; or
 - ii. The apprentice jockey is physically incapacitated.
- d. An apprentice jockey may ride quarter horses, provided that:
 - i. An apprentice jockey shall not claim an apprentice jockey weight allowance in the race; and
 - ii. The Department does not consider a winner in the race for the purpose of computing the expiration of the right to claim an apprentice jockey allowance.

E. Prohibited acts.

- 1. A jockey shall not fail or refuse to fulfill an engagement for a race or for a specified time unless:
 - a. The race or race card is canceled; or
 - b. A steward excuses the jockey.
- 2. A jockey shall not own, either in whole or in part, a horse registered for racing at a track where the jockey is riding.
- 3. A jockey shall not engage in any pari-mutuel wagering transaction except through the owner of and on the horse that the jockey rides.
- 4. A jockey attendant, jockey valet, or any licensee employed inside a jockey room shall not place a bet for themselves or for another person during the time that they are acting under the authority of their license.
- 5. A jockey shall not ride against a horse trained by the jockey's spouse except as part of an entry.

Historical Note

Adopted effective August 5, 1983 (Supp. 83-4).
Amended effective March 20, 1990 (Supp. 90-1). R19-2-109 recodified from R4-27-109 (Supp. 95-1). Amended by final rulemaking at 5 A.A.R. 812, effective February 24, 1999 (Supp. 99-1). Amended by final rulemaking at 10 A.A.R. 717, effective April 3, 2004 (Supp. 04-1).

R19-2-110. Jockey Agents

- A.** A jockey agent shall be accompanied by the jockey such jockey agent will represent when applying for a jockey agent's license.
- B.** A jockey agent shall not contract riding engagements for more than two jockeys and one apprentice jockey at the same time.
- C.** Only one fee shall be charged for a jockey agent's license.
- D.** A jockey agent may change a rider with the permission of the stewards.
- E.** A jockey agent shall not work in any other capacity at the track where such jockey agent is licensed.
- F.** A jockey agent may enter horses if such jockey agent has the permission of the horse's trainer.
- G.** Riding engagements shall be made only by a jockey or by such jockey's jockey agent.
- H.** A jockey agent shall not communicate with the jockey such jockey agent represents during racing hours. A jockey agent shall notify the jockey such jockey agent represents of late riding engagements through the stewards or designated official.
- I.** A jockey may act as such jockey's own agent. If such jockey chooses to do so:
 - 1. The jockey shall notify the stewards of such jockey's intention to represent him- or herself.

2. The jockey shall comply with all rules governing jockey agents.
 3. The jockey is not required to obtain a jockey agent's license.
- J.** When a jockey or such jockey's jockey agent wishes to terminate the agent agreement, the jockey and the jockey agent shall appear together before the stewards to advise them that their agreement has been terminated.

Historical Note

Adopted effective August 5, 1983 (Supp. 83-4).
Amended effective March 20, 1990 (Supp. 90-1). R19-2-110 recodified from R4-27-110 (Supp. 95-1).

R19-2-111. Trainers

- A.** Trainers shall be obligated to know the provisions of the rules governing racing in the state of Arizona.
- B.** Trainers and their employees shall accept the decisions of the stewards on all questions to which their authority extends, subject to the right of appeal to the Department pursuant to R19-2-123.
- C.** Trainers shall be responsible for the condition of horses under their care and are required to protect such horses from acts of other parties.
- D.** Trainers shall be responsible for determining that each person employed by them at a licensed track is licensed by the Department and that the owner of each horse which is to be entered by them in any race is licensed by the Department.
 1. Trainers shall refuse to act on behalf of any participant at a licensed track if they have reason to believe, in the exercise of reasonable discretion, that such a participant is not licensed by the Department.
 2. A trainer shall not start a horse in any race if the trainer has reason to believe that the owner or owners of the horse are not licensed by the Department before the race. A trainer may enter a horse for an unlicensed owner or owners in a race. If there are no horses on the also-eligible list for the race, the owner or owners must be licensed at least one hour before post time of the first race of the day or the trainer shall have the horse scratched. If there are horses on the also-eligible list, a trainer who entered a horse of an owner or owners who remain unlicensed at the designated scratch time for the race, shall have the horse scratched.
 3. Trainers shall report the existence of the circumstances set forth in subsections (D)(1) and (2) of this Section to the stewards.
- E.** Trainers shall file all registration papers with the racing secretary within 48 hours of their arrival on the grounds of the permittee.
- F.** Trainers shall ensure that each of their owners has a set of colors registered in the office of the racing secretary and possessed by the jockey room custodian before a horse is entered in a race if track colors are not in use.
- G.** Trainers shall pick up all registration papers and colors at the close of the meeting.
- H.** A trainer shall notify the stewards before the transfer of a horse to or from a trainer during a meeting. The stewards shall approve any transfer.
- I.** A trainer shall not shoe a horse that is not under the trainer's care except by permission of the stewards.
- J.** When a trainer is absent from the grounds where the trainer's horses are racing, the trainer shall provide a substitute licensed trainer to be responsible for the horse or horses. If there is a violation of subsection (C) or R19-2-112(16), the stewards shall determine whether the absent or substitute trainer is responsible. No provision of these rules relieves an absent

trainer of responsibility or limits the absent trainer's responsibility under subsection (C). Both the absent and substitute trainers shall sign a "Trainers' Responsibility Form" provided by the Department and be approved by a steward.

- K.** A trainer shall not have an ownership interest in a horse unless the trainer trains the horse and the horse is located at the track where the trainer trains. For purposes of this rule, a reversionary interest created by an agreement transferring control of a horse is not an ownership interest.
- L.** A trainer may employ an assistant trainer with the approval of the stewards. An assistant trainer shall comply with all requirements for a trainer prescribed by this Section and shall be responsible for all horses under the assistant trainer's care.

Historical Note

Adopted effective August 5, 1983 (Supp. 83-4).
Amended subsection (D) paragraph (2) effective February 7, 1984 (Supp. 84-1). Amended effective March 20, 1990 (Supp. 90-1). R19-2-111 recodified from R4-27-111 (Supp. 95-1). Amended by final rulemaking at 10 A.A.R. 717, effective April 3, 2004 (Supp. 04-1).

R19-2-112. Prohibited Acts

Generally:

1. A licensee shall not enter, or cause or permit to be entered, or start a horse a licensee knows or has reason to believe should be disqualified.
2. A veterinarian or plater, licensed to practice on a track under the jurisdiction of the Department, shall not own, lease, or train horses racing at the track on which they practice.
3. A person shall not participate in an unauthorized race on a track while a racing meeting is in progress.
4. A person shall not offer or receive money or other consideration for declaring an entry out of a purse or stakes race.
5. A person shall not possess, within the grounds of any permittee, an electrical, mechanical, or other device, other than ordinary equipment, which may be used to affect the speed or racing condition of a horse. Possession includes, but is not limited to, possession:
 - a. On the person;
 - b. In living or sleeping quarters;
 - c. In an assigned stall, tack room, or other area;
 - d. In a motor vehicle or trailer.
6. Other than a physician or veterinarian licensed by the Department, a person shall not possess, within the grounds of any permittee, any foreign or prohibited substance, injectable vial, hypodermic needle, syringe, or any other instrument which might be used for injection, without written permission of the stewards. Possession includes, but is not limited to, possession:
 - a. On the person;
 - b. In living or sleeping quarters;
 - c. In an assigned stall, tack room, or other area;
 - d. In a motor vehicle or trailer.
7. A licensee listed in A.R.S. § 5-104(F) shall not apply, inject, inhale, ingest, or use any prohibited substance while on permittee grounds, unless, upon the request of a steward, the licensee can produce evidence that the possession or use of a prohibited substance is legitimized by a lawfully issued prescription.
8. A jockey, apprentice jockey, exercise rider, or pony rider shall not consume intoxicating liquor on a race day, prior to completing riding commitments for the day.
9. A licensee or race track employee shall not accept, either directly or indirectly, a bribe, gift, or gratuity in any form

- which is intended to or might influence the results of a race or the conduct of a racing meeting.
10. A licensee, while on the premises of the permittee, shall not create a disturbance, be intoxicated, interfere with a racing operation, or act in an abusive or threatening manner to a racing official or other person.
 11. Only veterinarians licensed by the Department shall administer to or prescribe for horses on the premises of any permittee.
 - a. A licensed veterinarian shall maintain a written record of the name, date, and amount of any drugs or treatments prescribed or administered at the track.
 - b. Notwithstanding the provisions of subsection (11) of this rule, any veterinarian may treat a horse if an emergency involving the life or health of such horse exists.
 12. Notwithstanding the provisions of subsection (16) of this Section, a person shall not administer or cause to be administered a foreign substance, internally or externally, to a horse entered in a race, prior to the race on the calendar day in which the horse is to run, except that:
 - a. With permission of the Department veterinarian, a licensed veterinarian may administer furosemide or conjugated estrogens on the day of the race to control exercise-induced pulmonary hemorrhage, subject to the restrictions prescribed in R19-2-121(P)(5), (6), and (7). The Department veterinarian shall place these horses on the lasix list. The Department veterinarian shall grant permission for placement of a horse on the lasix list if a veterinarian licensed by the Department determines that a horse suffers from exercise-induced pulmonary hemorrhage or a racing regulatory agency has placed the horse on a bleeders' list at a track outside of Arizona.
 - b. A person shall not administer furosemide within four hours prior to post time of a race in which the horse is run.
 - c. A permittee shall clearly identify horses given furosemide on the program or on a list located in areas where mutuel tickets are sold.
 13. The Commission has established permissible trace levels of the following foreign substances, as defined in R19-2-102(15).
 - a. The trace level of Phenylbutazone shall not exceed 5 micrograms per milliliter of plasma of the horse.
 - b. The trace level of Oxyphenbutazone shall not exceed 5 micrograms per milliliter of plasma of the horse.
 14. A person shall not participate in the nerving of a horse intended to be entered in a race at a track within the state of Arizona.
 - a. Registration papers will not be accepted on nerved horses.
 - b. A person shall not enter a nerved horse in a race.
 - c. A person shall not race a horse which is desensitized by the application of cold, chemical, or mechanical freezing devices at the time of arrival at the receiving barn or saddling paddock.
 15. Test samples
 - a. Animal testing
 - i. A steward or Department veterinarian may subject an entry in a race to saliva, urine, blood, or other tests for the purpose of finding foreign substances.
 - ii. Persons approved by the Department shall take samples of saliva, urine, blood, or other substances.
 - iii. A steward may authorize the splitting of any sample.
 - iv. A Department veterinarian may require blood, urine, or saliva samples to be stored in a frozen state for future analysis.
 - v. The owner, trainer, or their representative may be present at all times during the taking and sealing of such tests and samples.
 - vi. The owner, trainer, or representatives of either shall sign documents evidencing the procedure.
 - vii. A person shall not interfere with the collection or procedures conducted under this rule.
 - b. Human testing
 - i. As set forth in A.R.S. § 5-104(C) and R19-2-112(8) and (10), a licensee shall immediately submit to blood, urine, breath, or other tests ordered by the stewards, if the stewards have reason to believe the licensee is under the influence of or in possession of any prohibited substance or has consumed alcohol in violation of subsection (8) or (10) of this Section.
 - ii. A licensee shall provide a test sample in the presence of a steward or the steward's designee, submitted in a container furnished by the Department and immediately sealed by the steward or steward's designee in the presence of the licensee being tested.
 - iii. The steward or steward's designee shall mark the container with the following items: sample identification number; time, date, and location where the sample was given; and the signature of Department personnel sealing the container.
 - iv. The steward or steward's designee shall submit the container to a Department-approved laboratory for analysis.
 - v. If laboratory analysis indicates the positive presence of any prohibited substance or alcohol in the tested licensee's sample, the licensee may be subject to license suspension or revocation or civil penalties, as set forth in R19-2-121(E)(3)(f) and A.R.S. § 5-108.05(A).
 - vi. Test results and information obtained during the testing process are accessible only to members of the Commission, the Director or designees of the Director, and the tested licensee. The Department shall keep the information in a locked, secured area of the Department office.
 - vii. The steward's or designee's compliance with these rules constitutes prima facie evidence that the chain of custody of the test samples is secure. The presiding officer in an administrative proceeding of the Department or Commission shall admit the results of such tests.
 16. The trainer, groom, and any other person charged with the custody and care of a horse is required to protect and guard the horse against the administration, either internally or externally, of any foreign substance. A positive test indicating the presence of a foreign substance (except as set forth in subsections (12) and (13) of this Section) creates the presumption of failure to meet the duty imposed by this rule.
 17. The owner of a horse disqualified in a race because of an infraction of these rules shall forfeit and return the purse

or stakes, the trophy received from the race, and the entry or subscription money.

- a. The stewards shall distribute winnings forfeited pursuant to this subsection among the remaining entitled entries in the race.
 - b. The stewards shall disqualify and may declare a horse unplaced for every purpose except pari-mutuel wagering if the chemical analysis performed pursuant to subsection (15)(a) of this Section indicates the presence of a foreign substance classified as Class 1 or Class 2 under the Association of Racing Commissioners International, Inc., February 14, 1995, Uniform Classification Guidelines for Foreign Substances incorporated by reference, on file with the Office of the Secretary of State, and not including any later amendments or editions.
 - c. The stewards may disqualify and declare a horse unplaced for every purpose except pari-mutuel wagering if the chemical analysis performed pursuant to subsection (15)(a) of this Section indicates the presence of a foreign substance classified as Class 3, Class 4, or Class 5 under the Association of Racing Commissioners International, Inc., February 14, 1995, Uniform Classification Guidelines for Foreign Substances incorporated by reference, on file with the Office of the Secretary of State, and not including any later amendments or editions.
 - d. The stewards may disqualify and declare a horse unplaced for every purpose except pari-mutuel wagering if the chemical analysis performed pursuant to subsection (15)(a) of this Section shows that a horse on the lasix list raced without the medication described in subsection (12) of this Section, or that the plasma of the horse contained trace levels of medication in excess of the level permitted by subsection (13) of this Section.
 - e. The Department veterinarian shall review all reports indicating the presence of a foreign substance and consult with the stewards prior to the initiation of disciplinary action. When a report indicates the presence of a substance classified as Class 3, Class 4, or Class 5, the Department veterinarian's review shall specifically address trace-level detection to prevent the initiation of disciplinary action based upon pharmacologically insignificant traces of a substance.
18. The Department may suspend the license of a licensee who refuses to make a payment for financial obligation incurred in connection with racing in this state.

Historical Note

Adopted effective August 5, 1983 (Supp. 83-4).
Amended paragraphs (10) and (11) effective June 6, 1986 (Supp. 86-3). Amended paragraphs (10) and (11) effective August 3, 1987 (Supp. 87-3). Amended effective November 30, 1988 (Supp. 88-4). Amended effective March 20, 1990 (Supp. 90-1). R19-2-112 recodified from R4-27-112 (Supp. 95-1). Amended effective January 12, 1996 (Supp. 96-1).

R19-2-113. Entries and Subscriptions

A. Entry.

1. An owner or trainer shall not register a horse for racing under these rules unless the horse is registered by the Jockey Club, American Quarter Horse Association, Arabian Horse Club Registry of America, Inc., Appaloosa Horse Club Inc., American Paint Horse Association,

American Donkey and Mule Society, or American Mule Association.

2. An owner or trainer shall list each person with an ownership interest in a horse on the back of the horse's registration papers.
3. An owner, trainer, or their authorized agent may enter a horse in person, by telephone, by telegram, or in writing.
4. The stewards shall consider a horse entered for a purse a "starting horse" unless they declare the horse out of the race.
5. A person nominating a horse in a stakes race shall write the person's full name, mailing address, and telephone number on the nomination form.
6. A person shall not enter a horse in more than one race in one day.
7. An owner shall not transfer a horse to a new trainer after entry.
8. An owner shall not enter a horse if the horse's performance records for the preceding calendar year are not printed in the Daily Racing Form Monthly Chart Book, unless the owner provides the horse's performance records to the racing secretary prior to entry.
9. An owner or trainer shall sign and certify a horse's performance record and shall include the following information for the horse's last four races in the record;
 - a. Where and when the horse raced;
 - b. The distance, the weight carried, and the amount earned.
 - c. The finishing position and time of the race.
10. The second half of an entry has no preference over a single entry except in stakes, handicaps, and qualifying races.
11. An owner entering two or more horses in a race shall indicate the owner's preference for the horse that is to start if the race overfills. A horse excluded because a race overfills receives no consideration.
12. Two or more horses that are entered in a race may be uncoupled for wagering purposes in stakes, handicaps, futurities, and maturities if approved by the stewards and:
 - a. Both horses are owned, in whole or in part, by the same person; or
 - b. Both horses are trained by a trainer who owns an interest in one of the horses.
13. In a race in which spouses who are both licensed trainers have entered horses, the trainers are not required to list an overfill preference unless there is "common ownership of the horses entered."
14. The racing secretary shall decide whether to use an "also-eligible" list for any meeting.
 - a. The racing secretary shall determine the number of "also-eligibles" if the entries of a race exceed the capacity of the starting gate.
 - b. If the number of entries to a race exceeds the number of horses permitted to start, the racing secretary shall determine the starters by lot in a drawing supervised by a steward and witnessed by those making entries. If any of the starters declare out, the racing secretary shall draw, by lot from the "also-eligible" list, the number of horses needed to fill the vacancies in the race.
 - c. The racing secretary shall assign horses, other than quarter horses, that gain a position in a race from the "also-eligible" list, to the outside post positions in the order in which they are drawn from the list. The racing secretary shall assign a quarter horse to the stall of a horse that is declared out.

- d. If a horse on the “also-eligible” list does not start because of insufficient declarations, the racing secretary shall place the horse on the preferred list. The racing secretary shall not place a horse on the preferred list if the owner does not accept the opportunity to start the horse.
 - e. A horse whose owner, trainer, or authorized agent has drawn its position in a race and entered it again for the next race day is called an “in today horse.”
 - i. If a race in which a horse is entered overfills, the racing secretary shall not consider the “in today horse” except in cases where the conditions read “Arizona Breds Preferred,” stakes, and handicaps.
 - ii. The racing secretary shall not consider a horse on the “also-eligible” list as an “in today horse” until it has been given a position in a race or an opportunity to run.
 - f. At tracks where entries are taken two or more days ahead of the date of the race, an owner, trainer, or authorized agent may re-enter a horse on the next date if it has been placed on the “also-eligible” list. If it is drawn into a race from its position on the “also-eligible” list, the horse shall be declared an “in today horse” and be withdrawn from the race the following day in favor of a horse on the “also-eligible” list of that race.
15. A person shall make a claim of preference at the time of entry by noting it on the entry blank or the preference will be lost.
- a. When a horse has been entered in a race, a person shall withdraw a horse only with permission of the stewards.
 - b. The racing secretary shall post a copy of the preferred list each afternoon, and any person making a claim of error shall do so by 10:00 a.m. of the following day. The stewards shall not recognize a claim of error made after this time.
16. If an owner or trainer does not declare a horse from the “also-eligible” list by the prescribed time, the racing secretary shall consider the owner or trainer willing to start the horse if another horse is scratched from the race. The racing secretary shall not place a horse on the preferred list if the owner does not accept the opportunity to start the horse.
17. A person shall not alter an entry after the closing of entries. The racing secretary may correct an error in an entry at any time.
18. If the name of a horse is changed, the racing secretary shall publish the new name and the former name in the official entries for the horse’s first three starts after the name change. If the name of an Arizona-bred horse is changed, the racing secretary shall report it to the Department in writing within 30 days, listing the new name and the former name.
- B. Conditions for entry.**
1. A person shall not enter a horse in a race unless its certificate of foal registration, certificate of foreign registration, or racing permit is on file in the racing office of the track at which the horse is to race, or unless permission is granted by the stewards. Foal certificates, which are registered with the racing secretary and are in transit between that office and the American Quarter Horse Association because of a transfer of ownership, are considered to be in the possession of the racing secretary.
 2. A horse that has reached its 14th birthday is ineligible to race in Arizona.
 3. The stewards shall not permit a horse to run for a purse or stakes unless it is entered in a race and is eligible for the race.
 4. The stewards may summon a person in whose name a horse is entered to produce proof that the horse entered is not the property, either in whole or in part, of a person who is disqualified, or to produce proof of the extent of a person’s interest in the horse. Failure to produce satisfactory proof shall result in the stewards declaring the horse out of the race if the stewards determine that it is necessary to protect the public peace, safety, or welfare.
 5. A horse is not qualified for entry if it is on the stewards’, paddock judge’s, starter’s, or veterinarian’s list, or if it has been ruled off.
 6. The racing secretary shall consider the performance record of a horse racing on the county fair circuit to determine its eligibility at a commercial meet. A county fair racing secretary shall place a county fair win on the back of the foal certificate.
 7. The owner, trainer, or authorized agent shall ensure that a horse that has not started within 45 days has one official workout before starting at a commercial meet.
- C. Starts.**
1. A person shall not start a horse in a race unless it is fully identified and tattooed, or otherwise authorized by the stewards. A person who participates in any manner in establishing the identity of a horse, including the breeder, owner, trainer, and identifier, is responsible for the accuracy of the information the person provides.
 2. An owner, trainer, or authorized agent shall not start a horse in a race until all stakes, forfeits, entry fees, and arrears due on the horse have been paid.
 3. The racing secretary shall not permit a horse to start in a stakes race unless it has passed the entry box on the day on which entries for the stakes race are taken.
 4. An owner, trainer, or authorized agent shall not start a horse in a race unless all persons having an ownership interest in the horse or an interest in the winnings of the horse have registered with the racing secretary.
 5. The racing secretary shall post the saddle-cloth numbers of the horses in a race after overnight entries are closed and post positions are drawn. If a horse with an assigned saddle-cloth number does not start or run the course, the stewards may require an explanation from the owner, trainer, or jockey.
- D. Fees.**
1. The entrance to a purse race is free unless otherwise stipulated in the conditions of the race. If the conditions require an entrance fee, the fee is paid at the time of entry.
 2. The person entering a horse is liable for nominating, sustaining, and starting fees. The subscriber or subscriber’s transferee are not entitled to a refund in the event of horse death, withdrawal, or mistake in a horse’s entry if the horse is eligible, except as provided in subsection (D)(3).
 3. The permittee shall not refund entrance money for a purse race that is run if a horse fails to start or dies unless otherwise provided in the conditions of the race.
 4. The permittee shall distribute the entrance money, starting, and subscription fees, as provided in the conditions of the race. If a race is not run, the permittee shall refund all stakes or entrance money.
 5. The death of a nominator or subscriber does not void an entry, subscription, or right of entry.

6. A person shall not transfer a horse to an owner or trainer to avoid disqualification. The person making or receiving such a transfer may be fined and suspended.
- E. Closing.**
1. The racing secretary shall close the entries for purse races at the time advertised in the condition book and shall not receive an entry after that time. If a race fails to fill, additional time may be granted by the stewards.
 2. In the absence of notice to the contrary by the permittee, nominations for stakes which close during or on the eve of a racing meeting close at the office of the racing secretary at the published time.
 3. The racing secretary shall not receive entries and declarations for stakes after the designated closing time.
 4. The racing secretary shall not accept an entry after a race has been drawn even though the number of horses on the "also-eligible" list is insufficient to provide a full field.
 5. The racing secretary shall consider a horse, withdrawn from a race after the overnight entries are closed, a scratch. The scratched horse loses all of its accrued preferences up to that date unless it is excused by the stewards.
- F. Declarations.**
1. An owner, trainer, or authorized agent shall declare a horse from a stakes, handicap, or qualifying race in writing no later than one hour prior to post time of the race.
 2. The racing secretary shall not give preference to a horse which is declared from the "also-eligible" list of a race for having entered in that race. The horse may retain the position it previously held on the preferred list if a full field is left in the race at scratch time.

Historical Note

Adopted effective August 5, 1983 (Supp. 83-4). Amended effective March 20, 1990 (Supp. 90-1). Age reference to "16th birthday" in subsection (B)(2) corrected to read "6th birthday" (Supp. 93-1). R19-2-113 recodified from R4-27-113 (Supp. 95-1). Amended effective April 7, 1995 (Supp. 95-2). Amended effective March 7, 1996 (Supp. 96-1). Amended by final rulemaking at 10 A.A.R. 717, effective April 3, 2004 (Supp. 04-1).

R19-2-114. Penalties and Allowances

- A.** Eligibility, penalties, and allowances of weight for all races shall be determined after consideration of the reports, records, and statistics published by the Daily Racing Form and by other racing statistical publications. Responsibility for weight carried and for eligibility shall remain with the owner and trainer.
 - B.** Penalties and allowances shall not be cumulative unless so declared by the conditions of the race. They shall take effect at the time of starting; provided, however, that in overnight events a horse shall have only the allowance to which it was entitled at the time of entry.
 - C.** Penalties shall be obligatory. Allowances shall be optional in whole or in part. In overnight events, allowances must be claimed at the time of entry.
 - D.** Failure to claim a weight allowance by overnight omission shall not be a cause for disqualification. A claim of weight allowance to which a horse is not entitled shall not be a cause for disqualification unless such incorrect weight is carried in the race. However, a fine may be imposed upon the person claiming allowance to which such person's horse is not entitled.
 - E.** A horse shall not receive an allowance of weight or be relieved from extra weight as a result of having lost one or more races. This rule does not prohibit a maiden allowance or an allowance to a horse that has not won a race within a specified period or a race of a specified value.
- F.** No horse shall incur a weight penalty for a placement from which it is disqualified, but a horse placed through disqualification of another horse shall incur the weight penalties of that placement. No such placement shall make a horse ineligible for a race which has already been run.
 - G.** When a race is in dispute, both the horse that finished first and any horse claiming the race shall be liable to all penalties attaching to the winner of that race until the matter is decided.
 - H.** Horses which have started for a claiming price in optional or combination races shall be considered to have started in a claiming race.
 - I.** Races written to be run under "scale weights" or "weights for age" shall be run under the scale approved by the Department.
 - J.** In races of intermediate length, the weights for the shorter distances shall be carried.
 - K.** In all races except handicap races and races in which conditions expressly provide otherwise:
 1. Two-year-old fillies are allowed three pounds.
 2. Fillies and mares 3 years old and older are allowed five pounds before the first of September and three pounds thereafter.
 3. The provisions of subsections (K)(1) and (2) of this Section shall not apply to quarter horse fillies and mares.
 - L.** The racing secretary may write races either above or below the scale, in the racing secretary's discretion; provided that:
 1. Not more than 10 pounds shall be deducted from the scale of weights for age with the exception of allowances in overnight races.
 2. The total allowances of any type shall not reduce the lowest weights below 100 pounds in any race.
 3. The provisions of subsection (L)(1) of this Section shall not apply to handicap races.
 4. The provisions of subsection (L)(2) of this Section shall not apply to 2-year-olds racing with older horses.
 - M.** Starter allowance eligibility conditions.
 1. A horse shall have started in a claiming race, or in an optional claiming race to be claimed, in order to establish eligibility in a starter allowance race.
 2. In addition to the provisions of subsection (M)(1) of this Section, to be eligible for a starter allowance a horse shall:
 - a. Have started for the claiming price designated in the conditions of the race or have started for a price less than that claiming race.
 - b. Not have won for a price higher than that designated in the conditions of the race since last starting for that price or for less than that price.
 - c. Not have won a race other than a claiming race since last starting for the claiming price designated in the conditions of the race or for less than that price.
 3. A horse claimed in a claiming race must subsequently start for a claiming price to establish new eligibility for a starter allowance race.
 4. Eligibility for a starter allowance race remains unchanged following a private sale.

Historical Note

Adopted effective August 5, 1983 (Supp. 83-4). Amended effective March 20, 1990 (Supp. 90-1). R19-2-114 recodified from R4-27-114 (Supp. 95-1). Amended by final rulemaking at 10 A.A.R. 717, effective April 3, 2004 (Supp. 04-1).

R19-2-115. Claiming Races: Eligibility for Claiming

In claiming races, any horse is subject to a claim for its entered price by any licensed owner of a horse duly registered for racing at the track, such owner's licensed authorized agent, or the holder of a claiming authorization issued by the stewards.

Historical Note

Adopted effective August 5, 1983 (Supp. 83-4).
Amended subsection (A) effective December 5, 1985 (Supp. 85-6). Amended effective March 20, 1990 (Supp. 90-1). Former Section R4-27-115 renumbered to R4-27-115, R4-27-115.02 through R4-27-115.07, and R4-27-115.09; new Section R4-27-115 renumbered from R4-27-115(A)(1) through (5) and (B) and amended effective September 8, 1992 (Supp. 92-3). R19-2-115 recodified from R4-27-115 (Supp. 95-1).

R19-2-115.01. Claiming Races: Duration of Race Meetings

For purposes of R19-2-115 through R19-2-115.10:

1. A commercial meeting includes county fair dates which may be run at the commercial track before, during, or after the commercial meeting.
2. A county fair meeting includes the entire county fair circuit, spring and fall.

Historical Note

Adopted effective September 8, 1992 (Supp. 92-3). R19-2-115.01 recodified from R4-27-115.01 (Supp. 95-1).

R19-2-115.02. Claiming Races: Steward Claiming Authorization

- A. The following persons may apply to the stewards for claiming authorization:
1. A licensed owner whose last horse has been lost by claim, death, or career-ending injury during a commercial or county fair meeting.
 2. A person licensed in partnership or other form of multiple ownership wanting to claim a horse in sole ownership, or currently licensed persons wanting to join in a multiple ownership venture. A licensed owner may not be a party to more than one stable name or use his or her legal name for racing purposes if already registered in a stable name.
 3. A licensed owner whose horse is not participating at an Arizona track during the current Arizona licensing cycle.
 4. A person making application for an owner's license who intends to obtain his or her first horse through claiming.
 - a. At least seven days prior to entering a claim, the applicant shall submit to the Department a completed owner's license application and fingerprint card, the owner's license fee, and evidence of current employment or other indication of financial responsibility. In addition, an applicant with previous pari-mutuel racing participation shall submit documentation that the applicant is in no way disqualified in this or any other jurisdiction.
 - b. Upon determination that an applicant has met all requirements for an owner's license, except the requirement of horse ownership, claiming authorization may be granted and claiming credentials may be issued.
 - c. Upon the successful claim of a horse, the owner's license shall be issued.
- B. A person applying for authorization pursuant to this rule shall submit written acknowledgment that a licensed trainer shall assume care and responsibility for any horse claimed.
- C. A person who claims a horse through authorization obtained under this rule shall start the claimed horse back pursuant to

R19-2-115 through R19-2-115.10 before claiming again in his or her own name or in partnership.

- D. Claiming authorization obtained pursuant to this rule shall be valid for six months or until the authorized person successfully claims a horse, which occurs first.

Historical Note

Section R4-27-115.02 renumbered from R4-27-115(A)(6)(a), (b), and (d), (C)(3), (4), (6)(c)(i) and (ii), (10)(a) and (12) and amended effective September 8, 1992 (Supp. 92-3). R19-2-115.02 recodified from R4-27-115.02 (Supp. 95-1).

R19-2-115.03. Claiming Races: Claiming Restrictions

- A. An authorized agent, although representing more than one owner, may not submit more than one claim in any one race, or claim a horse for himself or herself in the capacity of agent.
- B. When a stable consists of horses owned by more than one person and trained by the same trainer, not more than one claim may be entered on behalf of the stable in any one race.
- C. The stewards, at their discretion, may require any person making a claim for a horse to provide written affidavit that he or she is claiming the horse for his or her own account, or as authorized agent, and not for any other person.
- D. A person shall not offer to enter into an agreement to claim or not to claim, or attempt to prevent another person from claiming, any horse in a claiming race. A person shall not attempt to prevent anyone from running a horse in any race. Owners or trainers running horses in any claiming race shall not make any agreement for the protection of each other's horses.
- E. A person may not enter, or allow to be entered, in a claiming race a horse against which any lien is held, unless, when or before entering the horse, the written consent of the holder of the lien is filed with the clerk or the course or racing secretary.
- F. A person may not claim an ownership interest in a horse after the horse has run in a claiming race in the name of another person who, at the time of the race, had peaceable and undisputed possession of the horse.
- G. A person may not claim his own horse, or cause his own horse to be claimed, directly or indirectly, for his account.
- H. An owner shall not claim any horse in the care and custody of the owner's trainer.

Historical Note

Section R4-27-115.03 renumbered from R4-27-115(C)(1), (7) and (8), (F)(1), (2), and (3), (G)(1) and (2), (L), (M), and (N) and amended effective September 8, 1992 (Supp. 92-3). R19-2-115.03 recodified from R4-27-115.03 (Supp. 95-1).

R19-2-115.04. Claiming Races: Delivery of Claimed Horse

- A. Any horse claimed shall, after the running of the race, be delivered to the claimant. The claimant shall present written authorization from the stewards or their representative to the owner of the horse.
- B. Claimed horses which are sent to the detention area for post-race testing shall be delivered at the detention area. All other claimed horses shall be delivered pursuant to directions from the stewards on a meet-by-meet basis.
- C. The claimant of a horse not known to be designated for testing may require such procedure, provided that physical delivery of the claimed horse has not occurred and that the claimant shall pay testing costs. The original trainer shall maintain responsibility for the condition of the horse.
- D. No person shall refuse to deliver a claimed horse.

Historical Note

Section R4-27-115.04 renumbered from R4-27-115(H), (H)(1), (2), (3) and (4), and (I) and amended effective

September 8, 1992 (Supp. 92-3). R19-2-115.04 recodified from R4-2-115.04 (Supp. 95-1).

R19-2-115.05. Claiming Races: Irrevocability of Claim

Claimants shall not revoke their claims. Title to a claimed horse shall be vested in the successful claimant from the time the horse becomes a starting horse, and such claimant shall become the owner of the horse whether the horse is dead, unsound, or injured during or after the race. For purposes of the race in which a horse is claimed, the claimed horse shall run in the interest of and for the account of the owner for whom claimed.

Historical Note

Section R4-27-115.05 renumbered from R4-27-115(C)(10) and (11) and (E) and amended effective September 8, 1992 (Supp. 92-3). R19-2-115.05 recodified from R4-27-115.05 (Supp. 95-1).

R19-2-115.06. Claiming Races: Claimed Horse Racing and Ownership Restrictions**A. If a horse is claimed:**

1. It may not be sold or transferred to anyone wholly or in part, except in a claiming race, for a period of 30 days from the date of claim.
2. Unless reclaimed, the horse may not be returned to the same stable or under control or management of its former owner or trainer for a period of 30 days from the day of claim.
3. The horse may not race outside Arizona until the meeting at which it was claimed has closed or for a period of 60 days from the day of the claim, whichever is less, except to fulfill a stakes engagement transferring automatically to the new owner, or when the horse is entered and starts for a claiming price which would cause the horse to become ineligible to be reentered at the track where claimed.

B. All horses claimed in other states and racing here shall be subject to the conditions of the claiming restrictions in the state where the claim was made.**Historical Note**

Section R4-27-115.06 renumbered from R4-27-115(J)(1), (2), (3), and (4) and (K) and amended effective September 8, 1992 (Supp. 92-3). Amended effective December 17, 1993 (Supp. 93-4). R19-2-115.06 recodified from R4-27-115.06 (Supp. 95-1). Amended by final rulemaking at 10 A.A.R. 717, effective April 3, 2004 (Supp. 04-1).

R19-2-115.07. Claiming Races: Claiming Price and Determination of Winner of Claim

The claiming price of each horse in a claiming race shall be printed on the program, and all claims for the horse shall be for the amount so designated. If more than one claim is filed for the same horse, the disposition of the horse shall be determined by lots under the direction and supervision of one or more of the stewards or their designee.

Historical Note

Section R4-27-115.07 renumbered from R4-27-115(C)(9) and (D) and amended effective September 8, 1992 (Supp. 92-3). R19-2-115.07 recodified from R4-27-115.07 (Supp. 95-1).

R19-2-115.08. Claiming Races: Responsibility for Determining Sex of Horse

Notwithstanding any designation of sex appearing on the racing program or in any racing publication, the claimant of a horse shall be solely responsible for determining the sex of the horse claimed.

Historical Note

Section R4-27-115.08 adopted effective September 8, 1992 (Supp. 92-3). R19-2-115.08 recodified from R4-27-115.08 (Supp. 95-1).

R19-2-115.09. Claiming Races: Claiming Procedures

- A. All claims shall be made in writing on a form provided by the permittee. The form shall be properly completed, signed and enclosed in an envelope also provided by the permittee. The envelope shall have no identification marking other than the number of the race for which the claim is being made, and the day, month and year of the race. The envelope shall be sealed and deposited in a time-locked claim box provided for this purpose by the permittee. Money shall not accompany the claim.
- B. All claims shall be deposited in the claim box at least 10 minutes before post time of the race on which the claim is made.
- C. The stewards or their designee shall open the claim envelopes for each race when the horses for the race enter the track on the way from paddock to post. The stewards or their designee shall ascertain from the horsemen's bookkeeper whether the proper credit balance has been established with the permittee.

Historical Note

Section R4-27-115.09 renumbered from R4-27-115(C), (C)(2), (5), and (6) and amended effective September 8, 1992 (Supp. 92-3). R19-2-115.09 recodified from R4-27-115.09 (Supp. 95-1).

R19-2-115.10. Claiming Races: Disciplinary Action

A person violating any of the provisions of R19-2-115 through R19-2-115.09 shall be subject to discipline by the board of stewards, pursuant to Section R19-2-121(E).

Historical Note

Section R4-27-115.10 adopted effective September 8, 1992 (Supp. 92-3). R19-2-115.10 recodified from R4-27-115.10 (Supp. 95-1).

R19-2-116. Arizona Bred Eligibility and Breeders' Award Payments

- A. A breeder shall file a notarized certificate affirming eligibility under A.R.S. § 5-113(F), with the Department. The certificate shall include name, color, and sex of the foal; name of the sire; name of the dam; date and location of foaling; The Jockey Club registration number or American Quarter Horse Association number; name, address, and telephone number of the breeder; a statement that the animal is eligible pursuant to A.R.S. § 5-113(F), and that the person shown as the breeder was the owner of the dam at the time of foaling; and such other information as may be required by the Department to determine eligibility and shall be signed by the breeder. The breeder shall submit a copy of The Jockey Club registration papers with certificates for thoroughbreds.
 1. Certification is deemed to occur upon the Department's receipt of the completed certificate.
 2. The horse shall be certified by the Department at the time of the win to be eligible for an award.
- B. A permittee shall recognize any horse for which there is an Arizona Bred Certificate on file with the Department or an association contractor as an Arizona bred horse.
- C. For races that offer a guaranteed purse value of \$50,000 or less, the Department shall make an award based on the total amount earned by the winner, including nominating, sustaining, and starting fees. For races that offer a guaranteed purse value of more than \$50,000, the Department shall not include nominating, sustaining, or starting fees when calculating an award.

- D. The Department shall calculate and pay breeders' awards to eligible breeders.
1. Definitions
 - a. "Quarterly Breeders' Award" means an amount of money based on the quarterly breeders' award payment factor determined by the Department each fiscal year by October 30.
 - b. "Substitute Breeders' Award" means an amount of money based on a substitute payment factor because of the lack of sufficient money to pay conventional Quarterly Breeders' Awards.
 - c. "Supplemental Breeders' Award" means an amount of money that corrects a shortfall between conventional Quarterly Breeders' Awards and Substitute Breeders' Awards.
 - d. "End-of-year Bonus Award" means an amount of money that may be paid to breeders from available monies that remain in the breeders' award fund after payment of Quarterly Breeders' Awards, Substitute Breeders' Awards and Supplemental Breeders' Awards.
 2. The Department shall pay awards at the end of each fiscal year quarter, provided that the total amount of the awards payments does not exceed the total amount of money available in the fund less the amount required to be set aside for contingent liabilities in subsection (D)(8).
 3. Quarterly Breeders' Awards. Before October 30 of each year, the Department shall determine a quarterly breeders' award payment factor that will be applied during the entire fiscal year. The payment factor determined by the Department is not subject to appeal.
 - a. The Department shall evaluate anticipated revenues for the breeders' award fund and anticipated purses for eligible Arizona-bred animals and set the payment factor at a level that permits recipients of quarterly breeders' awards to receive awards throughout the fiscal year based on the same payment factor.
 - b. The Department shall notify representatives of each breeders' association of the quarterly breeders' award payment factor in writing before October 30 of each year.
 - c. The Department shall calculate quarterly breeders' awards by multiplying the amount of each purse won by an eligible animal during that quarter by the quarterly breeders' award payment factor established for the fiscal year.
 - d. The Department shall make quarterly breeders' awards not later than 30 days after the end of each quarter, unless full quarterly breeders' awards cannot be made due to the lack of available money in the fund.
 4. Substitute Breeders' Awards. The Department shall make substitute breeders' awards if there are sufficient monies in the fund to allow for an award but not enough monies to provide for full payments of quarterly breeders' awards based on the quarterly breeders' award payment factor.
 - a. The Department shall determine the substitute payment factor by dividing the total amount of monies in the Arizona breeders' award fund at the end of the quarter less the amount required to be set aside for contingent liabilities in subsection (D)(8) by the total amount of purses won by eligible Arizona-bred animals during that quarter.
 - b. The Department shall calculate substitute breeders' awards by multiplying the amount of each purse won by an eligible animal during that quarter by the substitute payment factor for that quarter.
 5. End-of-year bonus pool. After payment of all quarterly breeders' awards and any substitute breeders' awards has been calculated, the Department shall determine the amount of monies remaining in the fund. The end-of-year-bonus pool is the amount of monies remaining in the Arizona breeders' award fund after the payment of all quarterly breeders' awards for the fiscal year less the amount required to be set aside for contingent liabilities in subsection (D)(8).
 6. Supplemental Breeders Awards. The Department shall first pay any monies in the end-of-year bonus pool in the form of supplemental breeders awards to recipients of substitute breeders' awards.
 - a. The Department shall pay supplemental breeders' awards in an amount equal to the difference between the substitute breeders' award and the quarterly breeders' award the breeder would have received if there had been enough in the fund to pay an award based on the quarterly award payment factor.
 - b. In the event the end-of-year bonus pool cannot pay supplemental breeders' awards to make up for the shortfall to all substitute breeders' award recipients, the Department shall pay supplemental breeders' awards to all breeders eligible to receive a supplemental breeders' award on a pro-rata basis.
 - c. A breeder is eligible to receive a supplemental breeders' award from the end-of-year bonus pool only if the breeder received a substitute breeders' award during that fiscal year.
 - d. The Department shall not make supplemental breeders' awards if all eligible breeders received quarterly breeders' awards during the fiscal year.
 7. End-of-year Bonus Awards. The Department shall pay end-of-year bonus awards if monies remain in the end-of-year bonus pool following any supplemental payments.
 - a. The Department shall determine an end-of-year bonus payment factor by dividing the monies in the end-of-year bonus pool by the total amount of purses won by an eligible animal during the fiscal year.
 - b. The Department shall calculate end-of-year bonus awards by multiplying the amount of each purse won by an eligible animal by the bonus payment factor.
 8. Contingent liabilities. The Department shall retain \$10,000 in the Breeders' Award fund for contingent liabilities.
 9. The Department shall not make quarterly breeders' awards, substitute breeders' awards, supplemental breeders' awards or end-of-year bonus breeders' awards if the total amount available for distribution is less than \$10,000. In the event the Department does not pay an award because less than \$10,000 is available for distribution, the Department shall carry forward the amount in the fund for payment of awards when the Department next calculates awards.
 10. Appeal of Director's Rulings
 - a. The Director shall make the final decision concerning a breeders' award.
 - b. The Department shall give written notice of the decision to an applicant by mailing it to the address of record filed with the Department.
 - c. After service of the Director's decision, an aggrieved party may obtain a hearing under A.R.S. §§ 41-1092.03 through 41-1092.11.

- d. The aggrieved party shall file a notice of appeal with the Department within 30 days after receiving the notice prescribed in R19-2-116(D)(10)(b).
- e. The Department shall notify the Office of Administrative Hearings, which shall schedule and conduct the hearing.
- E. The permittees shall submit to the Department an Arizona Breeders' Award Report in the form prescribed by the Department. The report shall include name of the animal, name of the breeder, date of win, win purse amount, type of race, name of track, and such other information as may be required by the Department to calculate awards.
- F. The Arizona Thoroughbred Breeder's Association, Arizona Quarter Racing Association, Arizona Greyhound Breeder's Association, and such other associations as may represent breeders in this state may assist the Department in periodic reviews of eligibility lists and may provide such other assistance in administering the fund as may be required by the Department.
- G. At least every other three years the Commission shall select a committee, consisting of representatives of each breeders' association and the Department, which shall review this rule and submit written recommendations to the Commission.

Historical Note

Adopted effective August 5, 1983 (Supp. 83-4).
Amended subsection (A) effective December 5, 1985 (Supp. 85-6). Amended subsection (A) and added subsections (D) through (G) effective August 13, 1986 (Supp. 86-4). Amended subsection (D) effective February 19, 1987 (Supp. 87-1). Amended effective March 20, 1990 (Supp. 90-1). R19-2-116 recodified from R4-27-116 (Supp. 95-1). Amended effective January 10, 1997 (Supp. 97-1). Amended effective June 3, 1997 (Supp. 97-2).

R19-2-117. Objections

- A. Every objection shall be made by an owner or by such owner's authorized agent, a trainer, or the jockey of some other horse engaged in the same race, or by the officials of the course. Such objection shall be made to the stewards, who may require that the objection be made in writing with a copy thereof sent immediately to the Director.
 - 1. Any objection to a horse, pertaining to any matter occurring in a race, except as otherwise provided, shall be made before the official numbers of the horse's place in the race are posted on the odds board.
 - 2. Any objection to a horse that has run in a race on the grounds that it was not trained by a licensed trainer, or ridden by a licensed jockey, or that the names of all those having ownership in it or an interest in its winnings have not been registered with the secretary shall be made not later than the day after that upon which the race was run.
 - 3. Any objection on the grounds of fraudulent or intentional misstatement or omission in the entry under which a horse has run, or on the grounds that the horse which ran was not the horse it was represented to be in the entry or at the time of the race, or was not of the age it was represented to be shall be received within three days after the race.
- B. Every objection, unless otherwise provided, shall be made within 72 hours after the race is run and shall be determined by the stewards.
- C. Pending the determination of an objection, any money or prize which the horse objected to may have won, or may win in the race, shall be withheld until the objection is determined, and any sum payable to the owner of the horse objected to shall be

paid to the horsemen's book keeper and held for the person who may be determined to be entitled to it.

- D. Pending the disposition by the stewards, Department, or Commission of any question, both the horse which finished first and any horse which has claimed to be the winner of the race shall be liable to all the penalties attaching to the winner of that race until the matter is decided.
- E. If an objection to a horse which has won or been placed in a race is declared valid, that horse may be disqualified in the place in which he finished and replaced at the discretion of the stewards.
- F. The stewards shall have the power at any time, whether or not an objection has been made, to order an examination by such person or persons as they deem fit as to the age of any horse entered for a race, or which has run a race and shall withhold any money the horse may have won until such examination is made. If the horse is declared of wrong age, the expense of such examination shall be paid by the owner.
- G. No person shall lodge an unsubstantiated objection with the stewards.
- H. The stewards may require a cash deposit of \$200 to cover costs and expenses in determining an objection. The deposit posted herein may be forfeited if the objection should prove to be without foundation.
- I. Every objection which is not decided by the stewards during the meeting shall be filed in writing with the Director.
- J. Permission of the stewards shall be necessary before an objection may be withdrawn.

Historical Note

Adopted effective August 5, 1983 (Supp. 83-4).
Amended effective March 20, 1990 (Supp. 90-1). Section number corrected (Supp. 93-1). R19-2-117 recodified from R4-27-117 (Supp. 95-1).

R19-2-118. Scale of Weights for Age

Generally:

- 1. For thoroughbreds in races exclusively for 3-year-olds and up, the weight is 118 to 124 pounds; for 2-year-olds, the weight is 117 to 120 pounds.
- 2. For quarter horses in races exclusively for 3-year-olds or 4-year-olds, the weight is 126 pounds; and in races exclusively for 2-year-olds, it is 120 to 122 pounds.

Historical Note

Adopted effective August 5, 1983 (Supp. 83-4).
Amended effective March 20, 1990 (Supp. 90-1). Section number corrected (Supp. 93-1). R19-2-118 recodified from R4-27-118 (Supp. 95-1).

R19-2-119. Rules of the Race and Winnings

A. Generally

- 1. All track rules shall be posted conspicuously and a copy of said rules shall be filed with the Department.
- 2. All races shall be off at a regular interval. Post times shall be based upon the number of races run daily. The intervals shall be set by the permittee with the approval of the stewards.
- 3. No purse monies earned by a horse shall be paid to anyone except the horse's registered owners or their authorized agents.
- 4. In a stakes race which is a walkover, unless otherwise specified in the conditions, the entry which appears for the race may walk over the course and be declared the winner. Such a winner shall be entitled to the entire stakes and to the winning percentage of the purse.

B. Pre-race activity

1. The number on the saddle cloth of a horse shall correspond with its number on the daily program.
2. All horses shall parade and shall carry their weight from the paddock to the starting post.
3. If a horse is led to the post with permission of the paddock judge, it carries its weight and shall pass the stewards' stand on its way to the post.
4. After the horses are ordered to the starting post and until the stewards direct the track gates to be reopened, all persons except licensees designated by the stewards shall be excluded from the track.
5. After the horses have entered the track, not more than 12 minutes shall elapse during the parade of the horses to the post, except with the approval of the stewards.
6. After passing the stand once, the horses will be allowed to break formation, canter, warm up, or move in any other manner until they are within 100 yards of the post.

C. Races

1. All races shall be started by a starting gate approved by the Department.
 - a. A race may be started without a stall gate or a gate with the doors open may be used in case of necessity and with the permission of the stewards.
 - b. If a race is started without a stall gate, there shall be no start until, and no recall after, a starter's assistant has dropped his flag in response to the order of the official starter.
2. In the event of unavoidable delay in the starting of a race, the starter shall instruct the riders to dismount and to lead their horses.
3. When a horse, during the post parade, is deemed unfit to start or is injured by an accident in the gate, it may be excused by the stewards. Such a horse shall not be considered to have started in the race.
4. When a horse misbehaves in the gate and thereby unduly delays the start of a race, it may be excused by the starter and the stewards. Such a horse shall not be considered to have started in the race, but it shall be penalized by being put on the schooling list. Its entry in future races will be refused for a period of time to be determined by the starter, with the approval of the stewards.
5. No race shall be run when it is so dark that the horses cannot be plainly seen from the stand by the judges or stewards.
6. Every horse in a race is entitled to racing room and shall not be deliberately pocketed and, in a straightaway race, each horse shall maintain the position in the lane in which it starts as nearly as possible.
7. If a horse is ridden or drifts out of its lane in such a manner that it interferes with or impedes another horse in any way, a foul has been committed. The offending horse may be disqualified if the outcome of the race is affected by the foul and replaced at the discretion of the stewards in a manner as to correct the effect of the interference as nearly as possible. The provisions of this subsection shall apply to fouls caused by the horse or the jockey and fouls caused either carelessly or purposefully.
 - a. In the event of disqualification of any part of an entry, it shall be at the discretion of the stewards as to whether such disqualification shall extend to all or any part of the entry.
 - b. If the stewards rule that the foul referred to in subsection (C)(7) of this Section was caused by the horse, despite the obvious efforts of the jockey to maintain position in its lane, the jockey shall not be penalized.

- c. If the stewards rule that the foul referred to in subsection (C)(7) of this Section was caused by the jockey's failing to attempt to prevent the foul or willfully riding the horse out of its lane, the jockey shall be penalized.

8. In a race run around a turn, a horse which is in the clear may be taken to any part of the track. Weaving back and forth in front of another horse may be considered interference or intimidation and may be penalized.
9. A jockey shall not cause such jockey's horse to shorten stride with a view to complaint. If the stewards decide that an intentional foul was committed in the riding of a race or that any jockey was instructed or induced to ride in such a manner, all persons guilty of complicity shall be suspended.
10. When a horse is disqualified by the stewards under these rules, every horse in the race belonging wholly or in part to the same owner, or under the management of the same trainer, may be disqualified and replaced upon a finding of good cause by the stewards.
11. A horse shall be ridden across the finish line carrying its assigned weight in order to participate in the purse distribution of the race unless the nomination blank states otherwise.
12. No whip shall be carried on any 2-year-old in a race on the straightaway before March 1. After March 1, following satisfactory performance out of the gate with a whip and with the approval of the starter, a whip may be carried in such a race.
13. No owner, trainer, handler, or jockey shall attempt to prevent his horse from running its best and winning.

D. Dead heats

1. When a race results in a dead heat, the heat shall not be run off.
2. If a race results in a dead heat, all prizes to which the horses finishing in the dead heat would have been entitled shall be divided equally between them.
3. When a dead heat is run for second place, and an objection is made and sustained to the winner of the race, the horses which ran the dead heat shall be deemed to have run a dead heat for first place.
4. If the dividing owners cannot agree as to which of them is to have a cup or other prize which cannot be divided, the question shall be determined by lot by the permittee.
5. Each horse that runs a dead heat for a race or place shall be deemed a winner of that race or place and shall be liable as such winner for any penalty or disability attaching to the same.

E. Winnings or wins

1. Winnings shall include all prizes and wins up to the time appointed for the start and shall apply to all races in any country; provided that in county fair race meets not having an "also-eligible" list, winnings shall include all prizes and wins up to the time of entry. Maiden races at County Fair Race Meets shall be an exception to this rule.
2. Winnings shall include walking over or receiving forfeit but shall not include second and third money or the value of any prize not of money or not paid in money.
3. Winnings during the year shall be computed from the preceding January 1.
4. Winner of a certain sum shall mean winner of a single race of that value unless otherwise expressed in the conditions.
5. In estimating the net value of a race to the winner, all sums contributed by its owner or nominator shall be deducted from the amount won.

6. Winners or losers of steeplechases, hurdle races, thoroughbred races, or mixed quarter horse races shall be considered winners or losers on the flat, and winners or losers on the flat shall be considered winners or losers of steeplechases, hurdle races, thoroughbred races, or mixed quarter horse races.

Historical Note

Adopted effective August 5, 1983 (Supp. 83-4).
Amended effective March 20, 1990 (Supp. 90-1). Section number corrected (Supp. 93-1). R19-2-119 recodified from R4-27-119 (Supp. 95-1).

R19-2-120. Repealed

Historical Note

Adopted effective August 5, 1983 (Supp. 83-4).
Amended by adding subsection (O) effective November 23, 1983 (Supp. 83-6). Amended by adding subsection (P) effective January 24, 1985 (Supp. 85-1). Amended by adding subsections (Q) and (R) effective September 24, 1986 (Supp. 86-5). Amended by adding subsections (S), (T), (U) and (V) effective February 19, 1987 (Supp. 87-1). Amended by adding subsections (W) and (X) effective October 14, 1988 (Supp. 88-4). Repealed effective March 20, 1990 (Supp. 90-1). R19-2-120 recodified from R4-27-120 (Supp. 95-1).

R19-2-121. Officials

A. Generally

1. The term "track official" means the following persons employed by the permittee and approved and licensed by the Department: Director of Racing, one steward, mutuel manager, patrol judges, clerk of the scales, starter, timer, paddock judge, track veterinarian, track superintendent, racing secretary, assistant racing secretary, handicapper, horsemen's bookkeeper, jockey room custodian, and chief of security.
2. The term "Department official" means the following persons appointed by the Department: two stewards, state mutuel supervisor, Department veterinarian, identifier, and investigator. Certain "track officials" may be appointed by the Department for the county fair race meets.
3. One person may serve in more than one official position if the person can do so without detriment to any of the other positions, and if the person has the consent and approval of the Department; provided that neither the racing secretary nor the permittee director of racing may serve as a steward.
4. In all rulings by the stewards, a majority of the stewards is deemed to be controlling.
5. Vacancies
 - a. When a vacancy occurs among officials other than stewards, the stewards shall fill the vacancy prior to post time of the first race of the day or when the vacancy occurs. The appointment is effective only for the day unless the permittee fails to fill the vacancy on the following day and has notified the stewards of its action not less than one hour before the post time of the first race of the following day. An appointment shall be reported promptly to the Department.
 - b. Three stewards shall view the running of a race. If a vacancy occurs among the stewards, the stewards present shall appoint one or two persons to serve as temporary stewards. The stewards making the

appointment under this subsection shall report it in writing to the Department.

- c. In case of emergency, the stewards may appoint a substitute to fill a vacancy for that emergency only.

6. The Department shall not license minors as officials.
7. A person interested in the result of a race because of an ownership interest in any entered horse, bets, or otherwise shall not act as an official at the meeting.

B. Prohibited acts

1. An official or an official's assistant shall not purchase mutuel tickets on races.
2. An official or an official's assistant shall not consume alcoholic beverages while on duty.
3. An official shall not accept, directly or indirectly, a bribe, gift, or other form of gratuity which is intended to or might influence the results of a race or the conduct of a racing meeting.
4. An official or employee shall not write or solicit horse insurance at a racing meeting.
5. An official or employee at the meeting shall not buy or sell a contract upon a jockey or apprentice jockey for an official or employee or for another, either directly or indirectly.

C. Each official and employee shall report all observed violations of these rules to the stewards.

D. Complaints

1. A person with a grievance or complaint against a track official, an employee of the permittee, or a licensee shall submit it in writing to the stewards within five days of the alleged objectionable act or behavior. The stewards shall consider the matter, take appropriate action, and make a full report of their action to the Department.
2. A person with a grievance or complaint against an official or employee of the Department shall report it in writing to the Deputy Director of the Department within five days of the alleged objectionable act or behavior.
3. The Department reserves the right to demand a change of any official or employee for failure to comply with state rules.

E. Stewards

1. Two stewards appointed by the Director, and one steward appointed by the permittee and licensed by the Director, shall supervise each racing meeting.
 - a. Stewards' duties include being in attendance at the office of the racing secretary or on the grounds of the permittee on any day in which entries are being taken or racing is being conducted and representing the Department in all matters pertaining to the interpretation of the rules adopted by the Department.
 - b. The stewards shall advise the Director of all hearings and rulings made.
 - c. If a steward is unable to perform the steward's duties for more than one day, the steward shall immediately notify the Director of that fact so that an alternate steward may be named to act in the steward's place.
2. The stewards shall enforce the rules and statutes of the state of Arizona.
3. The stewards shall have the power to interpret the rules and to decide all questions not specifically covered by the rules. In all interpretations and decisions, the orders of the stewards supersede the orders of the permittee.
 - a. The stewards shall have control over and shall have free access to all stands, weighing rooms, enclosures, and all other places within the grounds of the permittee.

- b. The stewards shall investigate and render a decision promptly on each objection properly made to them pursuant to R19-2-117 of these rules. A majority of the stewards shall sign each ruling.
 - c. The stewards shall supervise all entries and declarations. They may refuse entries or the transfer of entries for violations of state rules or statutes.
 - d. The stewards shall regulate and control the conduct of officials and other persons attending or participating in a racing meeting.
 - e. The stewards shall have the right to: authorize a person or persons to enter into or upon and examine the buildings, stables, rooms, motor vehicles, trailers, or other places within the grounds of a licensed race track; inspect and examine the person, personal property, and effects of any person within the grounds; and seize any items prohibited under R19-2-112(5) and (6) or any other illegal article.
 - f. Under subsection (E)(6), the stewards may impose a civil penalty in an amount not to exceed \$1,000 on any person subject to the stewards' control for violation of these rules. After a hearing, the stewards may suspend a person violating any of these rules for up to 60 days and may rule off a licensee violating any of these rules. The stewards may impose both a civil penalty and suspension for the same violation. The stewards may refer any ruling made by them to the Director, recommending further action, including license revocation.
 - g. In all cases where laboratory reports or other evidence show the administration or presence of a foreign substance, the stewards shall immediately investigate the matter and may disqualify the horse, suspend the trainer or other person or persons involved, refer the matter to the Director, and impose a fine.
 - h. Every person or entry expelled or ruled off by any recognized turf authority for corrupt or fraudulent or improper practice or conduct is ruled off wherever these rules have force.
 - i. When a person has been suspended, the stewards shall rule off or expel every horse wholly or partly owned by the person so long as the person's suspension continues. The person is not qualified, whether acting as agent or otherwise, to subscribe for, enter, or run a horse in any race, in either the person's own name or that of another person. The stewards shall disqualify a horse if it is wholly or partly owned by the person or under the person's care, management, training, or supervision, or the person has an interest in the horse's winnings. At the time it is discovered, the stewards shall void an entry from a person or of a horse that stands ruled off or expelled. The person shall forfeit the entry or subscription money and shall return the money or prize won.
4. The stewards may excuse a horse that has left the paddock for the post if they consider that horse to be crippled, disabled, or unfit to run. In claiming races, if there is a claim entered on a horse so excused, the claim is invalid.
5. The stewards shall determine the finish of a race by the relative position of the noses of each horse. They shall immediately notify the pari-mutuel department of the numbers of the first four horses.
- a. The stewards shall promptly display the numbers of the first three horses in each race in the order that they finished. If the stewards differ as to their order, the majority shall prevail.
- b. The stewards may review the photo-finish picture provided by the permittee, to aid them in determining the finish of a race.
- i. In any instance where the pictures furnished are not adequate or usable, the stewards shall make the final decision.
 - ii. If the stewards consider it advisable to review the photo-finish picture, the stewards may post such placements as are in their opinions unquestionable without waiting for a picture. After reviewing the picture, they may make the other placements. The stewards shall not declare the race official until they have determined which horses finished first, second, and third.
- c. The stewards shall correct an error before the display of the sign "official" or recall the sign "official" if it has been displayed through error.
6. The stewards shall adhere to the following procedure when they have reason to believe that a rule has been violated by any person:
- a. The stewards shall summon the person to a hearing with all the stewards present.
 - b. The stewards shall give 24-hours' notice of the hearing to the person, in writing, on a form supplied by the Department. The stewards shall time and date the notice, and the person notified shall sign it. The stewards shall retain the original and include it as part of the case file. The stewards shall give a copy to the person summoned.
 - c. The stewards shall not impose a penalty until the hearing.
 - d. The stewards shall construe nonappearance of the summoned party as a waiver of the right to a hearing before the stewards.
 - e. The stewards shall permit the person summoned to present witnesses on the person's own behalf.
 - f. The stewards shall take appropriate action, including suspension or civil penalty or both, if there is substantial evidence to find a violation of these rules. The stewards shall promptly forward their written decision or ruling to the Director and to the party in question.
 - g. In the interest of the health, safety, and welfare of the people of the state of Arizona, the stewards may summarily declare a horse scratched and may suspend a license pending a stewards' hearing.
 - h. The stewards shall recover and forward to the Department any license they suspend.
 - i. A majority vote of the stewards shall determine all matters within their jurisdiction.
 - j. The stewards shall have the power to modify, change, or remit any ruling imposed by them.
 - k. The licensee shall promptly pay to the Department any civil penalty imposed by the stewards for deposit with the state treasurer.
7. During the term of suspension of an owner, trainer, or other person on a track under the jurisdiction of the Department, the stewards and the permittee shall ensure that a ruling against the offender is enforced.
- F. Racing secretary**
- 1. The duties of the racing secretary include:

- a. Reporting to the stewards all violations of these rules or of the regulations of the permittee which come to the racing secretary's attention.
 - b. Keeping a complete record of all races.
 2. The racing secretary or authorized representative shall inspect all papers and documents dealing with owners and trainers, partnership agreements, appointments of authorized agents, and adoption of stable names. The racing secretary may demand production of such documents and papers in order to verify their validity and authenticity and to ensure that the rules have been followed.
 3. The racing secretary shall write the conditions of all races and shall publish them sufficiently before closing time for entries. The racing secretary shall not alter the conditions after the time set for closing.
 - a. The racing secretary shall not write races that conflict with racing rules.
 - b. The racing secretary shall include or post a list of eligible horses in the conditions prior to the time of entry for every graded quarter-horse race. The racing secretary shall not add a horse to this list after entering has begun without the consent of those who have entered eligible horses.
 4. The racing secretary shall act as the official handicapper in all races.
 - a. The racing secretary shall assign weight to each nominee.
 - b. The racing secretary shall post the weights in handicaps before 10:30 a.m. on the day set for publication.
 5. The racing secretary shall determine the character and condition of substitute and extra races, subject to the stewards' approval.
 - a. If a stakes or overnight handicap does not fill, it may be replaced by another overnight race carrying a guaranteed purse consistent with the daily average purse.
 - b. If a race is canceled or declared off, the racing secretary may split any race programmed for the same day and which previously may have been closed.
 - c. The racing secretary shall give preference to races printed in the condition book over substitute and extra races.
 6. The racing secretary or the racing secretary's designee shall conduct the drawing of all races and immediately post an overnight listing of the horses in each race.
 7. The office of the racing secretary shall keep the preferred list of all horses.
 8. The racing secretary shall not allow any horse to start in a race unless the horse is entered in the name of the legal owner and unless the owner's name appears on the back of the registration papers or on a legal lease or bill of sale attached to the registration papers.
- G. Assistant racing secretary.** The assistant racing secretary shall assist the racing secretary in the performance of the racing secretary's duties, under the racing secretary's supervision.
- H. Starter**
1. The starter has:
 - a. Complete jurisdiction over the starting of any field of horses.
 - b. Authority to give orders necessary to ensure a fair start.
 - c. Authority to recommend to the stewards the fining or suspension of any person violating the starter's orders.
 2. The starter may place a horse on a schooling list. The racing secretary shall not accept an entry on a horse until it has been removed from the schooling list by the starter.
 3. The starter may recommend to the stewards that a horse which is unmanageable at the starting gate or which refuses to break properly, after a reasonable schooling period, be suspended.
- I. Starter's assistant**
1. The starter's assistant may help horses into the starting gate.
 2. The starter's assistant may handle or otherwise restrain unruly or fractious horses before the start.
- J. Clerk of the scales**
1. The duties of the clerk of the scales include:
 - a. Weighing all jockeys out and in.
 - b. Posting all overweights promptly after weighing.
 - c. Notifying a trainer that the trainer's jockey is overweight.
 - d. Reporting all late scratches, changes in riders, overweights, and corrected weights for posting on a bulletin board located in a place conspicuous to the wagering public.
 - e. Recording winning records of jockeys with apprentice certificates and attesting to the date and track on each line as provided on the jockey's apprentice certificate.
 2. A jockey shall not pass the scale more than seven pounds overweight without the consent of the stewards.
 3. A jockey shall not be more than one pound short at weigh in.
 4. The clerk of the scales shall report to the stewards any violations of weight rules or any attempt to alter specified weights.
- K. Paddock judge**
1. The duties of the paddock judge include:
 - a. Checking all contestants for each race.
 - b. Keeping a record of all equipment carried by the horses in each race under the paddock judge's jurisdiction.
 - c. Permitting no change of equipment unless the change is approved by the stewards.
 2. Only the owner or trainer of a horse, or the employees of each, shall touch a horse in the paddock without the permission of the paddock judge.
 3. The paddock judge shall report any irregularities to the stewards.
- L. Patrol judges**
1. The duties of the patrol judges include:
 - a. Viewing that portion of the track allotted to them.
 - b. Reporting to the stewards any irregular incident occurring during a race.
 2. The stewards may require patrol judges to submit written reports on each race.
 3. The number of patrol judges in use at a track may vary with the size of the track and with the need to ensure clean racing.
- M. Timers**
1. Timers shall accurately record the time of each race.
 2. Timers shall accurately record the fractional times of each race if required for the Daily Racing Form Chart.
 3. The timers shall use an electrical timing device approved by the Department in all races restricted to quarter horses.
- N. Jockey room custodian**
1. The duties of the jockey room custodian include:
 - a. Maintaining the jockey room in proper order as a restricted area.

- b. Seeing that jockeys conduct themselves in accordance with the rules of racing.
 - c. Seeing that jockeys are on time for their races.
 - d. Supervising the valets employed to assist the jockeys.
 - e. Assisting the clerk of scales to ensure jockeys have proper equipment and carry the correct weight.
2. The jockey room custodian shall report immediately to the stewards any colors not in the jockey room custodian's possession for a given day's racing.

O. Horsemen's bookkeeper

- 1. The horsemen's bookkeeper shall receive all stakes, forfeits, entrance monies, fees (including jockey fees), and purchase money in claiming races.
- 2. The horsemen's bookkeeper shall pay all money on deposit to the persons entitled to it within 14 days after the close of the meeting.
- 3. The horsemen's bookkeeper shall be bonded in an amount determined by the Director.
- 4. The horsemen's bookkeeper shall segregate and hold as trust funds all fees paid in added money events, early closing events, stakes, and futurities until the event is contested. The horsemen's bookkeeper shall submit proof of segregation by bank letter or bank statement to the Department through its authorized representative.
- 5. The horsemen's bookkeeper shall not pay purse money earned by a horse to anyone except its registered owners or their authorized agent. The Department shall determine when purse monies are released, based on results of laboratory analysis.
- 6. In the event of an objection or positive sample and upon notification by the stewards, the horsemen's bookkeeper shall hold the purse monies until released by the Department.

P. Veterinarians

- 1. The Department shall approve two official veterinarians, licensed to practice veterinary medicine by the state of Arizona. The permittee shall employ one of the official veterinarians, and the Department shall employ the other official veterinarian.
- 2. The Department veterinarian shall be in charge of all sample collection.
- 3. An official veterinarian shall inspect each horse in the receiving barn or paddock and shall recommend to the stewards the scratching of any horse the veterinarian finds to be unsafe to race or physically unfit to produce a satisfactory result in a race.
- 4. The track veterinarian shall examine all horses prior to a race.
- 5. Either the Department veterinarian or the track veterinarian shall place any horse deemed to be unsafe, unsound, or unfit on a suspension list approved by the stewards.
- 6. The racing secretary may accept the entry of a horse on the veterinarian's list only after approval by the track and Department veterinarian and if three calendar days have elapsed since the horse was placed on the veterinarian's list.
- 7. Every veterinarian licensed by the Department shall keep a written record of the veterinarian's practice on the grounds of a permittee relating to horses participating in racing.
 - a. This record includes:
 - i. The name of the horse treated,
 - ii. The nature of the horse's ailment,
 - iii. The type of treatment prescribed and performed for the horses,

- iv. The date and time of the treatment.
 - b. Veterinarians shall keep this record for practice engaged in at all licensed tracks.
 - c. A veterinarian shall produce this record without delay upon request of the stewards or the Department.
 - d. Veterinarians engaged in private practice on tracks under the jurisdiction of the Department shall be licensed by the Arizona State Board of Veterinarian Medical Examiners and the Department.
 - e. Only veterinarians licensed by the Department shall administer to or prescribe for horses on the premises of any permittee except in case of emergency (R19-2-112(A)(11)(b)).
 - f. The Department, acting on the recommendation of the Department veterinarian, shall evaluate all new and experimental medications and drugs and determine whether the medications and drugs may be used on the grounds.
8. If an official veterinarian determines that an injured horse should be destroyed, the official veterinarian shall destroy the horse quickly, humanely, and out of sight of the public unless any delay will prolong the suffering of the horse.

Q. Horse identifier

- 1. The horse identifier or designee shall examine all horses registered for racing at tracks under the jurisdiction of the Department.
- 2. The horse identifier shall ensure that all horses starting at any track in the state of Arizona are tattooed unless otherwise authorized by the stewards.
- 3. The horse identifier may make photographs or permanent identification records for horses referred to in subsection (Q)(1) of this Section. The horse identifier shall include the tattoo number, markings, cowlicks, dimples, and other characteristics of each horse on its identification record.

Historical Note

Adopted effective August 5, 1983 (Supp. 83-4).
 Amended subsections (A) and (D) effective November 30, 1988 (Supp. 88-4). Amended effective March 20, 1990 (Supp. 90-1). R19-2-121 recodified from R4-27-121 (Supp. 95-1). Amended effective September 14, 1995 (Supp. 95-3). Amended effective January 12, 1996 (Supp. 96-1). Amended effective August 7, 1996 (Supp. 96-3).
 Spelling correction made in subsection (1) "permittee" changed to "permittee" to reflect rules on file with the Office of the Secretary of State (Supp. 98-3). Amended by final rulemaking at 11 A.A.R. 5534, effective February 4, 2006 (Supp. 05-4).

R19-2-122. Transfers

- A.** Any change in the ownership or lease of a horse registered with the racing secretary must be effected by a bill of sale or lease agreement.
 - 1. A copy of the bill of sale or lease agreement shall be filed in the track office of the Department and with the racing secretary.
 - 2. The stewards shall be advised of any change in the ownership or trainer transfer of a horse registered with the racing secretary.
 - 3. A horse shall not be transferred to a new trainer after entry.
 - 4. More than one owner may be indicated on the program by the use of the name of one owner and the phrase "et al."
- B.** If a horse is sold with all its engagements or any part of them, the seller shall not strike it from such engagements.

1. In all private sales, the written acknowledgment of both parties that the horse was sold with all, or part of, its engagements is necessary to entitle the seller or buyer to the benefit of this rule. If certain engagements are specified, only those engagements so specified shall be sold with the horse.
2. In all public auctions, the advertised conditions of the sale are sufficient evidence of sale with all engagements. If certain engagements are specified, only those engagements so specified shall be sold with the horse.
3. If a horse is transferred with its engagements, that horse shall not be eligible to start in any stakes race unless, at the time of the running of the stakes or prior thereto, the transfer of the horse and its engagements is exhibited upon demand to the racing secretary.
4. No transfer of a horse or an engagement shall be made for the purpose of avoiding disqualification.

Historical Note

Adopted effective August 5, 1983 (Supp. 83-4).

Amended effective March 20, 1990 (Supp. 90-1). R19-2-122 recodified from R4-27-122 (Supp. 95-1).

R19-2-123. Procedure before the Department

A. Appeal of stewards' rulings and referrals

1. Any person or persons aggrieved by a ruling of the stewards may appeal to the Director. Such an appeal shall be filed in writing in the office of the Director within three days of the receipt of the steward's ruling.
2. The failure of the stewards to convene a hearing within 10 days after an objection is made shall be deemed a denial by the stewards and may be appealed by filing a written appeal in the office of the Director within 10 days from the date the objection was denied.
3. The appeal shall be signed by the person making said request or by such person's attorney and shall set forth such person's grounds for appeal and reasons for believing such person is entitled to a hearing.
4. A person filing an appeal of a ruling may be required by the Director or the Commission to furnish a bond in the amount equal to an assessed fine and an additional \$200 to cover the costs, which may be forfeited should the appeal be denied.
5. The stewards may refer any ruling made by them to the Director, recommending further action, including the revocation of a license suspended by the stewards. Upon receipt of such referrals, the Director shall review the record and may affirm, reverse, or modify the stewards' ruling or conduct such other proceedings as the Director may deem appropriate.
6. Upon the filing of a referral in the manner set forth above, the Director may fix a time and place for a hearing and shall give written notice of the hearing at least 20 days prior to the date set for the hearing, unless waived by the appellant.
7. Nothing contained in this Section shall affect the distribution of the pari-mutuel pools.
8. In case of an appeal or protest, the purse money affected shall be retained by the permittee subject to order of the Director.

B. License denial, suspension, or revocation

1. The Director may deny a license application without prior notice to the applicant. However, if the applicant files an appeal with the Director within 20 days of the receipt of the denial, the Director may fix a time and place for a hearing on the matter and shall give written notice of the

hearing at least 20 days prior to the date set for the hearing, unless waived by the applicant.

2. The Director may revoke or, independently of the stewards, suspend a license only after notice and opportunity for hearing. Notice of the hearing shall be given in writing at least 20 days prior to the date set for hearing, unless waived by the applicant.

C. Contested cases

1. All parties appearing before the Director or the Director's designee shall be afforded an opportunity to a hearing and the opportunity to respond and present evidence and argument on all issues.
2. Any party appearing before the Director or the Director's designee shall have the right to appear in person, or by counsel, except that a corporation may appear only through counsel. Any party may submit such party's case in writing. Failure of a party to appear for a hearing shall leave the Director free to act upon the evidence at hand without further notice to the parties. Proceedings may be reopened by the Director upon written petition of any party to the proceedings.

- D. Hearing officer. If the Director assigns a matter to a hearing officer, the hearing officer shall submit to the Director within 15 days after the conclusion of the hearing a written decision which shall include proposed findings of fact, conclusions of law and order. The decision of the hearing officer may be approved or modified by the Director. The decision of the hearing officer becomes the decision of the Director unless modified by the Director within 45 days.

E. Depositions

1. When any party desires to take the oral deposition of any witness residing outside the state or otherwise unavailable as a witness, such party shall file with the Director a petition for permission to take the deposition of such witness, showing the name and address of such witness and setting forth specifically and in detail the nature and substance of the testimony expected to be given by such witness. The application shall be granted if it appears from such petition that the witness resides outside the state or is otherwise unavailable and that the testimony of such witness is relevant and material. If such statement is not made specifically and in detail, so that the Director may determine therefrom the relevancy and materiality of the testimony of such witness, such petition may be denied.
2. The Director may, at the Director's discretion, designate the time and place and office at which such a deposition may be taken. The expense of any deposition shall be borne by the party applying to the Director for permission to take same.
3. Any deposition taken under this subsection shall be returned and filed with the Director within 30 days after permission for taking same is granted.

F. Service

1. Service of any decision, order, or other process may be made in person or by mail. Service by mail shall be made by enclosing the same or a copy thereof in a sealed envelope and depositing the same in the United States mail, postage prepaid, addressed to the party served, at the address as shown by the records of the Department.
2. The time periods prescribed or allowed by these rules, by order of the Department or by an applicable statute, shall be computed as provided in the Arizona Rules of Civil Procedure.
3. Service upon an attorney who has appeared on behalf of a party shall constitute service upon such party, except that papers required to be served upon the Director or Com-

mission shall in all cases be filed in the office of the Department with a copy served on the Attorney General.

4. Proof of service may be made by the affidavit or oral testimony of the person making such service.

G. Rehearing, review, or appeal

1. Except as provided in subsection (G)(7), any party in a contested case before the Director who is aggrieved by a decision rendered in such case may file with the Director, not later than 10 days after service of the decision, a written motion for rehearing or review of the decision specifying the particular grounds therefor. For purposes of this subsection, a decision shall be deemed to have been served when personally delivered or mailed to the party at such party's last known residence or place of business.
2. The motion for rehearing may be amended at any time before it is ruled upon by the Director. A response may be filed within 10 days after service of such motion or amended motion by any other party. The Director may require the filing of written briefs upon the issues raised in the motion and may provide for oral argument.
3. A rehearing or review of the decision may be granted for any of the following causes materially affecting the moving party's rights:
 - a. Irregularity in the administrative proceedings of the hearing officer or Director or the prevailing party, or any order or abuse of discretion, whereby the moving party was deprived of a fair hearing.
 - b. Misconduct of the hearing officer, Director, or the prevailing party.
 - c. Accident or surprise which could not have been prevented by ordinary prudence.
 - d. Newly discovered material evidence which could not with reasonable diligence have been discovered and produced at the original hearing.
 - e. Excessive or insufficient penalties.
 - f. Error in the admission or rejection of evidence or other errors of law occurring at the administrative hearing.
 - g. The decision is not justified by the evidence or is contrary to law.
4. The Director may affirm or modify the decision or grant a rehearing to all or any of the parties and on all or part of the issues for any of the reasons set forth in subsection (G)(3) of this subsection. An order granting a rehearing shall specify with particularity the ground or grounds on which the rehearing is granted, and the rehearing shall cover only those matters so specified.
5. Not later than 10 days after a decision is rendered, the Director may, on the Director's own initiative, order a rehearing or review of the Director's decision for any reason for which the Director might have granted a rehearing on motion of a party. After giving the parties or their counsel notice and an opportunity to be heard on the matter, the Director may grant a motion for rehearing for a reason not stated in the motion. In either case, the order granting such a rehearing shall specify the grounds therefor.
6. When a motion for rehearing is based upon affidavits they shall be served with the motion. An opposing party may, within 10 days after such service, serve opposing affidavits, which period may be extended for an additional period not exceeding 20 days by the Director for good cause shown or by written stipulation of the parties. Reply affidavits may be permitted.
7. If in a particular decision it is necessary for the immediate preservation of the public peace, health, and safety and if

a rehearing or review of the decision is impracticable, unnecessary, or contrary to the public interest, the decision may be issued as a final decision without an opportunity for a rehearing or review.

8. For purposes of this subsection the terms "contested case" and "party" shall be defined as provided in A.R.S. § 41-1001.
9. To the extent that the provisions of this rule are in conflict with the provisions of any statute providing for rehearing of decisions of the Director, such statutory provisions shall govern.

Historical Note

Adopted effective August 5, 1983 (Supp. 83-4).

Amended effective March 20, 1990 (Supp. 90-1). R19-2-123 recodified from R4-27-123 (Supp. 95-1).

R19-2-124. Procedure before the Commission

A. Appeal of Director's rulings

1. Any person or persons aggrieved by a ruling of the Director may appeal to the Commission. Such an appeal shall be filed in writing in the office of the Commission within 15 days after service of the Director's ruling.
2. The appeal shall be signed by the person making said request or by his attorney and shall set forth with specificity such person's grounds for appeal and reasons for believing such person is entitled to a hearing.
3. Upon the filing of an appeal set forth above, the Commission shall review the record and may affirm, reverse, or modify the Director's ruling or conduct such other proceedings as the Commission deems appropriate.

B. Permit denial, suspension, or revocation

1. The Commission may deny a permit application pursuant to a hearing upon 15 days notice.
2. The Commission shall revoke or suspend a permit only after notice and opportunity for hearing. Notice of the hearing shall be given in writing at least 20 days prior to the date set for hearing, unless waived by the applicant.
3. All parties appearing before the Commission shall be afforded an opportunity for a hearing and the opportunity to respond and present evidence and argument on all issues.
4. Any party appearing before the Commission shall have the right to appear in person, or by counsel, except that a corporation may appear only through counsel. Any party may submit such party's case in writing. Failure of a party to appear for a hearing shall leave the Commission free to act upon the evidence at hand without further notice to the parties. Proceedings may be reopened by the Commission upon written petition of any party to the proceedings.

C. Hearing officer. If the Commission assigns a matter to a hearing officer, the hearing officer shall submit to the Commission within 15 days after the conclusion of the hearing a written decision which shall include proposed findings of fact, conclusions of law and order. The decision of the hearing officer may be approved or modified by the Commission. The decision of the hearing officer becomes the decision of the Commission unless modified by the Commission within 45 days.

D. Depositions

1. When any party desires to take the oral deposition of any witness residing outside the state or otherwise unavailable as a witness, such party shall file with the Commission a petition for permission to take the deposition of such witness, showing the name and address of such witness and setting forth specifically and in detail the nature and substance of the testimony expected to be given by

such witness. The application may be granted if it appears from such petition that the witness resides outside the state or is otherwise unavailable and that the testimony of such witness is relevant and material. If such statement is not made specifically and in detail, so that the Commission may determine therefrom the relevancy and materiality of the testimony of such witness, such petition may be denied.

2. The Commission may, at its discretion, designate the time and place and office at which such a deposition may be taken. The expense of any deposition shall be borne by the party applying to the Commission for permission to take same.
3. Any deposition taken under this subsection shall be returned and filed with the Commission within 30 days after permission for taking same is granted.

E. Service

1. Service of any decision, order, or other process may be made in person or by mail. Service by mail shall be made by enclosing the same or a copy thereof in a sealed envelope and depositing the same in the United States mail, postage prepaid, addressed to the party served, at the address as shown by the records of the Department, except that notice of a hearing before the Commission shall be mailed by certified mail to the last known address of the parties as shown by the records of the Department.
2. Proof of service may be made by the affidavit or oral testimony of the person making such service.
3. The time periods prescribed or allowed by these rules, by order of the Department or by an applicable statute, shall be computed as provided in the Rules of Civil Procedure.
4. Service upon an attorney who has appeared on behalf of a party will constitute service upon such party. In the case of papers requested to be served upon the Commission, an original and five copies shall be filed in the office of the Department and a copy shall be served upon the Attorney General.

F. Rehearing or review

1. Except as provided in subsection (F)(7) of this subsection, any party in a contested case before the Commission who is aggrieved by a decision rendered in such case may file with the Commission, not later than 15 days after service of the decision, a written motion for rehearing or review of the decision, specifying the particular grounds therefor. For purposes of this subsection, a decision shall be deemed to have been served when personally delivered or mailed to the party at such party's last known residence or place of business.
2. The motion for rehearing may be amended at any time before it is ruled upon by the Commission. A response may be filed within 10 days after service of such motion or amended motion by any other party. The Commission may require the filing of written briefs upon the issues raised in the motion and may provide for oral argument.
3. A rehearing or review of the decision may be granted for any of the following causes materially affecting the moving party's rights:
 - a. Irregularity in the administrative proceedings of the hearing officer or Commission or the prevailing party, or any order or abuse of discretion, whereby the moving party was deprived of a fair hearing.
 - b. Misconduct of the hearing officer, Commission, or the prevailing party.
 - c. Accident or surprise which could not have been prevented by ordinary prudence.

- d. Newly discovered material evidence which could not with reasonable diligence have been discovered and produced at the original hearing.
- e. Excessive or insufficient penalties.
- f. Error in the admission or rejection of evidence or other errors of law occurring at the administrative hearing.
- g. The decision is not justified by the evidence or is contrary to law.

4. The Commission may affirm or modify the decision or grant a rehearing to all or any of the parties and on all or part of the issues for any of the reasons set forth in subsection (F)(3). An order granting a rehearing shall specify with particularity the ground or grounds on which the rehearing is granted, and the rehearing shall cover only those matters so specified.
5. Not later than 10 days after a decision is rendered, the Commission may, on its own initiative, order a rehearing or review of its decision for any reason for which it may have granted a rehearing on motion of a party. After giving the parties or their counsel notice and an opportunity to be heard on the matter, the Commission may grant a motion for rehearing for a reason not stated in the motion. In either case, the order granting such a rehearing shall specify the grounds therefor.
6. When a motion for rehearing is based upon affidavits, the affidavits shall be served with the motion. An opposing party may, within 10 days after such service, serve opposing affidavits, which period may be extended for an additional period not exceeding 20 days by the Commission for good cause shown or by written stipulation of the parties. Reply affidavits may be permitted.
7. If in a particular decision it is necessary for the immediate preservation of the public peace, health, and safety and if a rehearing or review of the decision is impracticable, unnecessary, or contrary to the public interest, the decision may be issued as a final decision without an opportunity for a rehearing or review.
8. For purposes of this subsection the terms "contested case" and "party" shall be defined as provided in A.R.S. § 41-1001.
9. To the extent that the provisions of this rule are in conflict with the provisions of any statute providing for rehearing of decisions of the Commission, such statutory provisions shall govern.

Historical Note

Adopted effective August 5, 1983 (Supp. 83-4).

Amended effective March 20, 1990 (Supp. 90-1). R19-2-124 recodified from R4-27-124 (Supp. 95-1).

R19-2-125. Arizona Stallion Awards

A. Definitions

1. "Arizona stallion" means an uncastrated, adult male horse that stands the entire breeding season in Arizona.
2. "Breeding year" means the period beginning January 1 and ending July 31.
3. "Fiscal year" means the period beginning July 1 and ending June 30.
4. "Owner" means the person who possesses the stallion at the time of the person's certification application for the fiscal year, according to the records of the Department.

B. Owner and lessee eligibility. For an owner or the lessee of an Arizona stallion to be eligible for an award of funds for a fiscal year:

1. The owner or lessee shall:

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- a. Apply for stallion certification by the due date set by the breeders association for complying with the requirement in subsection (D);
 - b. Submit the breeder report required in subsection (E); and,
 - c. Comply with subsection (F) if applicable.
 2. In the event of death or the retirement of a stallion, the owner or lessee remains eligible for awards if the requirements in subsection (D) are followed.
 3. The stallion shall be certified at the time its eligible Arizona-bred offspring earn purse money in races listed in subsection (H).
- C. Qualifications for Arizona stallion certification.** To qualify for Arizona stallion certification for the fiscal year, an owner or lessee shall:
1. Permanently domicile the stallion in Arizona from January 1 through July 31. During this time, the owner or lessee may move the stallion outside of Arizona for racing or for medical treatment;
 2. Register the stallion with the Arizona breed registry that corresponds to the stallion's national breed registry; and
 3. Notify the appropriate Arizona breed registry within 10 days of the stallion entering or leaving Arizona during the breeding year.
- D. Application procedure for stallion certification**
1. By the due date set by the appropriate Arizona breeders association, and approved by the Commission in accordance with subsection (D)(2)(b), an owner or lessee may apply for Arizona stallion certification for the fiscal year. The owner or lessee shall:
 - a. File an official application form with the Arizona breeders' association for each stallion owned or leased; and
 - b. Pay a certification fee for each stallion when the application form is filed.
 2. The Arizona breeders association shall:
 - a. Forward a legible copy of the completed application to the Department;
 - b. Set an application due date and reasonable certification fee, if these actions are authorized by the Commission in a contract permitted under A.R.S. § 5-114(D).
 3. The Commission shall review and approve or reject each contract for stallion certification.
- E. Breeding report**
1. A quarter horse stallion owner or lessee shall submit a legible copy of the annual "Stallion Breeding Report" to the breeders association monitoring quarter horse stallions by November 30 of the current breeding year.
 2. Except as provided in subsection (F), a thoroughbred stallion owner or lessee shall submit a legible copy of the annual "Report of Mares Bred" to the breeders association monitoring thoroughbred stallions by August 1 of the current breeding year.
- F. Thoroughbred stallion bred to quarter horse mares**
1. If a thoroughbred stallion is being bred to quarter horse mares, an owner or lessee shall send the application, fees, and breeding report required in subsections (D) and (E)(1) to the breeders association monitoring quarter horse stallions.
 2. If a thoroughbred stallion is being bred to thoroughbred and quarter horse mares, an owner or lessee shall send the application, fees, and breeding reports required in subsections (D) and (E) to both of the Arizona breeders associations.
- G. Disqualification and Reinstatement**
1. If a stallion owner or lessee fails to comply with applicable requirements in subsections (B), (C), (D), (E), and (F) the Department shall disqualify the owner or lessee from receiving an award of fund monies during the affected fiscal year.
 2. To reinstate eligibility for subsequent years, the owner or lessee shall pay the certification fee prescribed in subsection (D)(1)(b) and comply with applicable requirements in subsections (B), (C), (D), (E), and (F).
- H. Award races.** Except for maiden claiming and maiden allowance races at Arizona racetracks, the following are eligible races:
1. Quarter horses:
 - a. All races with a purse value of \$10,000 or more;
 - b. All allowance races;
 - c. At the Turf Paradise meet, all claiming races with a claiming price of \$3,500 or more; and
 - d. At other Arizona racetracks, all claiming races with a claiming price of \$2,500 or more.
 2. Thoroughbreds:
 - a. The Prescott Futurity, the Prescott Derby, and all races with a purse value of \$15,000 or more;
 - b. The Inaugural, the Mile High, and all allowance races;
 - c. At the Turf Paradise meet, all claiming races with a claiming price of \$6,000 or more; and
 - d. At other Arizona racetracks, all claiming races with a claiming price of \$3,500 or more.
- I. Fund distribution procedures**
1. The Arizona breeders associations shall submit to the Department, at least annually, a written report that contains the following information:
 - a. The names of certified Arizona stallions for the fiscal year;
 - b. The names of certified Arizona-bred offspring of the Arizona stallions. Arizona-bred horses may be certified by following the procedures prescribed in R19-2-116(A) and (B);
 - c. The first, second, and third place finishes of each certified Arizona-bred horse, sired by a certified Arizona stallion, in each eligible race; and,
 - d. The earnings in each race of each Arizona-bred horse sired by a certified Arizona stallion.
 2. The Department shall:
 - a. Hold 10% of the monies accumulated prior to the 1996-97 fiscal year for contingent liabilities;
 - b. Calculate a payment factor at the end of each fiscal year by dividing the total monies available, under subsections (I)(2)(d), (e), (f), or (g), by the total dollar value of purses, not to exceed \$30,000 per horse per race, won in eligible races during the fiscal year;
 - c. Multiply the payment factor by the total purse amount won in eligible races during the fiscal year;
 - d. Distribute to eligible owners or lessees 40% of the amount accumulated in the fund prior to the 1996-97 fiscal year and the amount earned by the fund during the 1996-97 fiscal year;
 - e. Distribute to eligible owners or lessees 25% of the amount accumulated in the fund prior to the 1996-97 fiscal year and the amount earned by the fund during the 1997-98 fiscal year;
 - f. Distribute to eligible owners or lessees 25% of the amount accumulated in the fund prior to the 1996-97 fiscal year and the amount earned by the fund during the 1998-99 fiscal year; and,

- g. Distribute to eligible owners or lessees the amount earned by the fund during the fiscal year for the years after the 1998-99 fiscal year.
- 3. The owner or lessee shall designate, on a form provided by the Department, the single payee to whom Arizona stallion award checks shall be issued when there is more than one owner of a stallion.
- J. Appeal of Director's rulings**
 - 1. The Director shall make the final decision concerning a stallion award.
 - 2. The Department shall give written notice of the decision to an applicant by mailing it to the address of record filed with the Department.
 - 3. After service of the Director's decision, an aggrieved party may obtain a hearing under A.R.S. §§ 1092.03 through 41-1092.11.
 - 4. The aggrieved party shall file a notice of appeal with the Department within 30 days after receiving the notice prescribed in R19-2-125(J)(2).
 - 5. The Department shall notify the Office of Administrative Hearings, which shall schedule and conduct the hearing.

Historical Note

Adopted effective November 7, 1996 (Supp. 96-4).

R19-2-126. Race Horse Adoption Grants

- A.** The Commission shall provide financial grants to nonprofit enterprises to promote the adoption of retired race horses. The Commission shall distribute all of the retired race horse adoption surcharge funds generated from A.R.S. § 5-104(G) to nonprofit enterprises.
- B. Procedures.**
 - 1. A nonprofit enterprise that wishes to receive a financial grant shall submit a Department-generated application form to the Commission. In 2005, the Commission shall set the date by which applications are to be received. After 2005, the Commission shall accept applications until March 1 of each year. The nonprofit enterprise shall provide the following information:
 - a. A written description of the nonprofit enterprise,
 - b. Proof of nonprofit status,
 - c. The proposed use of the grant,
 - d. A description of the nonprofit enterprise's procedures to acclimate the horses as required by subsection (C)(6),
 - e. A description of the nonprofit enterprise's adoption procedures as required by subsection (C)(7),
 - f. A copy of the application form and adoption agreement required by subsections (C)(7)(a) and (c), and
 - g. A copy of the transfer of registration or bill of sale required by subsection (C)(8).
 - 2. If the Commission finds that the adoption program of a nonprofit enterprise is in the best interest of the racing industry and this state, the Commission shall decide whether to make a grant to the nonprofit enterprise, the amount of the grant, and the date of disbursement of the grant.
 - 3. A recipient of a grant shall report annually to the Commission on a form provided by the Department to gather the following information:
 - a. The number of horses the nonprofit enterprise received;
 - b. The number of horses adopted;
 - c. The number of horses returned by an adoptee and reason for each return;
 - d. The actual use of the grant;
 - e. A list of people who adopted the horses, or a copy of the contract between the nonprofit enterprise and each adoptee; and
 - f. The most recent Articles of Incorporation filing with the Arizona Corporation Commission.
- C. Minimum qualifications.**
 - 1. The enterprise shall be nonprofit.
 - 2. The enterprise shall not:
 - a. Allow a horse to be used for racing, wagering, or slaughter; or
 - b. Place a horse with a humane society or research facility;
 - 3. The enterprise shall not euthanize an adoptable horse unless, as determined by a licensed veterinarian, it is medically necessary for humane reasons.
 - 4. The enterprise shall be affiliated with a racetrack that conducts horse racing. Affiliation is satisfied when the general manager or other executive from the racetrack submits to the Commission a written recommendation on behalf of the enterprise.
 - 5. The enterprise shall require that a licensed veterinarian perform a complete check-up on each horse before releasing the horse to an adoptee. The enterprise shall ensure that each horse receives all medical care necessary to maintain its good health.
 - 6. The enterprise shall employ procedures for acclimating a horse that include:
 - a. Exposure to the public,
 - b. Exposure to a new diet, and
 - c. Training for off-track life.
 - 7. The enterprise shall employ procedures for adopting-out horses that include:
 - a. An application process for prospective adoptees;
 - b. A visual check of each prospective adoptee's farm with written documentation of the visit;
 - c. A written adoption agreement between the enterprise and adoptee;
 - d. At a minimum, follow-ups conducted by phone or visit after seven and 30 days with written documentation; and
 - e. Procedures for the return of a horse.
 - 8. Before assuming care of a horse, the enterprise shall obtain a transfer of registration or bill of sale for the horse.
 - 9. The enterprise shall make available a person to complete and submit all filing requirements and to answer questions from a prospective or current adoptee.
 - 10. The enterprise shall keep a file on each horse that includes:
 - a. The transfer of registration or bill of sale;
 - b. The vaccination record, health record, and all veterinarian reports;
 - c. The adoptee's application form;
 - d. The written adoption agreement between the enterprise and adoptee; and
 - e. The written documentation of pre-adoption check and follow-ups.
 - 11. The enterprise shall state in the adoption agreement the rules and responsibilities required of the adoptee.
 - 12. The enterprise shall make the records required in subsection (C)(11) available for inspection by a representative of the Department.
 - 13. The enterprise shall allow the Department to inspect the facilities, farm, or location of the adopted horses.

Historical Note

New Section made by final rulemaking at 11 A.A.R.

1566, effective June 4, 2005 (Supp. 05-2).

ARTICLE 2. RACING REGULATION FUND

R19-2-201. Racing Regulation Fund

The Racing Regulation Fund, established by A.R.S. § 5-113.01, and administered by the Department of Racing, shall collect funding for regulation of racing from the pari-mutuel racing industry from the sources listed below. The Department shall review assessments from each source at least twice a year for the purposes of meeting its budget.

1. Annual license fees established by the Department and set forth in R19-2-202, except for those fees deposited to the Greyhound Adoption Fund pursuant to A.R.S. § 5-113(H).
2. A regulatory assessment based on the number of dark days on which wagering is conducted in excess of live racing days for each racetrack permittee issued a racing permit. The assessment shall be in an amount established by the Department and set forth in R19-2-204.
3. A regulatory assessment from all racetracks that have been issued a commercial racing permit to be paid from the amount deducted by the permittee from pari-mutuel pools. The assessment amount may be deducted from pari-mutuel pools in addition to the amounts the permittee is authorized to deduct in A.R.S. § 5-111(C). The assessment shall be based on amounts wagered on live and simulcast races from in-state and out-of-state wagering handled by the permittee in an amount established by the Department, and as set forth in R19-2-205. A permittee shall not reduce the amounts payable to the Department under this subsection for hardship tax credits under A.R.S. § 5-111(I) or for capital improvement credits under A.R.S. §§ 5-111.02 and 5-111.03.
4. License fees collected pursuant to A.R.S. § 5-230(A).
5. The overpayment of a regulatory assessment by a permittee shall be credited to and may be deducted from any regulatory assessment payment due from the permittee in the current fiscal or the following fiscal year.

Historical Note

New Section made by exempt rulemaking at 17 A.A.R. 1484, effective July 20, 2011 (Supp. 11-3). Amended by exempt rulemaking at 18 A.A.R. 3260, effective November 16, 2012 (Supp. 12-4).

R19-2-202. Licensing Fees

- A. When an applicant submits a license application pursuant to R19-2-106 or R19-2-306, the applicant shall also submit the fee listed in subsections (C) and (D). The Department shall ensure that a schedule of license and fingerprint processing fees is displayed prominently at each licensing location.
- B. A license shall be for a period of no less than one year except as stated in subsection (B)(1)(a).
 1. Horse racing licenses expire each year on June 30 except that:
 - a. Apprentice jockey licenses expire as provided in R19-2-109(D)(2); and
 - b. All licenses issued prior to July 1, 2013, will expire on June 30, 2014.
 2. Greyhound licenses expire each year on January 31 except that all licenses issued prior to February 1, 2013, will expire on January 31, 2014.
 3. Pari-mutuel licenses expire each year on January 31 except that all licenses issued prior to February 1, 2013, will expire on January 31, 2014.
- C. Annual License Fees

1. Group 1 (assistant starter/valet, coolout, exercise rider, groom, leadout, occupational, OTB [owner, manager], outrider, pari-mutuel [including OTB], pony person, security) - \$15.
 2. Group 2 (authorized agent-partial, greyhound hauler, jockey agent, vendor employee) - \$50.
 3. Group 3 (county fair manager, county fair treasurer, official) - \$100.
 4. Group 4 (assistant trainer, commercial track key people: owner [10% or more], general manager, assistant general manager, chief financial officer; owner, RBO [kennel, racing or breeding], stable name, temporary claim to owner, trainer) - \$150.
 5. Group 5 (apprentice jockey, authorized agent – full, combination RBO [racing/breeding combination], farrier/plater, jockey, owner/trainer, veterinarian) - \$200.
 6. Group 6 – fees above \$200
 - a. Tote companies - \$1,250;
 - b. All other vendors (video, photo finish, concessionaires, security) - \$500.
- D. Annual Permittee Fees.
1. Commercial racing permit (40 or fewer days of live racing or no live racing) - \$1,000;
 2. Commercial racing permit (more than 40 days of live racing) - \$2,500;
 3. County fair permit - \$250.

Historical Note

New Section made by exempt rulemaking at 17 A.A.R. 1484, effective July 20, 2011 (Supp. 11-3). Amended by exempt rulemaking at 18 A.A.R. 1752, effective July 1, 2012 (Supp. 12-2). Amended by exempt rulemaking at 19 A.A.R. 68, effective January 1, 2013 (Supp. 12-4).

R19-2-203. Repealed

Historical Note

New Section made by exempt rulemaking at 17 A.A.R. 1484, effective July 20, 2011 (Supp. 11-3). Repealed by exempt rulemaking at 18 A.A.R. 3260, effective November 16, 2012 (Supp. 12-4).

R19-2-204. Regulatory Assessment for Dark Day Simulcasting

- A. The Department shall collect an annual regulatory assessment from each racetrack permittee conducting horse or greyhound racing in Arizona and which qualifies under A.R.S. § 5-112 for dark day simulcasting.
- B. Each permittee shall pay an amount established by the Department based on the number of dark days on which wagering is conducted in excess of the number of live days approved in the racing permit issued the permittee.
 1. The Department shall at the start of the year on or before July 1 assess each permittee \$25 per dark day based upon the total number of dark days approved in the permittee's racing permit. The calculation will be determined by the number of dark days approved by the Arizona Racing Commission in excess of the number of live days approved each year during the period of the permit.
 2. The permittee shall transmit the total dark day assessment to the Racing Regulation Fund no later than July 15 of each year.

Historical Note

New Section made by exempt rulemaking at 17 A.A.R. 1484, effective July 20, 2011 (Supp. 11-3).

R19-2-205. Regulatory Wagering Assessment of Pari-mutuel Pools

- A. The Department shall establish and collect a regulatory wagering assessment payable from the amounts deducted from pari-mutuel pools by the permittee, in addition to the amounts the permittee is authorized to deduct in A.R.S. § 5-111(C) from amounts wagered on all live and simulcast races from in-state and out-of-state wagering authorized by the Department to the permittee. A permittee shall not reduce the amounts payable to the Department under this subsection for hardship tax credit under A.R.S. § 5-111(I) or for capital improvement credits under A.R.S. §§ 5-111.02 and 5-111.03.
- B. The racing regulation assessment for each racing meeting on all in-state and/or out-of-state, on-track, off-track, live, import and/or export wagers and/or wagers types shall be 0.55 per cent beginning January 1, 2013.
- C. Each permittee shall transmit its assessment daily, unless otherwise approved by the Department, to the Racing Regulation Fund beginning July 1, 2011. A report detailing the assessment shall be transmitted to the Director at the time the assessment is transmitted.
- D. The Department may audit the permittee's pari-mutuel accounts periodically under the authority of A.R.S. § 5-104.01. The permittee shall cooperate fully with the Department during these audits.

Historical Note

New Section made by exempt rulemaking at 17 A.A.R. 1484, effective July 20, 2011 (Supp. 11-3). Amended by exempt rulemaking at 18 A.A.R. 1316, effective July 1, 2012 (Supp. 12-2). Amended by exempt rulemaking at 19 A.A.R. 68, effective January 1, 2013 (Supp. 12-4).

ARTICLE 3. GREYHOUND RACING**R19-2-301. Power and Authority**

- A. All powers of the Department and Commission not specifically defined in these rules are reserved to the Department and Commission under the law creating the Department and Commission and specifying its powers and duties.
- B. The jurisdiction of the Department and Commission over matters covered by the statutes and the rules is continuous throughout the year.
- C. The statutes of the state of Arizona and the rules and the orders of the Department and Commission take precedence over the conditions of a race or of a racing meeting.
- D. The Director may sustain, reverse, or modify any penalty or decision imposed by the stewards.
- E. The Commission may sustain, reverse, or modify any penalty or decision imposed by the Director.

Historical Note

Adopted effective August 5, 1983 (Supp. 83-4). R19-2-301 recodified from R4-27-301 (Supp. 95-1).

R19-2-302. Definitions

In these rules, unless the context otherwise requires:

1. "Added money" means the money a permittee adds to the nominating and starting fees in a race.
2. "Adequate feed" means supplying the greyhound a quantity of foodstuffs daily for its age and weight to maintain a reasonable level of nutrition.
3. "Age" means the age of a greyhound as computed from the day the greyhound was whelped.
4. "Authorized agent" means a person appointed pursuant to R19-2-306(I) of these rules.
5. "Breeder" of a greyhound means the owner or lessee of its dam at the time of whelping.

6. "Breeding farm" means a facility where greyhounds are bred and raised.
7. "Breeding place" means the place of birth of a greyhound.
8. "Commission" means the Arizona Racing Commission.
9. "Course" means the track over which greyhounds race.
10. "Declaration" means the act of withdrawing an entered greyhound from a race.
11. "Department" means the Arizona Department of Racing.
12. "Director" means the Director of the Arizona Department of Racing.
13. "Entrance fee" means a fee set by the permittee which must be paid in order to make a greyhound eligible for a stakes race.
14. "Entry" means a greyhound eligible and entered in a race.
15. "Equipment" as applied to greyhounds means muzzles and number blankets.
16. "Exercise areas" are fenced locations where greyhounds are released to exercise for a short period of time and then returned to their kennel housing crates, or to their run housing.
17. "Field" means the entire group of greyhounds in a race.
18. "Foreign substance" means any drug, medicine, or any other substance foreign to the greyhound's body which does or may affect the racing condition of a greyhound or which does or may affect sampling or testing procedures. Foreign substances include, but are not limited to, stimulants, depressants, local anesthetics, narcotics, and analgesics.
19. "Grounds" means the entire area used by the permittee to conduct racing meetings including, but not limited to, the track, grandstand, kennels, concession areas, and parking facilities.
20. "Kennel housing" means any facility where greyhounds are housed indoors.
21. "Kennel owner" means a person who has a contract or agreement with a permittee to provide dogs to the permittee's facility.
22. "Lawfully issued prescription" means a prescription-only drug, as defined in A.R.S. § 13-3401, obtained directly or pursuant to a valid prescription or order from a licensed physician acting in the course of professional practice.
23. "Lessee" or "lessor" means a person who has leased a greyhound for racing or breeding purposes.
24. "Lure" means mechanical apparatus consisting of the following component parts: A stationary rail installed around the track and a reasonable decoy which shall be attached to the pole.
25. "Maiden" means a greyhound which at the time of starting has never won a race in any country on a recognized track or which has been disqualified after finishing first.
26. "Manager/Agent," for purposes of R19-2-327, means a person managing a racing kennel, breeding farm, or other operation.
27. "Matinee" means a schedule of races conducted upon a track in daylight hours.
28. "Meeting" means the entire period for which a permit to conduct racing has been granted to any permittee by the Department.
29. "Night performance" means a schedule of races conducted upon a race track during night hours.
30. "Nominating fee" means a fee set by the permittee which must be paid in order to make a greyhound eligible for a stakes race.
31. "Nomination" means the naming of a greyhound or its pup (offspring) to compete in a specific race or series of

- races, eligibility for which may be conditional upon the payment of a fee at the time of naming.
32. "Nominator" means the person in whose name a greyhound is nominated for a stakes or handicap race.
 33. "Off time" means the moment at which, on signal of the starter, the greyhounds break and run.
 34. "Other operation" means a facility where greyhounds are trained, or kept.
 35. "Owner" means any person possessing all or part of the legal title to a greyhound, or any person possessing all, or part of the legal interest in a racing kennel, breeding farm, or other operation.
 36. "Place" means the position in which a greyhound finishes in a race and, more specifically, win-first, place-second, and show-third.
 37. "Post position" means the position assigned to a greyhound for the start of a race.
 38. "Post time" means the time set for the arrival at the starting point of the greyhounds in a race.
 39. "Prohibited substance" means any substance regulated by A.R.S. Title 13, Chapter 34.
 40. "Race" means a contest among greyhounds for purse, stakes, premium, or wager for money, run in the presence of the racing officials of the track and of the Department.
 - a. "Hurdle race" means a race over a course in which jumps or hurdles are used.
 - b. "Match race" means a race between two or more greyhounds, each the property of different owners, on terms agreed upon by the owners and approved by the Department.
 - c. "Overnight race" means a race for which entries close 96 hours or less before the time set for the first race of the day on which such race is to be run.
 - d. "Purse race" means a race for money or other prize to which the owners of the greyhounds engaged in the race do not contribute an entry fee.
 - e. "Race on the flat" means a race over a course in which no jumps or other obstacles are placed.
 - f. "Stakes race" means a race in which any monies are to be deposited by the owners of the greyhounds engaged in the race, including a race in which money or other prize is added, and in which nominations must close more than 72 hours before the time for the first race of the day on which such stakes race is to be run.
 41. "Racing Regulation Fund" is a fund established by A.R.S. § 5-113.01 and administered by the Department, to receive funding for regulation from various pari-mutuel racing industry sources.
 42. "Racing kennel" means a kennel located off-track and operated under contract, or agreement with a permittee to provide greyhounds to the permittee's facility.
 43. "Recognized track" means a track where pari-mutuel wagering is authorized by law.
 44. "Ruled off" means the act of barring from the grounds of a permittee and denying all racing privileges.
 45. "Run housing" means a fenced area where greyhound puppies and nonracing greyhounds live and are permitted to move about freely.
 46. "Scratch" means the act of withdrawing an entered greyhound from a race after the drawing for post positions in that race has been completed. There shall be no substitutions or replacements after post positions have been drawn.
 47. "Scratch time" means the time set by the permittee for the withdrawing of entries from the races of that day.
 48. "Starting fee" means a fee set by the permittee which must be paid in order to start in a race. This fee is specified by the conditions of the race.
 49. "Starting greyhound" means a greyhound which leaves the paddock for the post, excluding:
 - a. A greyhound subsequently excused by the stewards, or
 - b. A greyhound whose starting box door does not open in front of it at the time the starter dispatches the field.
 50. "Subscription" means the act of nominating to a stakes race.
 51. "Supplemental fee" means a fee set by the permittee to make a greyhound eligible for a stakes race that must be paid at a time prescribed by the permittee.
 52. "Suspended" means that any privilege granted by the officials of a racing meeting or by the Commission or the Department has been temporarily withdrawn.
 53. "Sustaining fee" means a fee which must be paid periodically, as prescribed by the conditions of the race, in order to keep a greyhound eligible for that race.
 54. "Tote/totalizer" means the machines which sell mutuel tickets and the board on which the approximate odds are posted.
 55. "Track" means the course over which races take place.
 56. "Trainer" means the person employed by an owner or lessee to condition greyhounds for racing.
 57. "Turn-out pens" are enclosed, or fenced areas where racing greyhounds are briefly released from their kennel housing crates for the purpose of urinating and defecating.
 58. "Walkover" means a race in which there are not two or more greyhounds of separate interest sent postward.
 59. "Weighing in" means the act of recording weight of a greyhound taken at the first weighing in, in accordance with these rules.
 60. "Weighing out" means the act of recording weight of a greyhound previous to post time or time of the race in which it is entered.
 61. "Whelped" means the birth of a greyhound.

Historical Note

Adopted effective August 5, 1983 (Supp. 83-4).

Amended effective November 30, 1988 (Supp. 88-4).

Amended effective March 20, 1990 (Supp. 90-1).

Amended effective February 28, 1995; R19-2-302 recodified from R4-27-302 (Supp. 95-1). Amended by exempt rulemaking at 17 A.A.R. 1484, effective July 20, 2011 (Supp. 11-3).

R19-2-303. Permit Applications

- A. A person or persons, associations, or corporations desiring to hold or conduct a greyhound racing meeting within the state of Arizona shall file with the Commission its permit application that contains the information required in A.R.S. § 5-107 in paper copy and in an electronic medium. All electronic media submissions shall be compatible with the Department's computer system and software. If any addendum to the permit application cannot be submitted in an electronic medium, the applicant shall submit the addendum in a paper copy.
- B. The Department shall not issue a permit until the applicant has furnished evidence of compliance with A.R.S. § 23-901 et seq. (Workers' Compensation).
- C. Permit applicants shall submit to the Commission the names of the proposed track officials at least 60 days prior to the beginning of their meet, along with a short biographical sketch of

each official not previously licensed in the same capacity by the Department.

- D. A permit application shall specify the number of races to be run on a daily basis.
- E. Racing shall be conducted only on those days granted by permit.
- F. Permit Application Time-frames.
 - 1. Administrative completeness review time-frame.
 - a. Within 728 days after receiving an application package, the Department shall determine whether the application package contains the information required by subsections (A), (B), (C), and (D).
 - b. If the application package is incomplete, the Department shall issue a written notice that specifies what information is required and return the application. If the application package is complete, the Department shall provide a written notice of administrative completeness.
 - c. The Department shall deem an application package withdrawn if the applicant fails to file a complete application package within 180 days of being notified that the application package is incomplete.
 - 2. Substantive review time-frame. Within 30 days after receipt of a complete application package, the Commission, with the recommendation of the Department, shall determine whether the applicant meets all substantive requirements and issue a written notice granting or denying a permit.
 - 3. Overall time-frame. For the purpose of A.R.S. § 41-1073, the Department establishes the following time-frames for issuing a license:
 - a. Administrative completeness review time-frame: 728 days.
 - b. Substantive review time-frame: 30 days.
 - c. Overall time-frame: 758 days.
 - 4. Renewal and temporary permit time-frames. The administrative completeness review time-frame is 30 days, the substantive review time-frame is 30 days, and the overall time-frame is 60 days, excluding time for mailing. The renewal or temporary permit is considered administratively complete unless the Department issues a written notice of deficiencies to the applicant. Temporary permits are valid until a full permit is awarded or until the Commission revokes the temporary permit.

Historical Note

Adopted effective August 5, 1983 (Supp. 83-4).
 Amended effective March 20, 1990 (Supp. 90-1). R19-2-303 recodified from R4-27-303 (Supp. 95-1). Amended effective January 6, 1998 (Supp. 98-1). Amended by final rulemaking at 11 A.A.R. 5534, effective February 4, 2006 (Supp. 05-4).

R19-2-304. Permittee Responsibilities

- A. A permittee shall maintain the grounds in a neat, clean, and safe condition. If a steward determines that compliance does not exist, the steward shall require that the permittee immediately bring the grounds into compliance.
- B. A permittee shall not allow a person, corporation, firm, or association not licensed by the Department to do or perform any act at the permittee's track that requires a license under A.R.S. Title 5, Chapter 1, or these rules.
- C. A permittee shall ensure that employees of the permittee are licensed and shall furnish the Department a list of the employees upon request.
- D. A permittee shall take all steps necessary to deny access to the permittee grounds by a person who has been ruled off or whose license has been revoked or suspended.
- E. A permittee or any of its employees shall not obstruct in any way a representative of the Department acting in the performance of official duties.
- F. A permittee shall not knowingly allow on its grounds any betting or other operation in contravention of any law of Arizona or the United States.
- G. A permittee who knows of a violation of any racing rule or statute shall immediately report the violation to the Department and shall cooperate with the Department and state, federal, and local authorities in investigation of the violation.
- H. A permittee shall provide the following services at the track:
 - 1. An adequate security force that shall:
 - a. Maintain order;
 - b. Exclude from the grounds all handbooks, touts, and operators of gambling devices;
 - c. Exclude from the grounds all persons ruled off by the stewards or the Department;
 - d. Exclude from the grounds all persons not eligible for a license, pursuant to A.R.S. § 5-108, and all other undesirables; and
 - e. Report immediately to the stewards any licensee who, while on the premises of the permittee, creates a disturbance, is intoxicated, interferes with any racing operation, or acts in an abusive or threatening manner to any racing official or other person.
 - 2. A security guard stationed at the kennel area entrance that shall:
 - a. Deny entrance to all persons not holding a license or credentials issued by the Department or a Department pass issued by the permittee; and
 - b. Allow any person seeking employment with the permittee to have access to the kennel area for a period of one day, if:
 - i. The person is given a numbered card or temporary badge,
 - ii. A list of recipients of the numbered cards or temporary badges is provided to the track office of the Department upon request, and
 - iii. The numbered card or badge is retrieved by the security guard when the person leaves the restricted area.
 - 3. During a race meeting, a permittee shall provide 24-hour security at the entrance to the kennel compound. The permittee shall establish a system to monitor those who enter and leave the compound ensuring that only licensed personnel, authorized visitors, and those whose duties clearly require entry to the area are permitted access. A public safety officer or Department employee in the performance of official duties shall be granted access to the kennel compound. An unlicensed visitor shall be accompanied by a licensee or security personnel and shall obtain a temporary badge before entering the kennel compound. The licensee requesting the admittance of a visitor is responsible for the conduct of the visitor and shall ensure that the visitor complies with all Department rules.
 - 4. A furnished office, including utilities and necessary office equipment, for exclusive use of Department employees and officials.
 - 5. A uniformed security official approved by the Department shall be on duty in the test area during its regular business hours to:
 - a. Provide security, and
 - b. Monitor the collection procedure and sealing of samples taken from the greyhounds.

6. Adequate space and facilities so that the testing personnel may perform inspections, tests, and other collection procedures.
7. First aid quarters available during racing hours.
- I. A permittee shall ensure that wagering conducted upon the grounds of the permittee is done only under the pari-mutuel method as provided by statute and these rules and by the use of mechanical or other equipment as required by the Department. A permittee shall ensure that there is no bookmaking or betting other than by the pari-mutuel method.
- J. A permittee shall not allow the official racing of greyhounds on any track under its control unless:
 1. All track rules are posted conspicuously and a copy of the track rules is filed with the Department,
 2. The conditions of the race are written by the racing secretary at the meeting,
 3. The entries are made in accordance with the requirements in R19-2-316, and
 4. The race is programmed as a part of a regular racing card conducted under the pari-mutuel system.
- K. A simulcast originating from a racing facility within the state of Arizona may be permitted provided the out-of-state facility receiving the signal operates under the approval and regulation of an official agency of that state.
- L. Each day as soon as the entries have been closed and compiled and the declarations have been made, a permittee shall post a list of the entries in a conspicuous place.
- M. A permittee shall print a racing program each day that contains a list of permittee, track and racing officials, and permittee directors, along with pertinent rules designated by the Department.
- N. A permittee may not allow an official to act until the official's appointment has been approved by the Department; provided, however, that in the case of sickness or inability to act, the provisions of R19-2-309(A)(5) apply.
- O. A permittee shall provide a photo finish and videotape device approved by the Department to record all official races. The photographs and videotapes may be used to aid the stewards in determining the finishes of races. A permittee shall retain for three months all official race photographs and videotapes. The Department may require that specific photographs and videotapes be retained for a longer period or transmitted to the Department for use in administrative or judicial proceedings.
- P. The Department shall approve any automatic timing device installed by a permittee.
- Q. All permittees shall provide annual financial statements audited and certified by a firm approved by the auditor general.
 1. The audit shall comply with audit standards prescribed by the auditor general.
 2. The financial statements shall be prepared in accordance with generally accepted accounting practices.
- R. The following information shall accompany the financial statements on a form provided by the Department:
 1. The total amount of salaries and bonuses expense,
 2. Legal and accounting expenses attributable to racing-related matters,
 3. An explanation of the types of revenues and expenses classified in accounts titled "other,"
 4. Additional information requested by the Commission or the Department, and
 5. Financial statements submitted within 120 calendar days of the end of the calendar year.
- S. Each permittee shall comply with the provisions of Article 2 of this Chapter.

Historical Note

Adopted effective August 5, 1983 (Supp. 83-4).
 Amended subsection (Q) effective June 6, 1986 (Supp. 86-3). Amended effective March 20, 1990 (Supp. 90-1).
 Amended effective August 6, 1991 (Supp. 91-3). R19-2-304 recodified from R4-37-304 (Supp. 95-1). Amended by final rulemaking at 12 A.A.R. 1771, effective July 1, 2006 (Supp. 06-2). Amended by exempt rulemaking at 17 A.A.R. 1484, effective July 20, 2011 (Supp. 11-3).

R19-2-305. Charity Races

- A. A permittee shall provide the Commission with:
 1. The name of any nonprofit organization or corporation selected by the permittee as a charity entitled to benefit from a charity racing day or race.
 2. A list of the names and addresses of all directors, officers, and shareholders holding 10% or more of the total number of outstanding voting shares of the charitable corporation.
 3. A brief description of the purposes and activities to be benefited by monies received from the charity racing day or race.
 4. A copy of an Internal Revenue Service letter of determination qualifying the particular charity as an exempt organization or corporation for federal income tax purposes.
- B. No permittee shall charge any expenses incurred by operation of racing against the pari-mutuel handle of a charity racing day or race except those prorated expenses incurred on the day of that particular charity racing day or race.

Historical Note

Adopted effective August 5, 1983 (Supp. 83-4).
 Amended effective March 20, 1990 (Supp. 90-1). R19-2-305 recodified from R4-27-305 (Supp. 95-1).

R19-2-306. Licensing

- A. A person participating in any capacity in a racing meeting, including any person who performs services in connection with the conduct of the racing meeting, shall obtain a license from the Department, except:
 1. A person performing services during a county fair race meet who is identified by a steward as a volunteer; or
 2. A person owning less than 10 percent of outstanding shares of stock, regardless of classification or type, of any permittee or licensee.
- B. Applications
 1. To apply for a license, a person shall complete the license application prescribed by the Department.
 2. The Department may issue written instructions regarding the preparation and execution of the license application, and the instructions may be a part of or separate from the application form, or both.
 3. When an applicant submits a license application, the applicant shall also submit the fee established by the Department pursuant to R19-2-202(C). The Department shall ensure that a schedule of license and fingerprint processing fees is displayed prominently at each track.
 4. An applicant who is at least 18 years of age shall submit a full set of fingerprints to the Department. The fingerprints shall be taken by the Department or certified by a municipal police department, sheriff's office, or other authority acceptable to the Department.
 5. An applicant for a trainer license shall demonstrate knowledge and skill in protecting and promoting the safety and welfare of animals participating in racing meetings by passing an examination prescribed by the Department. An applicant who fails to pass the examina-

tion shall wait at least six months before retaking the examination.

6. An applicant for a racing license shall indicate on the license application whether the applicant hires employees or independent contractors to work at an Arizona racetrack. For the purposes of this Section, "employee" has the meaning in A.R.S. § 23-902(B) and "independent contractor" has the meaning in A.R.S. § 23-902(C).

- a. An applicant that hires employees to work at an Arizona racetrack shall provide proof of compliance with A.R.S. § 23-961(A) by providing to the Department a copy of the declaration page of the applicant's workers' compensation insurance policy.
- b. The Department shall notify the Industrial Commission of Arizona of an applicant that fails to provide proof of workers' compensation insurance as required in this Section. The Department shall notify the Industrial Commission of Arizona of an applicant that hires independent contractors to enable the Industrial Commission of Arizona to investigate the characterization of the applicant's workers as independent contractors.

- C. Each applicant and licensee shall know and follow the rules governing racing in Arizona.

D. License procedure

1. Under delegation from the Director, a steward shall grant or deny a temporary license and transmit the license application to the Director.
2. In considering each application for a license, a steward may require the applicant, as well as the applicant's endorsers, to appear before the steward and show that the applicant is qualified in every respect to receive the license requested. The steward shall grant a license only if the applicant meets all the requirements in A.R.S. Title 5, Chapter 1, and these rules.
3. Licensing time-frame.

- a. Administrative completeness review time-frame
 - i. Within 85 days after receiving a license application, the Department shall determine whether the license application contains the information required by subsection (B).
 - ii. If the license application is incomplete, the Department shall issue a written notice that specifies what information is required and return the license application. If the license application is complete, the Department shall provide a written notice of administrative completeness.
 - iii. The Department shall deem a license application withdrawn if the applicant or licensee fails to file a complete license application within 10 days of being notified that the license application is incomplete.
- b. Substantive review time-frame. Within five days after determining that a license application, is administratively complete, the Department shall determine whether the applicant or licensee meets all substantive requirements and the Director, or designee, shall issue a written notice granting or denying a license.
- c. Overall time-frame. For the purpose of A.R.S. § 41-1073, the Department establishes the following time-frames for issuing a license:
 - i. Administrative completeness review time-frame: 85 days.
 - ii. Substantive review time-frame: five days.

- iii. Overall time-frame: 90 days.

4. Temporary license. All licenses are temporary for 90 days under A.R.S. § 5-108(F). Unless the Director denies a license to an applicant, a temporary license automatically becomes the license after 90 days.
5. The Department shall perform a background investigation of an applicant including fingerprint processing through the Department of Public Safety and the FBI, and reviewing records of the Association of Racing Commissioners International, Inc., North American Pari-mutuel Regulators Association, information systems, courts, law enforcement agencies, and Department within the time-frame prescribed in subsection (D)(3).

E. Denials

1. A license may be denied if the applicant:
 - a. Has been or is intoxicated or a user of a narcotic as defined at A.R.S. § 36-2501(A)(8) within the grounds of the permittee, or
 - b. Fails to disclose the true ownership or interest in any greyhound.
2. When a license is denied, the Director shall report the reason for the denial in writing to the applicant and to the Association of Racing Commissioners International, Inc. and the North American Pari-mutuel Regulators Association.

F. General requirements and restrictions

1. A licensee who is employed in more than one category or who changes from one category to another shall be licensed in each category.
2. A licensee who is an official at different types of tracks (horse, harness, or greyhound) shall be licensed at each type of track.
3. The Director or designee shall not license a person who is less than 16 years of age in any capacity other than as an owner; and shall not license a person who is less than 18 as an official, trainer, or assistant trainer. A person who is less than 18 who is licensed as an owner, shall have a parent or guardian sign the owner's license application, assuming full financial responsibility for the owner, before that owner is eligible to be licensed.
4. When present in the kennel area of a greyhound track, the paddock area, or any other restricted area, a person shall wear in full view a photo identification badge issued by the Department or pass issued by the permittee.

G. Authorized agents

1. A person may hold a license solely as an authorized agent or be licensed as an authorized agent and be licensed in another category.
2. The principal shall sign the license application on behalf of an authorized agent and clearly identify the powers of the agent, including whether the agent is empowered to collect money from the permittee. The license application shall be either notarized or signed in the presence of a Department employee and a copy filed with the track bookkeeper. If there is a separate power of attorney, the principal shall file a copy of the instrument with the bookkeeper and the Department.
3. To change an agent's powers or revoke an agent's authority, the principal shall describe the changed powers or revoked authority in writing that is either notarized or signed in the presence of a Department official, and filed with the Department and the track bookkeeper.

Historical Note

Adopted effective August 5, 1983 (Supp. 83-4).
Amended subsections (G) and (I) effective January 25, 1985 (Supp. 85-1). Amended subsections (F) and (G)

effective December 5, 1985 (Supp. 85-6). Amended subsections (F) and (G) effective February 19, 1987 (Supp. 87-1). Amended subsections (A) and (B) effective October 23, 1987 (Supp. 87-4). Amended subsections (E), (F) and (G) effective November 30, 1988 (Supp. 88-4).

Amended effective March 20, 1990 (Supp. 90-1).

Amended effective January 13, 1995 (Supp. 95-1). R19-2-306 recodified from R4-27-306 (Supp. 95-1). Amended effective January 6, 1998 (Supp. 98-1). Amended by final rulemaking at 10 A.A.R. 4483, effective December 4, 2004 (Supp. 04-4). Amended by exempt rulemaking at 17 A.A.R. 1484, effective July 20, 2011 (Supp. 11-3).

R19-2-307. Kennel Names

- A.** A licensed owner wishing to race under a kennel name shall register with the Department and shall pay the fee set forth in these rules.
 - 1. Only owners may register or secure a license under a kennel name.
 - 2. A name other than the legal name(s) of the owner(s) shall be deemed to be a kennel name.
- B.** The registration referred to in paragraph (1) of this subsection shall include the identity of the individual, partnership, or corporation represented by the kennel name.
 - 1. All persons represented by a kennel name shall have owners' licenses.
 - 2. All persons represented by a kennel name shall sign an authorized agent's application which appoints one person to act as the agent for the kennel name.
 - 3. If the kennel name represents a corporation:
 - a. The corporation shall register to do business according to the laws of the state of Arizona;
 - b. The corporation shall submit a complete list of stockholders and the number of shares owned by each stockholder whose ownership exceeds 10% of the number of shares owned by each;
 - c. The corporation shall notify the Department immediately if any change of stock ownership occurs which exceeds 10%;
 - d. The corporate name under which the corporation does business in Arizona shall be considered a kennel name for purposes of these rules.
- C.** A kennel name other than a corporate kennel name may be changed at any time by registering a new kennel name and by paying the fee set forth in these rules.
- D.** A registered kennel name may be abandoned by a licensed owner after written notice of such abandonment has been given to the Department.
- E.** A kennel name must be plainly distinguishable from any other registered kennel name.
- F.** A licensed owner shall not register as his or her kennel name:
 - 1. One which the Department determines to be misleading to the public; or
 - 2. One which the Department determines to be unbecoming to the sport.
- G.** A licensed owner shall not be a party to more than one kennel name at one time.
- H.** A licensed owner shall not use his legal name for racing purposes if he or she has a registered kennel name within the state of Arizona.
- I.** Only one kennel shall be registered under a kennel name.
- J.** All persons represented by or operating under a kennel name shall be liable for all entry fees and penalties against the kennel.
- K.** The kennel name shall be carried on the official program as the name of the owner.

Historical Note

Adopted effective August 5, 1983 (Supp. 83-4).

Amended effective March 20, 1990 (Supp. 90-1). R19-2-307 recodified from R4-27-307 (Supp. 95-1).

R19-2-308. Owners, Kennel Owners, and Trainers

- A.** An owner, kennel owner, and trainer shall comply with the rules in this Article.
- B.** The decisions of the stewards on all questions to which the stewards' authority extends, are final, subject to the right of appeal to the Department pursuant to R19-2-322.
- C.** When a trainer or assistant trainer is absent from the kennel or grounds where the trainer's greyhounds are racing, the trainer or assistant trainer shall provide a substitute licensed trainer or assistant trainer responsible for the greyhounds. Both the absent and substitute trainer shall sign a "Trainers' Responsibility Form" approved by the stewards.
- D.** An owner, kennel owner, trainer, assistant trainer, race track employee, or other licensee shall not accept, directly or indirectly, any bribe, gift, or gratuity in any form with the intent to influence the result of any race.
- E.** The trainer of an entered greyhound shall bring the greyhound to the weighing-in room at the appointed time unless the stewards grant additional time for extenuating circumstances. If the greyhound is not brought to the weighing-in room at the appointed time, the stewards shall scratch the greyhound and the trainer may be fined for failing to do so.
- F.** A trainer shall report any greyhound, under the trainer's care or supervision, that is off racing form or is in poor physical condition to the racing secretary, who shall immediately notify the stewards. A reported greyhound shall not enter or start until approved by the track veterinarian and schooled to the satisfaction of the stewards. A trainer who violates this rule is subject to a civil penalty or suspension or to ruling off.
- G.** An owner, kennel owner, or trainer shall ensure that no medicine, antiseptic, fluid, or other matter containing any color that may cause the marring of identification marks is used on any part of a greyhound.
- H.** An owner, kennel owner, trainer, or other licensee with an interest in any greyhound at a meeting licensed by the Commission, who places a wager with or through any handbook, shall be:
 - 1. Ejected from the grounds of the permittee;
 - 2. Refused admission to the grounds of all other licensed permittees in the state of Arizona; and
 - 3. Denied entry of any greyhound by all permittees in Arizona.
- I.** A trainer shall not have an ownership interest in a greyhound located at the track at which the trainer trains unless the trainer trains the greyhound. For purposes of this rule, a reversionary interest in a greyhound, pursuant to a lease or other agreement that transfers control of the greyhound, is not an ownership interest.
- J.** The kennel owner or trainer shall ensure that each greyhound owner is licensed before the greyhound runs in a race.

Historical Note

Adopted effective August 5, 1983 (Supp. 83-4).

Amended effective November 30, 1988 (Supp. 88-4). Amended effective March 20, 1990 (Supp. 90-1). R19-2-308 recodified from R4-27-308 (Supp. 95-1). Amended by final rulemaking at 12 A.A.R. 1771, effective July 1, 2006 (Supp. 06-2).

R19-2-309. Officials

- A.** Generally
 - 1. Track official" means the following persons employed by a permittee and approved and licensed by the Depart-

ment: Director of Racing, one steward, mutuel manager, clerk of scales, starter, timer, paddock judge, veterinarian, track superintendent, racing secretary, assistant racing secretary, chart writer, kennel master, and operator of the mechanical lure.

2. The following are the "Department Officials" appointed by and representing the Department: two stewards, state mutuel supervisor, a Department veterinarian, and an investigator.
3. One person may serve in more than one official position if such person can do so without detriment to any of the other positions, and if such person has the consent and approval of the Department, provided that neither the racing secretary nor the permittee director of racing may serve as a steward.
4. In all rulings by the stewards, majority of the stewards is deemed to be controlling.
5. Vacancies:
 - a. When a vacancy occurs among officials other than stewards, the stewards shall fill the vacancy prior to post time of the first race of the day or when the vacancy occurs. The appointment shall be effective only for the day unless the permittee fails to fill the vacancy on the following day and has notified the stewards of its action not less than one hour before the post time of the first race of the following day. Such an appointment shall be reported promptly to the Department.
 - b. If a vacancy occurs among the stewards, the stewards present shall appoint one or two persons to serve as temporary stewards. Appointments made under this rule shall be reported in writing to the Department.
 - c. In case of emergency, the stewards may appoint a substitute to fill a vacancy for that emergency only.
6. Minors shall not be licensed as officials.
7. A person with an interest in the result of a race because of an ownership interest in an entered greyhound, a bet, or in any other manner may not act as an official at the meeting.
8. "Employee" means any person, other than a track official, who is employed by a permittee.

B. Prohibited acts

1. An official or the official's assistant shall not purchase mutuel tickets on races.
2. An official or the official's assistant shall not consume alcoholic beverages while on duty.
3. A licensee or a race track employee shall not accept, directly or indirectly, any bribe, gift, or gratuity in any form that is intended to or might influence the results of any race or the conduct of any racing meeting.
4. An official or employee shall not write or solicit dog insurance at any meeting.

C. Each official and employee shall report all observed violations of these rules to the stewards.

D. Complaints

1. A grievance or complaint against a track official, an employee of the permittee, or a licensee shall be submitted to the stewards in writing within five days of the alleged objectionable act or behavior. The stewards shall consider the matter, take whatever action is deemed to be appropriate, and make a full report of their action to the Department.
2. A grievance or complaint against an official or employee of the Department shall be reported to the Director or the

Director's designee in writing within five days of the alleged objectionable act or behavior.

3. The Department reserves the right to demand a change of any official or employee for good cause.

E. Stewards

1. Two stewards appointed by the Director and one steward appointed by the permittee and licensed by the Director shall supervise each racing meeting.
 - a. The Stewards shall be in attendance at the office of the racing secretary or on the grounds of the permittee on any day that entries are taken or racing is conducted, and represent the Department in all matters pertaining to interpretation of the Department's rules.
 - b. The stewards shall advise the Director of all rulings and hearings held.
 - c. If a steward is unable to perform the steward's duties for an extended period of time, the steward shall immediately notify the Director so that an alternate steward may be named to act in the steward's place.
2. The stewards shall enforce the rules and statutes of the state of Arizona.
3. The stewards shall interpret the rules and decide all questions not specifically covered by the rules. In these interpretations, an order of the stewards supersedes an order of the permittee.
 - a. The stewards shall have control over and shall have free access to all stands, enclosures, and all other places within the grounds of the permittee.
 - b. The stewards shall investigate and render a decision promptly on each objection properly made to them under R19-2-320. A majority of the stewards shall sign each ruling.
 - c. The stewards shall supervise all entries and declarations. They may refuse entries or the transfer of any entries for violations of the rules or of the statutes.
 - d. The stewards shall have the power to regulate and control the conduct of all officials and all other persons attending or participating in any manner in a racing meeting.
 - e. The stewards, in order to maintain necessary safety and health conditions and to protect the public confidence in greyhound racing as a sport, shall have the right to authorize a person or persons in their behalf to enter into or upon the buildings, kennels, rooms, motor vehicles, trailers, or other places within the grounds of a licensed race track, to examine same, and to inspect and examine the person, personal property, and effects of any person within such place, and to seize any items prohibited under R19-2-311(5) and (6) or any other illegal article.
 - f. Under subsection (E)(6), the stewards may impose a civil penalty in an amount not to exceed \$1,000 on any person subject to the stewards' control for violation of these rules. After a hearing, the stewards may suspend a person violating any of these rules for up to 60 days and may rule off a licensee violating any of these rules. The stewards may impose both a civil penalty and suspension for the same violation. The stewards may refer any ruling made by them to the Director recommending further action, including license revocation.
 - g. When the state laboratory reports or other evidence shows the administration or presence of a foreign substance, the stewards shall immediately investigate the matter and may disqualify the affected grey-

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- hound, suspend the trainer or other person involved, refer the matter to the Director, and impose a fine.
 - h. A person or greyhound expelled or ruled off by a recognized racing authority for corrupt, fraudulent, or improper practice or conduct is ruled off wherever these rules have force.
 - i. When a person is under suspension, the stewards shall rule off or expel every greyhound wholly or partly owned by the person while the suspension continues. The person under suspension is not qualified, whether acting as agent or otherwise, to subscribe for, or to enter or run any greyhound in any race, in either the person's name or that of any other person. A greyhound of which the person under suspension is wholly or partly the owner, or which is under the person's care, management, training, or supervision, or in the winnings of which the person has any interest, is not qualified to be entered to run in any race. If an entry is received from a person or for a greyhound that stands ruled off or expelled, the entry is void, and any entry or subscription money is forfeited. A person who wins any money or prize under a voided entry shall return the money or prize to the track.
 4. The stewards may excuse a greyhound that has left the paddock for the post if they consider the greyhound to be crippled, disabled, or unfit to run.
 5. The stewards shall determine the finish of a race by the relative position of the muzzles or noses of each greyhound. They shall immediately notify the permittee parimutuel department of the numbers of the first four greyhounds.
 - a. The stewards shall promptly display the numbers of the first four greyhounds in each race in order of their finishes. If the stewards differ in their placing, the majority shall prevail.
 - b. The stewards may consult the photo finish device provided by the permittee to aid them in determining the finish of a race.
 - i. In any instance where the pictures furnished are not adequate or usable, the decision of the stewards shall be final and need not be governed in any manner by the photograph.
 - ii. If it is considered advisable to consult a picture from the photo finish device, the stewards may post the placements that are, in their opinions, unquestionable without waiting for a picture. After consulting the picture they shall post the other placements. A race may not be declared official until the stewards have determined the greyhounds finishing first, second, third, and fourth.
 - c. The rules shall not prevent the stewards from correcting an error before the display of the sign "official" or from recalling the sign "official" if it is displayed through error.
 6. The stewards shall adhere to the following procedure when they have reason to believe that a rule has been violated by any person:
 - a. The stewards shall summon the person to a hearing with all the stewards present.
 - b. The stewards shall give 24-hours' notice of the hearing to the person, in writing, on a form supplied by the Department. The stewards shall time and date the notice, and the person notified shall sign it. The stewards shall retain the original and include it as part of the case file. The steward shall give a copy to the person summoned.
 - c. The steward shall not impose a penalty until the hearing.
 - d. The stewards shall construe nonappearance of the summoned person as a waiver of the right to a hearing before the stewards.
 - e. The stewards shall permit the person summoned to present witnesses on the person's own behalf.
 - f. The stewards shall take appropriate action, including suspension, civil penalty, or both if there is substantial evidence to find a violation of these rules. The stewards shall promptly forward their written decision or ruling to the Director and to the person in question.
 - g. In the interest of the health, safety, and welfare of the people of the state of Arizona, the stewards may summarily declare a greyhound scratched and may suspend a license pending a stewards' hearing.
 - h. The stewards shall recover and forward to the Department any license they suspend.
 - i. A majority vote of the stewards shall determine all matters within their jurisdiction.
 - j. The stewards have the power to modify, change, or remit any ruling imposed by them.
 - k. A licensee against whom a civil penalty is assessed shall promptly pay to the Department the civil penalty for deposit with the state treasurer.
 7. During the term of suspension of an owner, trainer, or other person on a track under the jurisdiction of the Department, the stewards and the permittee shall ensure that a ruling against the owner, trainer, or other person is enforced.
- F. Racing secretary
1. The racing secretary shall:
 - a. Report to the stewards all violations of these rules or of the rules of the permittee that come to the racing secretary's attention; and
 - b. Keep a complete record of all races.
 2. The racing secretary or the racing secretary's designee shall inspect all papers and documents dealing with owners and trainers, partner agreements, appointments of authorized agents, and adoption of kennel names. The racing secretary may demand production of documents and papers to verify their validity and authenticity and to ensure that the rules have been followed.
 3. The racing secretary shall write the conditions of all races and publish them sufficiently before closing time for entries to allow them to be read by all owners and trainers. The racing secretary shall not alter the conditions after the time set for closing. The racing secretary shall not write races that conflict with the rules.
 4. The racing secretary shall act as the official handicapper in all races.
 5. The racing secretary shall determine the character and condition of substitute and extra races, and shall submit them to the stewards for approval.
 - a. A substitute or extra race shall not carry a lower guaranteed purse than the race that it replaces.
 - b. If a race is canceled or declared off, the racing secretary may split any race programmed for the same day which previously may have been closed.
 6. The racing secretary or the racing secretary's designee shall conduct the drawing of all races and immediately post an overnight listing of the greyhounds in each race.

7. The racing secretary shall not allow any greyhound to start in a race unless the greyhound is entered in the name of the legal owner and unless the owner's name appears on the registration papers or on a legal lease or bill of sale attached to the registration papers.
- G. Assistant racing secretary.** The duty of the assistant racing secretary shall be to assist the racing secretary in the performance of the racing secretary's duties and under the racing secretary's supervision.
- H. Starter**
1. The starter has complete jurisdiction over the start of any field of greyhounds, authority to give orders necessary to ensure a fair start, and authority to recommend to the stewards that a person who violates the starter's orders be fined or suspended.
 2. A greyhound shall start from a starting box approved by the Department. A starter shall ensure there is no start until, and no recall after, the doors of the starting box have opened. The starter shall report any cause of delay to the stewards.
 3. A false start due to any faulty action of the starting box, break in the machinery, or other cause, is void. The greyhounds may be started again as soon as practicable or the race may be canceled at the discretion of the stewards.
- I. Clerk of the scales**
1. The clerk of the scales shall:
 - a. Weigh all greyhounds in and out;
 - b. Post the scale sheet of weights promptly after weighing;
 - c. Prevent any greyhound from passing the scales or running with an overweight or an underweight of more than two pounds. The clerk of scales shall promptly notify the paddock judge, who shall report to the stewards, any infraction of the rules as to weight or weighing; and
 - d. Report all late scratches and weights on a bulletin board located in a place conspicuous to the wagering public.
 2. The clerk of the scales shall report to the stewards any violations of weight rules or any attempt to alter specified weights.
 3. The clerk of scales shall weigh in and weigh out all greyhounds with the muzzle, collar, and lead strap.
 4. The clerk of scales shall keep a list of all greyhounds known as "weight losers" and notify the presiding steward as to the weight loss before each race.
- J. Paddock judge**
1. Identification of greyhounds:
 - a. The paddock judge shall check all greyhounds for each race.
 - b. A greyhound shall not start in a schooling or purse race unless it has been fully identified and checked against the card index system of identification maintained by the permittee. The paddock judge shall complete an identification card for each greyhound before the greyhound is entered for a schooling or purse race.
 - c. A permittee shall keep and maintain a card index system for identification of each greyhound racing at a meeting. The cards shall contain the names of the owner and trainer and the breeding, weight, color, sex, and characteristic markings, tattoos, scars, and other identification features peculiar to the greyhound.
 2. Under the supervision of the paddock judge, the kennel master shall unlock the kennels immediately before weigh-in time to see that the kennels are in perfect repair and that nothing has been deposited in any of the kennels for the greyhounds' consumption. The kennel master shall ensure that the kennels are sprayed, disinfected, and kept in proper sanitary condition. The kennel master or assistant shall receive the greyhounds from their trainers, one at a time, ensure that the greyhounds are placed in their kennels, and remain on guard from that time until the greyhounds are removed for the last race.
3. As each greyhound is weighed in the clerk of scales shall attach an identification tag to the collar indicating the number of the race in which the greyhound is entered and its post position. The tag shall not be removed until the greyhound has been weighed out and blanketed.
 4. The paddock judge shall not allow anyone to weigh in a greyhound for racing unless the person has a valid owner's, trainer's, or assistant trainer's license issued by the Department.
 5. After the greyhounds are placed in the lockout kennels, only the kennel master, racing official, a person approved by the Department, or a designated representative of the Department is allowed in or near the lockout kennels.
 6. The paddock judge shall carefully compare the identification card with the greyhound while in the paddock before post time.
 7. Before leaving the paddock for the starting box, the paddock judge shall ensure that every greyhound is equipped with a regulation muzzle and blanket. The paddock judge shall approve the muzzles and blankets and carefully examine them in the paddock before the greyhound leaves for the post.
 8. The paddock judge shall keep on hand, ready for use, extra muzzles of all sizes, lead straps, and collars.
 9. The paddock judge shall report all corrupt practices and irregularities to the stewards.
- K. Timer**
1. The timer shall accurately record the official time of each race, which shall be taken from the opening of the doors of the starting box. A steward may also perform this function.
 2. A permittee shall install an automatic timing device approved by the Department. The timer shall use the time shown on the timing device as the official time of the race if the timer is satisfied that the timing device is functioning properly. If the timing device is not functioning properly, the timer shall use the time shown on the stopwatch the timer operates. The track announcer shall announce the time to the public if the stopwatch time is used as the official time of the race.
- L. Chart writer**
1. The chart writer shall compile the information necessary for a program printed for each racing day. The program shall list the names of the greyhounds that are to run in each of the races for that day. The names shall appear in the order of post position designated by numerals placed at the left and in line with the names of the greyhounds in each race. The numerals shall also be prominently displayed on each greyhound.
 2. All past performances as shown in the program shall be in dated order of the races or official schoolings, with the last performance appearing on the first line. The program or form sheet shall also contain the name, color, sex, date of whelping, breeding, established racing weight, number of starts in official races and number of times finishing first, second, and third, name of the owner and trainer, distance of the race, the track record, and any other infor-

mation that will enable the public to properly judge the greyhound's ability.

3. When the name of a greyhound is changed, both the new name and the former name shall be published in the official entries and program for the greyhound's next three starts.

M. Veterinarians

1. The Department shall approve official veterinarians licensed to practice veterinary medicine in the state of Arizona. Each permittee shall employ one official veterinarian who is known as the track veterinarian. The Department shall employ the other official veterinarian.
2. The Department veterinarian shall be in charge of all sample collection.
3. The track veterinarian shall be present during all official races and all official schooling races and shall observe each greyhound as it enters the lockout kennel, examine it when it enters the paddock before the race, and recommend to the stewards that a greyhound be scratched when the veterinarian deems the greyhound unsafe to race or physically unfit to produce a satisfactory effort in a race.
4. The track veterinarian shall place a greyhound deemed unsafe, unsound, or unfit on a suspension list and shall post the list in a conspicuous place available to all owners, trainers, and officials.
5. After a greyhound is placed on a suspension list, it shall not race until it is removed from the list by the track veterinarian with the approval of the Department veterinarian.
6. The Department veterinarian shall inspect and report to the Department the condition of every kennel at the track of the permittee. The inspections shall be made at a time of the Department's choosing. The report filed with the Department shall cover the general physical condition of the dogs, sanitary conditions of the kennels, segregation of bitches in season, segregation of sick dogs, the types of medicine found in use, and any other matters or conditions that the Department veterinarian deems worthy of note.
7. The entry of a greyhound on the Department veterinarians' suspension list is accepted only after final approval by both the track and Department veterinarians and after a minimum of three calendar days from the date the greyhound was placed on the veterinarians' list.
8. Every veterinarian licensed by the Department shall keep a written record of the veterinarian's practice on the grounds of a permittee relating to greyhounds participating in racing.
 - a. This record shall include:
 - i. The name of the greyhound treated;
 - ii. The nature of the greyhound's ailment;
 - iii. The type of treatment prescribed and performed for the greyhounds; and
 - iv. The date and time of such treatment.
 - b. The veterinarian shall keep this record for practice engaged in at all licensed tracks.
 - c. The veterinarian shall produce this record without delay upon request of the stewards or the Department.
 - d. Veterinarians engaged in private practice on tracks under the jurisdiction of the Department shall be licensed by both the Arizona State Board of Veterinarian Medical Examiners and the Department.
 - e. Only a veterinarian licensed by the Department shall administer to or prescribe for a greyhound on the premises of a permittee except in case of emergency.

- f. A new or experimental medication or drug shall not be used on the grounds of a permittee unless the Department, acting on the recommendation of the Department veterinarian, approves the new or experimental medication or drug.

Historical Note

Adopted effective August 5, 1983 (Supp. 83-4). Amended subsections (A) and (E) effective November 30, 1988 (Supp. 88-4). Amended effective March 20, 1990 (Supp. 90-1). R19-2-309 recodified from R4-27-309 (Supp. 95-1). Amended effective August 7, 1996 (Supp. 96-3). Amended by final rulemaking at 11 A.A.R. 5534, effective February 4, 2006 (Supp. 05-4).

R19-2-310. Lead-outs

- A. Owners, trainers, or attendants shall not be allowed to lead their greyhounds from the paddock to the starting box except in schooling races. The greyhounds shall be led from the paddock to the starting box by lead-outs provided by each permittee and licensed by the Department.
 1. Lead-outs shall be assigned to post position by the paddock judge or his or her designee by lot before the first race of each race program; a record thereof shall be maintained.
 2. Lead-outs shall be required to present a neat appearance and conduct themselves in an orderly manner and must be attired in clean uniforms provided by the permittee.
 3. The lead-out shall handle the greyhound in a humane manner, put the greyhound in its proper box before the race, and then retire to an assigned place.
- B. Lead-outs are prohibited from holding any conversation with the public either in the paddock, en route to the starting post, or while returning to the paddock.
- C. No lead-out shall be permitted to have any interest in the greyhounds racing for said permittee.
- D. Lead-outs are prohibited from wagering on the result of any greyhound racing at the track to which they are assigned.

Historical Note

Adopted effective August 5, 1983 (Supp. 83-4). Amended effective March 20, 1990 (Supp. 90-1). R19-2-310 recodified from R4-27-310 (Supp. 95-1).

R19-2-311. Prohibited Acts

Generally:

1. No licensee shall enter, cause, or permit to be entered or to start a greyhound which he or she knows or has reason to believe should be disqualified.
2. No veterinarian licensed to practice on a track under the jurisdiction of the Department shall own, lease, or train greyhounds racing at the track on which he or she practices.
3. No person shall participate in any unauthorized race on a track while a racing meeting is in progress.
4. No person shall offer or receive any money or other consideration for declaring any entry out of a purse or stakes race.
5. No person shall possess, within the grounds of any permittee, any electrical, mechanical, or other device, other than ordinary equipment, which may be used to affect the speed or racing condition of a greyhound. Such possession includes, but is not limited to, possession:
 - a. On the person,
 - b. In living or sleeping quarters,
 - c. In an assigned kennel, feed room, or other area,
 - d. In a motor vehicle or trailer.

6. No person other than a physician or veterinarian licensed by the Department may possess, within the grounds of any permittee, any foreign or prohibited substance, injectable vial, hypodermic needle, syringe, or any other instrument which might be used for injection, without written permission of the stewards. Such possession includes, but is not limited to, possession:
 - a. On the person,
 - b. In living or sleeping quarters,
 - c. In an assigned kennel, feed room, or other area,
 - d. In a motor vehicle or trailer.
7. No licensee listed in A.R.S. § 5-104 shall apply, inject, inhale, ingest, or in any way use any prohibited substance while on permittee grounds, unless, upon the request of a steward, a licensee can produce evidence that the possession or use of a prohibited substance is pursuant to a lawfully issued prescription.
8. No licensee or race track employee shall accept, either directly or indirectly, any bribe, gift, or gratuity in any form which is intended to or might influence the results of any race or the conduct of any racing meeting.
9. No licensee, while on the premises of the permittee, shall create a disturbance, be intoxicated, interfere with any racing operation, or act in an abusive or threatening manner to any racing official or other person.
10. No person other than a veterinarian licensed by the Department shall administer to or prescribe for greyhounds on the grounds of any permittee.
 - a. Reports of any drugs or treatments prescribed or administered at the track shall be made to the Department in a manner it shall set forth.
 - b. Notwithstanding the provisions of subsection (10), any veterinarian may treat a greyhound if an emergency involving the life or health of such greyhound exists.
11. Notwithstanding the provisions of subsection (16)(a), no person shall administer or cause to be administered to any greyhound entered in a race any foreign substance, internally or externally, in the 24-hour period prior to the scheduled post time for the first race of the day in which the greyhound is to run.
12. The Racing Commission has established permissible trace levels of the following foreign substances as defined by R19-2-302(18).
 - a. The trace level of procaine shall not exceed 6 micrograms per milliliter in the urine of the greyhound.
 - b. The trace level of barbiturates shall not exceed one microgram per milliliter in the urine of the greyhound.
13. No person shall run in a race a greyhound which is desensitized at the time of arrival at the paddock by applying cold, chemical, or mechanical freezing devices.
14. Any person licensed by the Department found guilty of using live rabbits, cats, or fowl in the training of racing greyhounds may be fined or suspended or both by the stewards, who shall report all such cases to the Department.
15. Any licensee who refuses to make payment for financial obligation incurred in connection with racing in this state may be subject to license suspension by the Department.
16. Test samples.
 - a. Animal testing.
 - i. Any greyhound in any race may be subjected by the order of a steward or Department veterinarian to urine, blood, or other tests for the purpose of determining the presence of any foreign substance.
 - ii. Samples of urine, blood, or other test substances shall be taken by persons approved by the Department.
 - iii. A steward may authorize the splitting of any sample.
 - iv. The Department veterinarian may require blood or urine samples to be stored in a frozen state for future analysis.
 - v. The owner, trainer, or their representative may be present at all times during the taking and sealing of such tests and samples.
 - vi. Documents evidencing the procedure shall be signed by the owner, trainer, or assistant trainer.
 - b. Human testing.
 - i. As set forth in A.R.S. § 5-104(C) and subsection (7), licensee shall immediately submit to blood, urine, or other tests ordered by the stewards, if the stewards have reason to believe said licensee is under the influence of or in possession of any prohibited substance or has consumed alcohol in violation of subsection (9).
 - ii. A test sample shall be taken in the presence of a steward or the steward's designee, submitted in a container furnished by the Department and immediately sealed by the steward or steward's designee in the presence of the licensee being tested.
 - iii. The container shall be marked with the following items:
 - (1) Sample identification number;
 - (2) Time, date, and location where the sample was given; and
 - (3) The signature of Department personnel sealing the container.
 - iv. The container shall be submitted to a Department-approved laboratory for analysis of the sample, in order to determine the presence of alcohol or any substance.
 - v. If laboratory analysis indicates the presence of any prohibited substance in the tested licensee's sample, for which no law fully issued prescription exists, said licensee may be subject to license suspension or revocation or civil penalties, as set forth in R19-2-309(E)(3)(f) and A.R.S. § 5-108.05(A).
 - vi. Test results and information obtained during the testing process shall be accessible only to members of the Commission, the Director or designees of the Director, and the tested licensee and shall be kept in a locked, secured area of the Department office.
 - vii. Compliance with these rules shall be prima facie evidence that the chain of custody of the test samples is secure, and the results of such tests shall be admissible in any administrative procedure of the Department or Commission.
17. The trainer, assistant trainer, and any other person who is charged with the custody and care of a greyhound are required to protect and guard the greyhound against the administration, either internally or externally, of any foreign substance. A positive test indicating the presence of

any foreign substance (except as set forth in subsection (12)) shall give rise to a presumption that the persons referred to in this subsection have failed to meet the duties imposed upon them.

18. No person shall interfere in any manner with the collection or procedures conducted under this subsection.
19. The owner of any greyhound disqualified in a race because of an infraction of these rules shall forfeit and return any portion of the purse or stakes and any trophy received from such race and shall forfeit any entry or subscription money.
 - a. Any winnings which are forfeited pursuant to this subsection shall be redistributed among the remaining entries in the race entitled thereto.
 - b. Any greyhound shall be disqualified and may be declared unplaced for every purpose except parimutuel wagering if the chemical analysis performed pursuant to subsection (16)(a) of this Section indicates the presence of any foreign substance.

Historical Note

Adopted effective August 5, 1983 (Supp. 83-4).

Amended effective November 30, 1988 (Supp. 88-4).

Amended effective March 20, 1990 (Supp. 90-1). R19-2-311 recodified from R4-27-311 (Supp. 95-1). Citations corrected in subsections 12 and 17 at the request of the Arizona Department of Racing (Supp. 96-4).

R19-2-312. Registration and Transfers

- A. The National Greyhound Association of Abilene, Kansas, (NGA) is the official breeding registry of all greyhounds. The Greyhound Publications, Inc., Information System is the official recordkeeping agency of all greyhound performances and maintains the past performance lines on every greyhound raced at a track licensed by a racing jurisdiction. The Department may certify any greyhound whose registration is attributable to arbitrary, discriminatory, or other unreasonable action or inaction on the part of either agency.
- B. If for any reason the Greyhound Information System ceases operation, the kennel owner is responsible for furnishing the racing secretary with the last six past performance lines when applicable.
- C. The registry and recordkeeping agencies are self-funding, and may charge reasonable fees for their services.
- D. A greyhound shall not be entered for racing or schooling at any official track unless it:
 1. Is tattooed or permanently identified in a manner acceptable to the NGA;
 2. Is registered in the NGA stud book; and
 3. Has its last six performance lines, if applicable, and racing history made available to the racing secretary from the Greyhound Information System.
- E. The NGA breeding registry furnishes all necessary information to the Greyhound Information System when greyhounds are registered and named. A reasonable fee per start shall be deducted from the weekly purses by the track and paid to the Greyhound Information System.
- F. Each track shall provide a copy of the official chart of its races to the Greyhound Information System.
- G. The NGA Breeding Registry and transfer files and the Greyhound Publications, Inc., Information System shall be available to Department officials upon request.
- H. In case of emergency, written authority from the NGA to sign declarations of partnerships shall be given to the racing secretary.

- I. An owner of a greyhound cannot assign the owner's share or any part of it without the written consent of the other partners. The consent shall be filed with the racing secretary.
- J. A certificate of registration for a greyhound shall be filed with the racing secretary at the race track where the greyhound is to be schooled, entered, or raced.
- K. The certificates of registration shall be available at all times for inspection by the stewards.
- L. A transfer of any title to, leasehold in, or other interest in greyhounds schooled, entered, or racing at any track under the jurisdiction of the Department shall be registered and recorded with the National Greyhound Association of Abilene, Kansas.
- M. The Department shall not recognize a title, leasehold, or other interest in a greyhound until the title, leasehold, or other interest is evidenced by written instrument filed with and recorded by the National Greyhound Association of Abilene, Kansas and certified copies of the instrument are filed with the Department and the racing secretary at the race track where the greyhound is to be schooled, entered, or raced.
- N. If a greyhound is sold or transferred, or any interest in a greyhound is sold or transferred, during a meeting or after the greyhound has been registered for a meeting, a copy of the bill of sale shall be filed with the racing secretary and forwarded by the racing secretary to the Department.
- O. If a greyhound is sold with its engagements, or any part of them, the seller cannot strike it out of any engagements. In all cases of private sales, the written acknowledgment of both parties that the greyhound was sold with the engagements is necessary to entitle the seller or buyer to the benefit of this rule. If certain engagements are specified, only those are sold with the greyhound. If the greyhound is sold by public auction, and if certain engagements are specified, only those engagements are sold with the greyhound.
- P. If a greyhound or any interest in a greyhound is sold to a disqualified person, the greyhound's racing engagements are void as of the date of sale.
- Q. In case of transfer of a greyhound with its engagements, the greyhound shall not be eligible to start in any stakes, unless the transfer of the greyhound and its engagements is provided to the racing secretary.
- R. A transfer of a greyhound or engagement shall not be made for the purpose of avoiding disqualification. A person that makes or receives a transfer to avoid disqualification may have a civil penalty invoked or be ruled off by the stewards.
- S. A partnership shall register with the Department. The partnership shall provide the name and address of every person with an interest in a greyhound, the relative proportions of the interest, and the terms of any sales with contingencies or arrangements, which are signed by each party or by an authorized agent, and file this information with the racing secretary. This information shall be provided to the Department before the beginning of the race meet. All persons listed on the partnership registration are jointly and severally liable for all stakes and forfeits.
- T. Statements of partnerships, sales with contingencies, or arrangements, shall declare who receives the winnings, in whose name the greyhound shall run, and who has the power of entry or declaration of forfeit. This information shall be provided to the Department upon request.

Historical Note

Adopted effective August 5, 1983 (Supp. 83-4).

Amended effective March 20, 1990 (Supp. 90-1). R19-2-312 recodified from R4-27-312 (Supp. 95-1). Amended by final rulemaking at 12 A.A.R. 1771, effective July 1, 2006 (Supp. 06-2).

R19-2-313. Leases

- A. The lessee of a greyhound shall file a copy of the Uniform Greyhound Certificate of Lease agreement with the Department. The lease agreement shall include:
1. The name of the greyhound,
 2. The name and address of the owner,
 3. The name and address of the lessee,
 4. The kennel name of each party, and
 5. The terms of the lease.
- B. A corporation with more than 10 stockholders who are the registered or beneficial owners of stock or membership in the corporation may not lease a greyhound owned or controlled by it to any person or partnership for racing purposes.
- C. The Department shall not grant an owner's license to a lessee of a corporation described in subsection (B).
- D. A corporation leasing greyhounds for racing purposes in this state, shall file with the Department, upon request, a report listing the stockholders and members, as well as additional business information the Department may specify. More than one owner may be indicated on the program by the use of the name of one owner and the phrase "et al".

Historical Note

Adopted effective August 5, 1983 (Supp. 83-4).
Amended effective March 20, 1990 (Supp. 90-1). R19-2-313 recodified from R4-27-313 (Supp. 95-1). Amended by final rulemaking at 12 A.A.R. 1771, effective July 1, 2006 (Supp. 06-2).

R19-2-314. Weights and Weighing

- A. Each greyhound shall be weighed in not less than one hour before the time of the first race of the day.
- B. Before a greyhound is allowed to school or to race at a track, the owner or trainer shall establish the racing weight of the greyhound with the clerk of scales.
- C. At weighing-in time, if there is a variation of more than two pounds from the greyhound's established weight, the stewards shall order the greyhound scratched.
- D. At weighing-out time, if a greyhound loses more than two pounds while in the lockout kennels, the stewards shall order the greyhound scratched. However, upon opinion from the veterinarian that the loss of weight while in the lockout kennels does not impair the racing condition of the greyhound, the stewards may allow the greyhound to race.
- E. The weight regulations provided in subsections (A), (B), (C) and (D) above shall be printed in the daily program.
- F. The established racing weight of a greyhound may be changed on written request of the owner or trainer and by consent of the stewards, if the change is made at least four calendar days before the greyhound is allowed to race at the new weight.
1. A greyhound with a weight change of more than one pound shall be schooled at least once at the discretion of the stewards at the new established weight before being eligible for starting.
 2. A greyhound that has not raced or schooled officially for three weeks shall be allowed to establish new racing weight with the consent of the stewards and shall be schooled officially immediately upon receipt of the consent.
- G. The stewards have the authority to order that a greyhound entered in a race be weighed at any time from entry into the lockout kennel until post time.
- H. Immediately after being weighed in, a greyhound shall be placed in a lockout kennel under the supervision of the paddock judge. Only the paddock judge, veterinarian, kennel master, clerk of scales, lead-out, steward, or Department representative shall be allowed in or near the lockout kennels.

Historical Note

Adopted effective August 5, 1983 (Supp. 83-4).
Amended effective March 20, 1990 (Supp. 90-1). R19-2-314 recodified from R4-27-314 (Supp. 95-1). Amended by final rulemaking at 12 A.A.R. 1771, effective July 1, 2006 (Supp. 06-2).

R19-2-315. Schooling

- A. A schooling race shall be at a distance not less than the distance nearest to 5/16 mile in use at the track.
- B. Each official schooling race shall consist of at least six greyhounds. However, if this condition creates a hardship, less than six may be schooled with the permission of the stewards.
- C. Hand schooling shall not be considered official.
- D. A greyhound that has not raced for 10 racing days or more shall be officially schooled at least once at its racing weight before being eligible for entry.
- E. A greyhound in an official schooling race shall race at its established racing weight and shall start from the box wearing blankets.
- F. An owner, trainer, or authorized agent who is responsible for greyhounds that are booked to race on tracks licensed by the Commission, and who permit the greyhounds to be officially schooled on any track in Arizona or elsewhere that is not approved by the Commission during these bookings, shall be subject to immediate license revocation.
- G. A greyhound may be ordered on the official schooling list by the stewards at any time for good cause and shall be schooled officially and satisfactorily before being allowed to enter a race.
- H. Each permittee shall provide a photo finish camera, approved by the Department, that operates at all official schooling races.
- I. A permittee shall make provision for an adequate number of official schooling races, to be run both before and during a meeting, to allow for the qualification of greyhounds.
- J. A greyhound that fails to meet the established qualifying time shall not be permitted to start in a race other than futurity or stakes races.
- K. Official schooling shall be maintained throughout a meeting up to at least one week before the last scheduled date of the meeting.
- L. The distance of official schooling races and number of greyhounds in these races shall appear on the Form chart.
- M. Only two official schooling lines shall be required for greyhounds in futurity races.
- N. A greyhound on the veterinarian's list or stewards' suspension list shall not be schooled officially except as provided in R19-2-317(E)(6).

Historical Note

Adopted effective August 5, 1983 (Supp. 83-4).
Amended effective March 20, 1990 (Supp. 90-1). R19-2-315 recodified from R4-27-315 (Supp. 95-1). Amended by final rulemaking at 12 A.A.R. 1771, effective July 1, 2006 (Supp. 06-2).

R19-2-316. Entries and Subscriptions

- A. Condition for entry
1. The racing secretary shall not allow a greyhound to be entered in a race unless the full name of every person having an ownership in the greyhound or accepting the trainer's percentage or having any interest in its winnings is registered with the racing secretary. A change in a greyhound's ownership or interest made during that meeting shall be registered with the racing secretary; a copy of this shall be delivered promptly to the Department by the racing secretary of the track where the greyhound is racing.

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2. The racing secretary shall not allow a greyhound to be entered in a race unless the conditions in R19-2-313 pertaining to registration are met.
 3. The racing secretary shall not allow a greyhound to enter or start unless it is conditioned by a licensed trainer or owner-trainer.
 4. The racing secretary shall not allow a greyhound to enter or start in a race unless it has been fully identified and tattooed. A person who participates in any manner in establishing the identity of a greyhound, including the breeder, owner, trainer, and identifier, is responsible for the accuracy of the information the person provides.
 5. The stewards may require a person in whose name a greyhound is entered to produce proof that the greyhound is not the property, either wholly or in part, of any person who is disqualified, or to produce proof of the extent of the person's interest in the greyhound. If the stewards are not satisfied as to the ownership of the greyhound, they may declare the greyhound out of the race.
 6. A permittee shall establish a qualifying time for its 3/8- and 5/16-mile races. The permittee shall notify the stewards at least three days before the first day of official racing of the qualifying time established and specify time which, while in effect, shall be continuously posted on the notice board at the track and approved by the stewards.
 - a. A change in the established qualifying time during the course of a meeting may only be made with the approval of the stewards.
 - b. The racing secretary shall not allow a greyhound to enter or race if the greyhound fails to meet the established qualifying time except in a futurity or stakes race.
 7. A greyhound is not eligible to enter or race if:
 - a. The greyhound is ruled off or suspended.
 - b. The owner or trainer is ruled off the track or suspended until the greyhound is made eligible either by reinstatement of its owner or trainer or a transfer or bona fide sale to an ownership or trainer acceptable to the stewards.
 - c. The greyhound is on the schooling list or on the veterinarian's list.
 - d. The greyhound is under the age of 12 months.
 8. A greyhound or kennel whose entry is ordered refused at any recognized meeting because of inconsistent racing shall not be permitted to race on any track where these rules are in force during the continuance of such ruling.
 9. At least three past performances of a greyhound shall be available for the program.
 10. A trainer shall remove an off-form greyhound from the active list. Failure to do so is grounds for suspension of the greyhound.
 11. A greyhound that has been retired for conditions or worming shall be brought back to racing weight before being entered.
 12. The stewards may allow a greyhound that has not raced in three or more weeks to establish new racing weight.
 13. The racing secretary shall not allow a greyhound in season on the track nor shall she be eligible to school officially or to race if in milk.
- B. Entry**
1. The racing secretary receives entries and declarations.
 2. Each entry in a race shall be in the name of the registered owner or in the kennel name.
 3. The racing secretary shall not allow a greyhound to run in any race unless it has been and continues to be duly entered.
 4. A greyhound eligible at the time of entry continues to be qualified, except in an overnight event in which the greyhound shall be eligible at the time of the start.
 5. A kennel owner, trainer, or authorized agent may enter a greyhound in person, by telephone, by facsimile, or in writing.
 6. A greyhound entered for a purse shall be a "starting greyhound" unless it has been declared out by the stewards.
 7. An entry from a person or of a greyhound that stands suspended or expelled is void. The Department shall refund any money paid for a void entry. A person who wins money with a void entry shall return the money to the Department.
 - a. The entry form to a stakes race shall include the full name and post office address of the person making the entry.
 - b. A person with an interest in a greyhound less than the interest of another person is not entitled to assume any of the rights or duties of an owner as provided by these rules, including the right of entry and declaration.
 - c. Joint subscriptions and entries may be made by any one or more of the owners. However, all partners and each of them shall be jointly and severally liable for all fees and forfeits.
 - d. Nominations for stakes races received and post-marked before midnight of the day of closing shall be valid if received 24 hours in advance of closing of overnight entries.
 - e. If the invalidity of any entry or declaration in a stakes race is alleged, satisfactory proof that the entry or declaration was timely made shall be presented within a reasonable time or the entry or declaration shall be deemed not received.
- C. Closing**
1. The racing secretary shall close entries for purse races at the advertised time. An entry shall not be received after that time. If a race fails to fill, additional time for entries may be granted by the stewards.
 2. Entries and declarations for stakes races that close during or on the eve of a racing meeting shall close at the office of the racing secretary. Closing sweepstakes at all other times shall be at the office of the permittee.
 3. The racing secretary shall not accept entries or declarations for stakes after the designated time.
 4. A greyhound may not start in a stakes race unless it has passed the entry box on the day on which entries for the stakes race are taken.
 5. There shall be at least six different kennel owners in each race. An owner or trainer may have no more than two greyhounds in a race without the permission of the stewards. The requirements of this subsection are applicable to all greyhound races, including all short field races of five or fewer greyhounds. Prior approval of the stewards shall be obtained before conducting any race in which five or fewer greyhounds are entered.
 6. If the number of entries to any purse race exceeds the number of greyhounds that, because of track limitations, may start, the starters for the race shall be determined by lot in the presence of those making entries.
 7. The post position of greyhounds shall be assigned by lot or drawing supervised by the stewards and the racing secretary, at a time and place posted on the trainer's bulletin

board. The draw shall occur at least one day before the running of the race, so that any and all owners, trainers, or authorized agents interested may be present.

- a. A change shall not be made in any entry after closing of entries, but an error may be corrected.
 - b. Each greyhound entered for a purse shall be a starter unless it is declared or scratched.
8. The permittee may withdraw or change any unclosed race.
 9. Following the close of entries, the racing secretary shall compile and conspicuously post the entries.
 10. The holder of any claim, whether a mortgage bill, sale, or lien of any kind, against a greyhound, shall file the claim with the racing secretary before the time the greyhound is entered. The claimholder shall forfeit all rights in any winnings of the greyhound before the claim is filed.

D. Fees

1. Unless otherwise stipulated in the conditions of a race, there is no charge to enter a greyhound in a purse race. When the conditions require an entrance fee, the fee shall accompany the entry.
2. A person entering a greyhound shall pay the nominating, sustaining, and starting fees. Except as provided in subsections (D)(3) and (D)(4) fees are nonrefundable.
3. Entrance fees to a purse race that is run are not refundable unless otherwise provided for in the conditions of the race.
4. Entry, starting, and subscription fees shall be distributed as provided for in the conditions of the race. If a race is not run, all stakes or entrance money shall be refunded.
5. The death of the nominator or subscriber does not void entry, subscription, or right of entry of a greyhound.
6. A greyhound may not start in a race unless any stake or entrance money for that race is paid.
7. A person entering a greyhound is liable for the entrance money or stake.
8. The entry of a greyhound in a sweepstakes is a subscription to the sweepstakes making the subscriber liable for stake and forfeit fees. If the subscriber properly transfers the entry, the subscriber is liable for stake and forfeit fees only if the transferee defaults. The seller of a greyhound with an engagement is liable for stake or forfeit fees if the engagement is not kept.
 - a. If a person is prevented by these rules from entering or starting a greyhound for a race without paying arrears for which the person would not otherwise be liable, the person may, by paying the arrears, enter or start the greyhound and have the arrears placed on the forfeit list as due to the person.
 - b. If the seller of a greyhound with an engagement is compelled to pay arrears because of the purchaser's default, the seller may place the amount of the forfeit list as due from the purchaser to the seller. This rule also applies in the transfer of an entry when the transferee defaults.
 - c. With the approval of the stewards, the racing secretary may waive the obligations incurred by this Section.
 - d. If the racing secretary permits a greyhound to start in a race without the entrance money or stake having been paid, the racing secretary is liable for the entrance money or stake.
9. An entry in a sweepstakes is a subscription and may not be withdrawn.

Historical Note

Adopted effective August 5, 1983 (Supp. 83-4).

Amended effective March 20, 1990 (Supp. 90-1). R19-2-316 recodified from R4-27-316 (Supp. 95-1). Amended by final rulemaking at 12 A.A.R. 1771, effective July 1, 2006 (Supp. 06-2).

R19-2-317. Rules of the Race

A. Pre-race activity.

1. A greyhound shall race under its registered owner's name as shown on the registration papers or upon Department approval.
2. All races shall start at regular intervals. Post times shall be based upon the number of races scheduled to run daily. The intervals shall be set by the permittee with the approval of the stewards.
3. A greyhound shall be identified and exhibited in the paddock before post time of the race in which it is entered.
4. A greyhound shall wear the regulation muzzle and blanket while racing. The muzzle and blanket of each greyhound shall be carefully examined:
 - a. In the paddock by the paddock judge before the greyhound leaves for the post;
 - b. Before the stewards at the stewards' stand; and
 - c. By the starter at the starting box.
5. After the greyhounds have entered the track, the parade of the greyhounds to the post shall be no longer than 15 minutes, unless a delay is unavoidable.
6. After the greyhounds leave the paddock on their way to the starting point, and until the stewards signal the start of the race, all persons except the designated licensees shall be excluded from the course.
7. If a greyhound is injured after weigh-in, the greyhound may be excused by the stewards on the advice of the track veterinarian and shall not be considered a starter.

B. Races

1. A race is not declared official by the stewards unless the lure precedes the greyhounds at all times during the race. If, during the race, a greyhound catches or passes the lure, the stewards shall declare it "no race" and all monies wagered shall be refunded.
2. The stewards shall closely observe the operation of the lure and hold the lure operator to strict accountability for any inconsistency of operation. The lure shall be kept at a reasonable distance in advance of the greyhounds.
3. If a greyhound dwells in the box when the doors of the starting box open at the start, there shall be no refund.
4. If a greyhound bolts the course, runs in the opposite direction, or does not run the entire prescribed distance for the race, all rights in the race are forfeited and no matter where it finishes the stewards shall declare the finish of the race as if the greyhound was not a contender. However the greyhound shall be considered a starter.
5. If a greyhound bolts the course or runs in the opposite direction during the running of the race and in so doing, in the opinion of the stewards, alters the outcome of the race, the stewards shall declare it "no race" and all monies wagered shall be refunded.
6. If it appears that a greyhound may interfere with the running of the race because of failure to leave the starting box, or accident, or for any other reason, a person under the supervision of the stewards may remove the greyhound from the track. However the greyhound shall be considered a starter.
7. If a race is marred by jams, spills, or racing circumstances other than accident regarding the machinery or outside interference, and three or more greyhounds finish, the stewards shall declare the race official, but if fewer than

three greyhounds finish, the stewards shall declare it “no race” and all monies wagered shall be refunded.

8. Each permittee shall provide a camera approved by the Department for the purpose of taking photographs of all finishes of all races including schooling races.
9. A greyhound ruled off for fighting or quitting is suspended on any track operating under the jurisdiction of the Commission.
10. If the owner, trainer, or handler of a greyhound is found guilty of an act that prevents the greyhound from running its best, the Department shall suspend the license of the owner, trainer, or handler.

C. Dead heats

1. When a race results in a dead heat, the race shall not be run off. When two greyhounds run a dead heat for first place, all prizes to which the first and second greyhounds are entitled shall be divided equally between them. This applies in dividing prizes whatever the number of greyhounds running a dead heat and whatever places for which the dead heat is run.
2. When a dead heat for win occurs, each greyhound involved in the dead heat shall be considered a winner and is liable for any penalty attached to the winning of the race.
3. If the owners of the greyhounds involved in a dead heat cannot agree on the disbursement of a cup or other prize that cannot be divided, the cup or prize shall be determined by lot.

D. Winnings

1. Winnings include all prizes earned up to the time appointed for the start and shall apply to all races wherever run. Winnings shall include earnings from a walk over or receiving forfeit, but do not include second and third money, or the value of any non-monetary prize. Winnings during the year shall be determined from the preceding January 1.
2. Winner of a certain sum shall mean winner of a single race of that value unless otherwise expressed in the conditions.
3. In estimating the net value of a race to the winner, all sums contributed by the owner or nominator are deducted from the amount won.

E. Declarations and scratches

1. Declarations in purse races shall be made by the kennel owner, trainer, or authorized agent to the racing secretary or his or her assistant at least one-half hour before the time designated for the drawing of post positions on the day before the day on which the greyhound is to race, or at the time appointed by the racing secretary.
2. Declarations in sweepstakes shall be made in the same manner as provided for making entries in sweepstakes to the racing secretary, who shall record the day and hour of receipt and give early publicity to the sweepstakes.
3. A declaration in a stakes race shall be made in writing by the kennel owner or trainer of a greyhound or by the kennel owner's authorized agent.
4. The declaration of a greyhound is irrevocable.
5. A greyhound that is withdrawn from a race after the overnight entries are closed is deemed a scratch. The declared greyhound shall lose all preference accrued up to that date unless excused by the stewards.
 - a. To scratch a greyhound entered in a race, sufficient cause shall be given to satisfy the stewards, and the cause shall be reported immediately.
 - b. The owner or trainer of a greyhound that is scratched because of a violation of a racing rule shall be penal-

ized or suspended for six racing days. Scratches for other causes may be disciplined at the discretion of the stewards.

- c. If a trainer fails to have a greyhound entered at the track at the appointed time for weighing in causing the scratch of the greyhound, the stewards shall impose a forfeiture and may suspend or fine the person responsible.
 - d. If three or more greyhounds are withdrawn or scratched in any one race, the stewards may cancel the race.
 - e. The stewards may scratch a greyhound entered in a race for sufficient cause.
6. A greyhound scratched from a race because of overweight or underweight shall receive a six-day suspension and shall school back before starting in an official race. Scratched greyhounds may school during their suspension.

Historical Note

Adopted effective August 5, 1983 (Supp. 83-4).
Amended effective March 20, 1990 (Supp. 90-1). R19-2-317 recodified from R4-27-317 (Supp. 95-1). Amended by final rulemaking at 12 A.A.R. 1771, effective July 1, 2006 (Supp. 06-2).

R19-2-318. Repealed

Historical Note

Adopted effective August 5, 1983 (Supp. 83-4).
Amended effective March 20, 1990 (Supp. 90-1). R19-2-318 recodified from R4-27-318 (Supp. 95-1). Section repealed by final rulemaking at 12 A.A.R. 1771, effective July 1, 2006 (Supp. 06-2).

R19-2-319. Arizona Bred Eligibility and Breeders' Award Payments

- A. A breeder shall file a notarized certificate affirming eligibility under A.R.S. § 5-113(F) with the Department. The certificate shall include name, color, and sex of the animal; name of the sire; name of the female; date and location of whelping; National Greyhound Association registration number; left and right ear identification numbers; name, address, and telephone number of the breeder; a statement that the animal is eligible pursuant to A.R.S. § 5-113(F) and that the person shown as the breeder was the owner of the female at the time of whelping; and such other information as may be required by the Department to determine eligibility and shall be signed by the breeder. The breeder shall submit a copy of the National Greyhound Association registration papers with the certificate.
 1. Certification is deemed to occur upon the Department's receipt of the completed certificate.
 2. The greyhound shall be certified by the Department at the time of the win to be eligible for an award.
- B. A permittee shall recognize any greyhound for which there is an Arizona Bred Certificate on file with the Department as an Arizona bred greyhound.
- C. Breeders' awards are not to be paid on nominating, sustaining, or starting fees.
- D. The Department shall calculate and pay breeders' awards to eligible breeders.
 1. Definitions.
 - a. “Quarterly Breeders' Award” means an amount of money based on the quarterly breeders' award payment factor determined by the Department each fiscal year by October 30.
 - b. “Substitute Breeders' Award” means an amount of money based on a substitute payment factor because

- of the lack of sufficient money to pay conventional Quarterly Breeders' Awards.
- c. "Supplemental Breeders' Award" means an amount of money that corrects a shortfall between conventional Quarterly Breeders' Awards and Substitute Breeders' Awards.
 - d. "End-of-year Bonus Award" means an amount of money that may be paid to breeders from available monies that remain in the breeders' award fund after payment of Quarterly Breeders' Awards, Substitute Breeders' Awards and Supplemental Breeders' Awards.
2. The Department shall pay awards at the end of each fiscal year quarter, provided that the total amount of the awards payments does not exceed the total amount of money available in the fund less the amount required to be set aside for contingent liabilities in subsection (D)(8).
 3. Quarterly Breeders' Awards. Before October 30 of each year, the Department shall determine a quarterly breeders' award payment factor that will be applied during the entire fiscal year. The payment factor determined by the Department is not subject to appeal.
 - a. The Department shall evaluate anticipated revenues for the breeders' award fund and anticipated purses for eligible Arizona-bred animals and set the payment factor at a level that permits recipients of quarterly breeders' awards to receive awards throughout the fiscal year based on the same payment factor.
 - b. The Department shall notify representatives of each breeders' association of the quarterly breeders' award payment factor in writing before October 30 of each year.
 - c. The Department shall calculate quarterly breeders' awards by multiplying the amount of each purse won by an eligible animal during that quarter by the quarterly breeders' award payment factor established for the fiscal year.
 - d. The Department shall make quarterly breeders' awards not later than 30 days after the end of each quarter, unless full quarterly breeders' awards cannot be made due to the lack of available money in the fund.
 4. Substitute Breeders' Awards. The Department shall make substitute breeders' awards if there are sufficient monies in the fund to allow for an award but not enough monies to provide for full payments of quarterly breeders' awards based on the quarterly breeders' award payment factor.
 - a. The Department shall determine the substitute payment factor by dividing the total amount of monies in the Arizona breeders' award fund at the end of the quarter less the amount required to be set aside for contingent liabilities in subsection (D)(8) by the total amount of purses won by eligible Arizona-bred animals during that quarter.
 - b. The Department shall calculate substitute breeders' awards by multiplying the amount of each purse won by an eligible animal during that quarter by the substitute payment factor for that quarter.
 5. End-of-year bonus pool. After payment of all quarterly breeders' awards and any substitute breeders' awards has been calculated, the Department shall determine the amount of monies remaining in the fund. The end-of-year-bonus pool is the amount of monies remaining in the Arizona breeders' award fund after the payment of all quarterly breeders' awards for the fiscal year less the amount required to be set aside for contingent liabilities in subsection (D)(8).
 6. Supplemental Breeders Awards. The Department shall first pay any monies in the end-of-year bonus pool in the form of supplemental breeders awards to recipients of substitute breeders' awards.
 - a. The Department shall pay supplemental breeders' awards in an amount equal to the difference between the substitute breeders' award and the quarterly breeders' award the breeder would have received if there had been enough in the fund to pay an award based on the quarterly award payment factor.
 - b. In the event the end-of-year bonus pool cannot pay supplemental breeders' awards to make up for the shortfall to all substitute breeders' award recipients, the Department shall pay supplemental breeders' awards to all breeders eligible to receive a supplemental breeders' award on a pro-rata basis.
 - c. A breeder is eligible to receive a supplemental breeders' award from the end-of-year bonus pool only if the breeder received a substitute breeders' award during that fiscal year.
 - d. The Department shall not make supplemental breeders' awards if all eligible breeders received quarterly breeders' awards during the fiscal year.
 7. End-of-year Bonus Awards. The Department shall pay end-of-year bonus awards if monies remain in the end-of-year bonus pool following any supplemental payments.
 - a. The Department shall determine an end-of-year bonus payment factor by dividing the monies in the end-of-year bonus pool by the total amount of purses won by an eligible animal during the fiscal year.
 - b. The Department shall calculate end-of-year bonus awards by multiplying the amount of each purse won by an eligible animal by the bonus payment factor.
 8. Contingent liabilities. The Department shall retain \$10,000 in the Breeders' Award fund for contingent liabilities.
 9. The Department shall not make quarterly breeders' awards, substitute breeders' awards, supplemental breeders' awards or end-of-year bonus breeders' awards if the total amount available for distribution is less than \$10,000. In the event the Department does not pay an award because less than \$10,000 is available for distribution, the Department shall carry forward the amount in the fund for payment of awards when the Department next calculates awards.
 10. Appeal of Director's Rulings
 - a. The Director shall make the final decision concerning a breeders' award.
 - b. The Department shall give written notice of the decision to an applicant by mailing it to the address of record filed with the Department.
 - c. After service of the Director's decision, an aggrieved party may obtain a hearing under A.R.S. §§ 41-1092.03 through 41-1092.11.
 - d. The aggrieved party shall file a notice of appeal with the Department within 30 days after receiving the notice prescribed in R19-2-319(D)(10)(b).
 - e. The Department shall notify the Office of Administrative Hearings, which shall schedule and conduct the hearing.
- E. The permittees shall submit to the Department an Arizona Breeders' Award Report in the form prescribed by the Department. The report shall include name of the animal, name of the

breeder, date of win, win purse amount, type of race, name of track, and such other information as may be required by the Department to calculate awards.

- F. The Arizona Thoroughbred Breeder's Association, Arizona Quarter Racing Association, Arizona Greyhound Breeder's Association and such other associations as may represent breeders in this state may assist the Department in periodic reviews of eligibility lists and may provide such other assistance in administering the fund as may be required by the Department.
- G. At least every other three years, the Commission shall select a committee, consisting of representatives of each breeders' association and the Department, which shall review this rule and submit written recommendations to the Commission.

Historical Note

Adopted effective August 5, 1983 (Supp. 83-4).
Amended subsection (A) effective August 21, 1985 (Supp. 85-4). Amended subsection (A) and added subsections (D) through (G) effective August 13, 1986 (Supp. 86-4). Amended subsection (D) effective February 19, 1987 (Supp. 87-1). Amended effective March 20, 1990 (Supp. 90-1). R19-2-319 recodified from R4-27-319 (Supp. 95-1). Amended effective January 10, 1997 (Supp. 97-1).

R19-2-320. Objections

- A. An objection to a greyhound may be made by an owner, the owner's authorized agent, a trainer of another greyhound engaged in the same race, or by the officials of the course. An objection shall be made to the stewards, who may require that the objection be made in writing with a copy sent immediately to the Director.
- B. The stewards may require a cash deposit of \$200 to cover costs of determining an objection. The deposit posted may be forfeited if the stewards determine the objection is without foundation.
- C. If the stewards are not able to decide an objection during the meeting, the stewards shall require that the objection be made in writing and forwarded to the Director.
- D. An objection, unless otherwise provided, shall be made within 72 hours after the race is run and shall be determined by the stewards.
- E. An objection pertaining to any matter occurring in a race, except as otherwise provided, shall be made before the stewards declare the race official.
- F. Any objections to a greyhound that has run in a race on the grounds that it was not trained by a licensed trainer, or that the names of all those having ownership in it or an interest in its winnings have not been registered with the secretary, shall be made not later than the day after the race.
- G. Any objection on the grounds of fraudulent or purposeful misstatement or omission in the entry under which a greyhound has run, or on the grounds that the greyhound which ran was not the greyhound it was represented to be in the entry or at the time of the race, may be received any time within three days after the race.
- H. Any objection to a decision of the clerk of the scales shall be made before the greyhounds leave the paddock for the start of the race.
- I. Pending the determination of an objection, any money or prize which the greyhound objected to may have won, or may win in the race, shall be withheld until the objection is determined, and any sum payable to the owner of the greyhound objected to shall be held for the person who may be determined to be entitled to it.

- J. Pending the disposition by the stewards, Director, or Commission of any question, both the greyhound which finished first and any greyhound which is claimed to be the winner shall be liable for all penalties attaching to the winner of the race until the matter is decided.
- K. If an objection to a greyhound which has won or which has been placed in a race is declared valid, that greyhound is disqualified, and the other greyhounds in the race are entitled to place in the order in which they finished. The purses shall be redistributed.
- L. A person shall not lodge an unsubstantiated objection with the stewards.
- M. If all the greyhounds in the race have run at wrong weights, or over a wrong course or distance, and objection is made before the official confirmation of the placing of the greyhound in the race, the stewards shall declare it "no race."
- N. To withdraw an objection, the person that made the objection shall obtain the permission of the stewards.

Historical Note

Adopted effective August 5, 1983 (Supp. 83-4).
Amended effective March 20, 1990 (Supp. 90-1). R19-2-320 recodified from R4-27-320 (Supp. 95-1). Amended by final rulemaking at 12 A.A.R. 1771, effective July 1, 2006 (Supp. 06-2).

R19-2-321. Repealed

Historical Note

Adopted effective August 5, 1983 (Supp. 83-4).
Amended by adding subsection (O) effective September 17, 1984. Amended subsection (D) paragraph (6) effective October 18, 1984 (Supp. 84-5). Amended by adding subsection (P) effective April 4, 1985 (Supp. 85-2). Amended subsection (N) effective November 29, 1985 (Supp. 85-6). Amended subsection (P) paragraph (19) effective June 6, 1986 (Supp. 86-3). Amended by adding subsections (Q), (R), (S), (T), (U) and (V) effective February 19, 1987 (Supp. 87-1). Amended by adding subsections (W) and (X) effective October 14, 1988 (Supp. 88-4). Repealed effective March 20, 1990 (Supp. 90-1). R19-2-321 recodified from R4-27-321 (Supp. 95-1).

R19-2-322. Procedure before the Department

- A. Appeal of stewards' rulings and referrals
 1. Any person or persons aggrieved by a ruling of the stewards may appeal to the Director. Such an appeal must be filed in writing in the office of the Director within three days of the receipt of the steward's ruling.
 2. The failure of the stewards to convene a hearing within 10 days after the objection is made shall be deemed a denial by the stewards and may be appealed by filing a written appeal in the office of the Director within 10 days from the date the objection was denied.
 3. The appeal shall be signed by the person making said request or by his or her attorney and shall set forth the grounds for appeal and reasons for believing he or she is entitled to a hearing.
 4. A person filing an appeal of a ruling may be required by the Director or the Commission to furnish a bond in the amount equal to an assessed fine and an additional \$200 to cover the cost, which may be forfeited should the appeal be denied.
 5. The stewards may refer any ruling made by them to the Director recommending further action including the revocation of a license suspended by the stewards. Upon receipt of such referrals, the Director shall review the record and may affirm, reverse, or modify the stewards'

ruling or conduct such other proceedings the Director deems appropriate.

6. Upon the filing of an appeal in the manner set forth above, the Director shall fix a time and place for said hearing and shall give written notice of the hearing at least 20 days prior to the date set for the hearing, unless waived by the appellant.
7. Nothing contained in this Section shall affect the distribution of the pari-mutuel pools.
8. In case of an appeal or protest, the purse money affected will be retained by the permittee subject to order of the Director.

B. License denial, suspension, or revocation

1. The Director may deny a license application without prior notice to the applicant. However, if the applicant files an appeal with the Director within 20 days of the receipt of the denial, the Director shall fix a time and place for a hearing on the matter and shall give written notice of the hearing at least 20 days prior to the date set for the hearing, unless waived by the applicant.
2. The Director may revoke or, independently of the stewards, suspend a license only after notice and opportunity for hearing. Notice of the hearing shall be given in writing at least 20 days prior to the date set for hearing, unless waived by the applicant.

C. Contested cases

1. All parties appearing before the Director or his or her designee shall be afforded an opportunity for a hearing and the opportunity to respond and present evidence and argument on all issues.
2. Any party appearing before the Director or his or her designee shall have the right to appear in person or by counsel, except that a corporation may appear only through counsel. Any party may submit his or her case in writing. Failure of a party to appear for a hearing shall leave the Director free to act upon the evidence at hand without further notice to the parties. Proceedings may be reopened by the Director upon written petition of any party to the proceedings.

D. Hearing officer. If the Director assigns a matter to a hearing officer, the hearing officer shall submit to the Director within 15 days after the conclusion of the hearing a written decision which shall include proposed findings of fact, conclusions of law and order. The decision of the hearing officer may be approved or modified by the Director. The decision of the hearing officer becomes the decision of the Director unless modified by the Director within 45 days.

E. Depositions

1. When any party desires to take the oral deposition of any witness residing outside the state or otherwise unavailable as a witness, such party shall file with the Director a petition for permission to take the deposition of such witness, showing the name and address of such witness and setting forth specifically and in detail the nature and substance of the testimony expected to be given by such witness. The application shall be granted if it appears from such petition that the witness resides outside the state or is otherwise unavailable and that the testimony of such witness is relevant and material. If such statement is not made specifically and in detail, so that the Director may determine therefrom the relevancy and materiality of the testimony of such witness, such petition may be denied.
2. The Director may, at his or her discretion, designate the time and place and office before which such a deposition may be taken. The expense of any deposition will be

borne by the party applying to the Director for permission to take same.

3. Any deposition taken under this rule shall be returned and filed with the Director within 30 days after permission for taking same is granted.

F. Service

1. Service of any decision, order, or other process may be made in person or by mail. Service by mail shall be made by enclosing the same or a copy thereof in a sealed envelope and depositing the same in the United States mail, postage prepaid, addressed to the party served at the address shown by the records of the Department.
2. The time periods prescribed or allowed by these rules, by order of the Department, or by an applicable statute, shall be computed as provided in the Rules of Civil Procedure.
3. Service upon an attorney who has appeared on behalf of a party will constitute service upon such party, except that papers required to be served upon the Director or Commission shall in all cases be filed in the office of the Department, with a copy served on the Attorney General.
4. Proof of service may be made by the affidavit or oral testimony of the person making such service.

G. Rehearing, review, or appeal

1. Except as provided in subsection (G)(7), any party in a contested case before the Director who is aggrieved by a decision rendered in such case may file with the Director, not later than 10 days after service of the decision, a written motion for rehearing or review of the decision, specifying the particular grounds therefor. For purposes of this subsection, a decision shall be deemed to have been served when personally delivered or mailed to the party at his or her last known residence or place of business.
2. The motion for rehearing may be amended at any time before it is ruled upon by the Director. A response may be filed within 10 days after service of such motion or amended motion by any other party. The Director may require the filing of written briefs upon the issues raised in the motion and may provide for oral argument.
3. A rehearing or review of the decision may be granted for any of the following causes materially affecting the moving party's rights:
 - a. Irregularity in the administrative proceedings of the hearing officer or Director or the prevailing party, or any order or abuse of discretion, whereby the moving party was deprived of a fair hearing.
 - b. Misconduct of the hearing officer, Director, or the prevailing party.
 - c. Accident or surprise which could not have been prevented by ordinary prudence.
 - d. Newly discovered material evidence which could not with reasonable diligence have been discovered and produced at the original hearing.
 - e. Excessive or insufficient penalties.
 - f. Error in the admission or rejection of evidence or other errors of law occurring at the administrative hearing.
 - g. That the decision is not justified by the evidence or is contrary to law.
4. The Director may affirm or modify the decision or grant a rehearing to all or any of the parties and on all or part of the issues for any of the reasons set forth in subsection (G)(3). An order granting a rehearing shall specify with particularity the ground or grounds on which the rehearing is granted, and the rehearing shall cover only those matters so specified.

5. Not later than 10 days after a decision is rendered, the Director may, on his or her own initiative, order a rehearing or review of his or her decision for any reason for which he or she might have granted a rehearing on motion of a party. After giving the parties or their counsel notice and an opportunity to be heard on the matter, the Director may grant a motion for rehearing for a reason not stated in the motion. In either case, the order granting such a rehearing shall specify the grounds therefor.
6. When a motion for rehearing is based upon affidavits, they shall be served with the motion. An opposing party may within 10 days after such service serve opposing affidavits, which period may be extended for an additional period not exceeding 20 days by the Director for good cause shown or by written stipulation of the parties. Reply affidavits may be permitted.
7. If in a particular decision it is necessary for the immediate preservation of the public peace, health, and safety, and if a rehearing or review of the decision is impracticable, unnecessary, or contrary to the public interest, the decision may be issued as a final decision without an opportunity for a rehearing or review.
8. For purposes of this subsection the terms "contested case" and "party" shall be defined as provided in A.R.S. § 41-1001.
9. To the extent that the provisions of this rule are in conflict with the provisions of any statute providing for rehearing of decisions of the Director, such statutory provisions shall govern.

Historical Note

Adopted effective August 5, 1983 (Supp. 83-4).

Amended effective March 20, 1990 (Supp. 90-1). R19-2-322 recodified from R4-27-322 (Supp. 95-1).

R19-2-323. Procedure before the Commission

A. Appeal of Director's rulings.

1. Any person or persons aggrieved by a ruling of the Director may appeal to the Commission. Such an appeal must be filed in writing in the office of the Commission within 15 days after service of the Director's ruling.
2. The appeal shall be signed by the person making said request or his or her attorney and must set forth with specificity his or her grounds for appeal and reasons for believing he or she is entitled to a hearing.
3. Upon the filing of an appeal set forth above, the Commission shall review the record and may affirm, reverse, or modify the Director's ruling or conduct such other proceedings as the Commission deems appropriate.

B. Permit denial, suspension, or revocation.

1. The Commission may deny a permit application pursuant to a hearing upon 15 days notice.
2. The Commission may revoke or suspend a permit only after notice and opportunity for hearing. Notice of the hearing shall be given in writing at least 20 days prior to the date set for hearing, unless waived by the applicant.
3. All parties appearing before the Commission shall be afforded an opportunity for a hearing and the opportunity to respond and present evidence and argument on all issues.
4. Any party appearing before the Commission shall have the right to appear in person or by counsel, except that a corporation may appear only through counsel. Any party may submit his or her case in writing. Failure of a party to appear for a hearing shall leave the Commission free to act upon the evidence at hand without further notice to the parties. Proceedings may be reopened by the Com-

mission upon written petition of any party to the proceedings.

- C. Hearing officer. If the Commission assigns a matter to a hearing officer, the hearing officer shall submit to the Commission within 15 days after the conclusion of the hearing a written decision which shall include proposed findings of fact, conclusions of law and order. The decision of the hearing officer may be approved or modified by the Commission. The decision of the hearing officer becomes the decision of the Commission unless modified by the Commission within 45 days.

D. Depositions.

1. When any party desires to take the oral deposition of any witness residing outside the state or otherwise unavailable as a witness, such party shall file with the Commission a petition for permission to take the deposition of such witness, showing the name and address of such witness and setting forth specifically and in detail the nature and substance of the testimony expected to be given by such witness. The application shall be granted if it appears from such petition that the witness resides outside the state or is otherwise unavailable and that the testimony of such witness is relevant and material. If such statement is not made specifically and in detail, so that the Commission may determine therefrom the relevancy and materiality of the testimony of such witness, such petition may be denied.
2. The Commission may, at its discretion, designate the time and place and office before which such a deposition may be taken. The expense of any deposition will be borne by the party applying to the Commission for permission to take same.
3. Any deposition taken under this rule shall be returned and filed with the Commission within 30 days after permission for taking same is granted.

E. Service.

1. Service of any decision, order, or other process may be made in person or by mail. Service by mail shall be made by enclosing the same or a copy thereof in a sealed envelope and depositing the same in the United States mail, postage prepaid, addressed to the party served, at the address shown by the records of the Department, except that notice of a hearing before the Commission shall be mailed by certified mail to the last known address of the parties as shown by the records of the Department.
2. Proof of service may be made by the affidavit or oral testimony of the person making such service.
3. The time periods prescribed or allowed by these rules, by order of the Department or by an applicable statute, shall be computed as provided in the Rules of Civil Procedure.
4. Service upon an attorney who has appeared on behalf of a party will constitute service upon such party. In the case of papers requested to be served upon the Commission, an original and five copies shall be filed in the office of the Department and a copy shall be served upon the Attorney General.

F. Rehearing or review.

1. Except as provided in subsection (7), any party in a contested case before the Commission who is aggrieved by a decision rendered in such case may file with the Commission, not later than 15 days after service of the decision, a written motion for rehearing or review of the decision specifying the particular grounds therefor. For purposes of this subsection, a decision shall be deemed to have been served when personally delivered or mailed to the party at his or her last known residence or place of business.

2. The motion for rehearing may be amended at any time before it is ruled upon by the Commission. A response may be filed within 10 days after service of such motion or amended motion by any other party. The Commission may require the filing of written briefs upon the issues raised in the motion and may provide for oral argument.
3. A rehearing or review of the decision may be granted for any of the following causes materially affecting the moving party's rights:
 - a. Irregularity in the administrative proceedings of the hearing officer or Commission or the prevailing party, or any order or abuse of discretion, whereby the moving party was deprived of a fair hearing.
 - b. Misconduct of the hearing officer, Commission, or the prevailing party.
 - c. Accident or surprise which could not have been prevented by ordinary prudence.
 - d. Newly discovered material evidence which could not with reasonable diligence have been discovered and produced at the original hearing.
 - e. Excessive or insufficient penalties.
 - f. Error in the admission or rejection of evidence or other errors of law occurring at the administrative hearing.
 - g. That the decision is not justified by the evidence or is contrary to law.
4. The Commission may affirm or modify the decision or grant a rehearing to all or any of the parties and on all or part of the issues for any of the reasons set forth in subsection (F)(3). An order granting a rehearing shall specify with particularity the ground or grounds on which the rehearing is granted, and the rehearing shall cover only those matters so specified.
5. Not later than 10 days after a decision is rendered, the Commission may, on its own initiative, order a rehearing or review of its decision for any reason for which it may have granted a rehearing on motion of a party. After giving the parties or their counsel notice and an opportunity to be heard on the matter, the Commission may grant a motion for rehearing for a reason not stated in the motion. In either case, the order granting such a rehearing shall specify the grounds therefor.
6. When a motion for rehearing is based upon affidavits, the affidavits shall be served with the motion. An opposing party may within 10 days after such service serve opposing affidavits, which period may be extended for an additional period not exceeding 20 days by the Commission for good cause shown or by written stipulation of the parties. Reply affidavits may be permitted.
7. If in a particular decision it is necessary for the immediate preservation of the public peace, health, and safety and if a rehearing or review of the decision is impracticable, unnecessary, or contrary to the public interest, the decision may be issued as a final decision without an opportunity for a rehearing or review.
8. For purposes of this subsection the terms "contested case" and "party" shall be defined as provided in A.R.S. § 41-1001.
9. To the extent that the provisions of this rule are in conflict with the provisions of any statute providing for rehearing of decisions of the Commission, such statutory provisions shall govern.

Historical Note

Adopted effective August 5, 1983 (Supp. 83-4).

Amended effective March 20, 1990 (Supp. 90-1). R19-2-323 recodified from R4-27-323 (Supp. 95-1).

R19-2-324. Greyhound Housing

A. Kennel housing facilities:

1. Facilities shall be constructed and maintained in good repair to ensure protection from exposure or hazards that could endanger the greyhounds.
2. Bedding shall be provided for all greyhounds. Heat, insulation, or additional bedding adequate to provide warmth shall be provided when the indoor temperature is below 50 degrees Fahrenheit. Facilities shall have operational cooling devices so the indoor temperature does not exceed 85 degrees Fahrenheit.
3. Facilities shall be provided for greyhounds under the age of eight weeks and for females within two weeks of whelping. The facility shall be disinfected on a daily basis and separate from a racing kennel.
4. Facilities shall at all times provide ventilation to all greyhounds by means of doors, windows, vents, air conditioning, or an evaporative cooling system.
5. Walls and floors shall be constructed to lend themselves to efficient cleaning and sanitizing.
6. Ample lighting shall be provided by natural or artificial means or both to allow efficient cleaning of the facilities, routine inspection of the facilities, and the greyhounds contained therein.
7. Each facility shall have at least one turn-out pen.
8. A minimum of one functional fire extinguisher shall be available at each kennel facility.
9. Facilities shall be cleaned and disinfected at least weekly or more frequently as may be necessary to reduce disease hazards, odors, fleas, ticks and vermin.
10. Smoking shall not be allowed in kennel housing.

B. Run housing.

1. Buildings and structures shall be constructed and maintained in good repair to ensure protection from exposure or hazards that could endanger the greyhounds.
2. Sufficient shelter shall be provided to accommodate all greyhounds to allow access to shade from direct sunlight and regress from exposure to inclement weather. Heat, insulation, or bedding adequate to provide warmth shall be provided when the atmospheric temperature is below 50 degrees Fahrenheit.
3. The run area shall be kept free of debris, brush, feces or any unsanitary or hazardous materials that could endanger the greyhounds.
4. Fencing for the run shall be a minimum of 4 feet high. Material for fencing shall be such that the health and safety of the greyhounds are not endangered. Fences shall be maintained in satisfactory repair.
5. Run housing shall be cleaned at least daily or more frequently as may be necessary to reduce disease hazards and odors.

C. Kennel housing crates.

1. The crates shall be of sound construction and maintained in good repair to protect the greyhounds from injury.
2. Construction materials and maintenance shall allow the greyhounds to be kept clean and dry. Walls and floors shall be impervious to urine and other moisture.
3. The shape and size of the crate shall afford ample space for the greyhounds to comfortably turn about, stand erect, sit and lie, but the crate shall not be smaller than 31 inches wide, 42 inches long and 32 inches high.
4. The greyhounds shall be removed from their crate at least four times in each 24-hour period. The release time shall be sufficient to relieve bodily functions and to loosen cramped muscles.

5. Except as provided in R19-2-328 (B), there shall be only one greyhound per crate.
6. Crates shall be cleaned and sanitized at least daily or more frequently as may be necessary in order to maintain a sanitary living environment for the greyhounds.

Historical Note

Adopted effective March 1, 1995; R19-2-324 recodified from R4-27-324 (Supp. 95-1).

R19-2-325. Grounds of the Racing Kennel, Breeding Farm, or Other Operation**A. General.**

1. Food supplies and bedding materials shall be stored to protect them from contamination or infestation by vermin or other factors which would render the food or bedding unsanitary. All meat shall be kept frozen or refrigerated until such time that it is to be thawed for immediate consumption.
2. Washrooms, basins, or sinks shall be readily accessible for maintaining cleanliness among greyhound caretakers and sanitizing of food and water utensils. Running water shall be immediately available and hot water shall be obtainable on the premises to properly disinfect dishes, utensils, or other equipment.
3. Waste materials shall be removed at least daily and disposed of at least weekly to minimize vermin infestation, odors, and disease hazards.
4. Dropping buckets shall have lids in place except while in use and shall be stored in an area removed from kennel housing and run housing.
5. Space shall be provided to prevent crowding and to allow freedom of movement and comfort to the greyhounds.
6. Females in estrus shall not be housed with racing dogs or males except for breeding purposes.
7. Cleaning supplies and pesticides shall be stored in a secure area completely separate from food, bedding storage, and greyhounds.
8. The grounds shall be free of weeds and other materials that may constitute a fire or other hazard and that may create a breeding ground for fleas and ticks.
9. Racing kennels, breeding farms, and other operations in Arizona shall apply for a license to operate from the Department. Greyhounds bred, whelped, raised, trained, or kenneled by unlicensed Arizona operations shall not be eligible to race within Arizona.

B. Turn-out pens and exercise areas.

1. Fencing for turn-out pens and exercise areas shall be a minimum of 5 feet high. Material for fencing shall be such that the health and safety of the greyhounds are not endangered. Fences shall be maintained in satisfactory repair.
2. Ample lighting shall be provided by natural or artificial means or both to view the greyhounds while in the turn-out pens and to allow efficient cleaning thereof.
3. Turn-out pens and exercise areas shall be free of debris, brush, feces, or any unsanitary, or hazardous materials that could endanger the greyhounds.
4. The greyhound shall be supervised at all times while in the turnout pens.
5. Sufficient shelter shall be provided to accommodate all greyhounds in the exercise areas and turn-out pens to allow access to shade from direct sunlight and regress from exposure to inclement weather.
6. Turn-out pens shall be cleaned at least daily or more frequently as may be necessary to reduce disease hazards and odors.

7. Fresh sand shall be added to soak up urine at least annually or more frequently as may be necessary to reduce disease and odors.
8. Buildings and structures present in or around the turn-out pens or exercise areas shall be constructed and maintained in good repair to ensure protection from exposure or hazards that could endanger the greyhounds.

Historical Note

Adopted effective March 1, 1995; R19-2-325 recodified from R4-27-325 (Supp. 95-1). Amended effective August 7, 1996 (Supp. 96-3).

R19-2-326. General Care of Greyhounds in a Racing Kennel, on a Breeding Farm, or on Another Operation

- A. All greyhounds shall be properly cared for on a daily basis. This includes physically inspecting the greyhounds for sores, cuts, abrasions, muzzle bums, fleas, ticks, and providing adequate feed.
- B. Greyhounds shall be provided with clean, fresh water in run housing, exercise areas, and turnout pens at all times.
- C. All food and water dishes shall be free of mold and slime.
- D. Greyhounds shall be reasonably free of ticks and fleas. Care shall be taken to ensure that the greyhounds do not ingest chemicals used to control fleas and ticks.
- E. Sick, diseased, or injured greyhounds shall be provided with proper veterinary care.
- F. Muzzles used shall be lightweight, plastic, or padded wire tape. Worn, broken, or rusted muzzles are prohibited.
- G. All greyhounds shall be vaccinated annually against common canine diseases such as parvo, rabies, distemper, hepatitis, adenovirus type 2, parainfluenza, and leptospira. Current records shall be kept and available for review by the Department inspector.

Historical Note

Adopted effective March 1, 1995; R19-2-326 recodified from R4-27-326 (Supp. 95-1).

R19-2-327. Personnel of the Racing Kennel, Breeding Farm, or Other Operation

- A. The owner of the racing kennel, breeding farm, or other operation manager / agent, or supervising personnel shall be present at least once in each 24-hour period to supervise and to ascertain that the care of the greyhounds and maintenance of the facilities conform to all of the rules.
- B. A sufficient number of employees shall be utilized to provide the required care of greyhounds and maintenance of the facilities.
- C. The racing kennel, breeding farm, or other operation shall be licensed by the Department. If the owner of the racing kennel, breeding farm, or other operation is not physically present to run the racing kennel, breeding farm, or other operation, the owner's manager / agent shall also be licensed by the Department.

Historical Note

Adopted effective March 1, 1995; R19-2-327 recodified from R4-27-327 (Supp. 95-1).

R19-2-328. Transportation of Greyhounds

- A. When transported within the state, all greyhounds shall be hauled in crates designed for the sole purpose of transporting greyhounds. These crates shall be a minimum of two feet wide, three feet long, and 34 inches high.
- B. When transporting racing greyhounds to and from the race-track, there shall be allowed a maximum of two greyhounds per crate, provided that there is enough space for each greyhound to comfortably turn about sit, lie, and stand erect. When

otherwise transporting greyhounds within the state, there shall be allowed only two greyhounds per crate provided that there is enough space for each greyhound to comfort ably turn about, sit, lie and stand erect.

- C. The crates shall be of sound construction and maintained in good repair to ensure that the health and safety of the greyhounds are not endangered.
- D. Floors and lower sides of the crates shall be constructed or shall be covered on the inner surfaces to contain excreta and bedding materials.
- E. The crates shall be cleaned and sanitized at least daily, or more frequently as may be necessary in order to maintain a sanitary environment for the greyhounds.
- F. Hauling vehicles shall provide ventilation that reaches each greyhound by means of windows, vents, air conditioner or an evaporative cooling system. Air conditioning, or evaporative cooling devices in good working order shall be provided when the atmospheric temperature is above 90 degrees Fahrenheit to provide comfort to the greyhounds during transport. Heat, insulation or bedding adequate to provide warmth shall be provided when the atmospheric temperature is below 50 degrees Fahrenheit.
- G. Greyhounds in hauling vehicles shall be inspected at least once in each four-hour period and their needs attended to immediately. Water shall be provided at each four-hour interval check.
- H. Racing kennels, breeding farms, or other operations that receive greyhounds transported from out-of-state locations shall maintain a log. The log shall include:
 - 1. The name of each greyhound,
 - 2. Left and right ear tattoo numbers or other permanent identification acceptable to the National Greyhound Association,
 - 3. The names of owners or lessees,
 - 4. The date of shipping or receiving,
 - 5. Purpose (breeding, racing, training), and
 - 6. Name of hauling company and driver.
- I. Newly arriving out-of-state greyhounds shall be housed separately until a physical evaluation can be made for the presence of ticks, or fleas and the administration of proper treatment.

Historical Note

Adopted effective March 1, 1995; R19-2-328 recodified from R4-27-328 (Supp. 95-1). Amended by final rulemaking at 12 A.A.R. 1771, effective July 1, 2006 (Supp. 06-2).

R19-2-329. Disposition of Greyhounds

- A. Racing kennels, breeding farms, or other operations shall maintain a log as to the disposition of individually registered greyhounds at the end of their breeding, racing, or nonracing careers. The log shall include:
 - 1. The name of each greyhound,
 - 2. Left and right ear tattoo numbers or other permanent identification acceptable to the National Greyhound Association,
 - 3. The names of owners or lessees,
 - 4. Date career ended and reason why, and
 - 5. Destination.
- B. Every effort shall be made to adopt the greyhounds not used for racing or breeding purposes.
- C. Greyhounds transported to an adoption agency, breeding farm, or other location at the end of their breeding, racing, or non-racing careers are subject to the transportation requirements in R19-2-328.

Historical Note

Adopted effective March 1, 1995; R19-2-329 recodified from R4-27-329 (Supp. 95-1). Amended by final

rulemaking at 12 A.A.R. 1771, effective July 1, 2006 (Supp. 06-2).

R19-2-330. Inspection Procedure for a Racing Kennel, Breeding Farm, or Other Operation

- A. All racing kennels, breeding farms, or other operations shall be available for inspection at all times by representatives of the Department. Hauling vehicles used to transport greyhounds are considered part of the general equipment of the operation and as such shall be subject to inspection.
- B. Inspections shall be unannounced.
- C. A representative of the racing kennel, breeding farm, or other operation shall be present to assist the investigator during the inspection.
- D. A copy of the inspection report detailing the findings of the inspection shall be left by the investigator at the racing kennel, breeding farm, or other operation.
- E. A follow-up inspection shall be conducted by the Department if corrective measures are required, or if sick, or poorly maintained grey hounds are found. The Department may seek assistance from Animal Control authorities for the removal and treatment of sick and poorly maintained greyhounds.

Historical Note

Adopted effective March 1, 1995; R19-2-330 recodified from R4-27-330 (Supp. 95-1).

R19-2-331. Greyhound Adoption Grants

- A. The purpose of the grants is to promote the adoption of racing greyhounds as domestic pets. A maximum of 25% of the license fees generated from A.R.S. § 5-104(F)(7) and (8) shall be distributed to nonprofit enterprises pursuant to A.R.S. § 5-104(G).
- B. Procedures.
 - 1. The enterprise shall submit a Department-generated application form to the Commission by March 1 of each year the enterprise may desire to apply for a grant. The application form shall require the following information:
 - a. A written description of the enterprise and proposed use of the grant;
 - b. Proof of nonprofit status;
 - c. A description of its procedures to acclimate the greyhounds required by A.A.C. R19-2-331(C)(6);
 - d. A description of its adoption procedures required by A.A.C. R19-2-331(C)(7);
 - e. A copy of the application form and the adoption agreement required by A.A.C. R19-2-331(C)(7)(a) and (c); and
 - f. A copy of the owner release form required by A.A.C. R19-2-331(C)(9).
 - 2. The Commission shall decide which enterprise shall receive a grant, the amount of the grant, and the date of disbursement of such grant.
 - 3. The recipients of the grants shall report quarterly to the Commission on a form provided by the Department to gather the following information:
 - a. The number of greyhounds the enterprise received;
 - b. The number of greyhounds adopted;
 - c. The number of greyhounds returned and reason for return;
 - d. The actual use of the grant; and
 - e. A list of people who adopted the greyhounds, or make available to the Department copies of the contracts between the agency and the adoptee.
- C. Minimum qualifications.
 - 1. The enterprise shall be nonprofit.
 - 2. The enterprise shall not:

- a. Allow the greyhounds to be used for racing, wagering, or hunting;
 - b. Place the greyhounds in a pound, humane society, or research facility;
 - c. Resell the greyhounds; or
 - d. Place the greyhounds for resale.
3. The enterprise shall not euthanize an adoptable greyhound unless, as determined by a licensed veterinarian, it is medically necessary for humane reasons.
 4. The enterprise shall be affiliated with a racetrack that conducts greyhound racing. Affiliation is satisfied when the general manager, or other executive from the racetrack submits to the Commission a written recommendation on behalf of the enterprise.
 5. The enterprise shall require that a licensed veterinarian perform a complete check-up on each greyhound. Each greyhound shall be spayed, or neutered, and vaccinated as necessary.
 6. The enterprise shall employ procedures for acclimating greyhounds, which include:
 - a. Exposure to the public;
 - b. Exposure to a household environment which may include stairs, couches, toys, mirrors, tables;
 - c. Exposure to cats; and
 - d. Exposure to a new diet.
 7. The enterprise shall employ procedures for adopting-out greyhounds, which include:
 - a. An application process for prospective adoptees;
 - b. A visual check of each prospective adoptee's home with written documentation;
 - c. A written adoption agreement between the enterprise and adoptee;
 - d. At a minimum, follow-ups conducted by phone, or visit after seven days and 30 days with written documentation; and
 - e. Procedures for the return of greyhounds.
 8. The enterprise shall comply with the housing requirements set forth in R19-2-324.
 9. The enterprise shall have an owner release form for each greyhound in their care.
 10. The enterprise shall make available a person to answer questions from a prospective, or current adoptee.
 11. The enterprise shall keep a file on each greyhound. The file shall include:
 - a. The owner release form;
 - b. The vaccination record, health record, and spay, or neuter record;
 - c. The greyhound personality profile;
 - d. The written adoption agreement between the enterprise and adoptee;
 - e. The written documentation of visits and follow-ups; and
 - f. The adoptee's application form.
 12. The enterprise shall make available to the adoptee an owner's manual, or other packet of information.
 13. Records required by A.A.C. R19-2-331(C)(11) shall be subject to inspection by representatives of the Department.
- B. Within 10 days of whelping, the breeder shall provide notice of whelping to the Department on a Department-approved form. This notice shall include the names of all owners or lessees of the dam at the time of whelping who will be entitled to breeders' awards at a later date. The breeder shall also provide a copy of the Breeding Acknowledgment Form returned to the breeder by the National Greyhound Association (NGA).
 - C. Within 90 days of whelping, the breeder shall provide tattoo numbers of greyhounds from the litter to the Department on a Department-approved form.
 - D. The breeder shall apply for Arizona-bred certification by submitting to the Department the completed application form provided by the Department and a National Greyhound Association Individual Registration Application. The application shall include the names of all owners or lessees of the dam at the time of whelping who shall be entitled to breeders' awards.
 - E. The breeder shall comply with the following rules in order to be eligible for Arizona-bred certification:
 1. A greyhound must be present in Arizona for not less than six months of its first year.
 2. During the greyhound's first year, the breeder shall notify the Department whenever the greyhound is removed from the state.
 3. The Department may conduct inspections at any time to ensure that greyhounds meet the residency requirement.
 - F. The breeder shall make the litter available for inspection by the representatives of the Department at any time. The Department representative shall conduct the inspection of the litter at a location licensed by the Department and designated on the Breeding Acknowledgement Form within 30 days of whelping. The Department representative may conduct additional inspections of the litter to verify tattoo numbers and ensure compliance with requirements of A.R.S. § 5-114(C).
 - G. If the greyhound and its breeder qualify by meeting requirements set forth in subsections (A) through (E), the Department shall certify that the greyhound is Arizona bred and mail all necessary documents, including the National Greyhound Association Individual Registration Application form, to the NGA. A greyhound is considered Arizona bred as of the date indicated on the Department's certificate.
 - H. If the Breeder is ineligible for breeders' awards, the Director shall send a letter to the applicant explaining the ineligibility.
 - I. The Department shall retain a copy of the NGA registration certificate and mail the original to the registered breeder.
 - J. Denial. The Director may deny an application for Arizona-bred certification for any of the following reasons:
 1. Failure to notify the Department of whelping as required by subsection (B),
 2. Failure to provide the greyhound tattoo numbers as required in subsection (C),
 3. Failure to meet the residency requirements in subsection (E)(1) or failure to meet the notification requirement of subsection (E)(2), and
 4. Material misstatement by the breeder.
 - K. The Department shall use information contained in applications and notices submitted to the Department in the event of a conflict between Department records and records of another organization.
 - L. An applicant may appeal a decision of the Director by following the requirements in R19-2-322.

Historical Note

Adopted effective February 28, 1995; R19-2-331 recodified from R4-27-331 (Supp. 95-1).

R19-2-332. Certifying a Greyhound Arizona Bred

- A. A breeder shall be properly licensed pursuant to A.R.S. § 5-107.01(B) in order to certify an Arizona-bred greyhound.

Historical Note

Adopted effective January 6, 1998 (Supp. 98-1).

ARTICLE 4. TELETRACKING

Section R19-2-401 was adopted and subsequently amended

under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to A.R.S. § 41-1005(A)(18). Exemption from the rulemaking process means that the agency did not submit these rules to the Secretary of State's Office for publication in the Register as proposed rules, the agency was not required to accept public comment, and the rules were not approved by either the Governor's Regulatory Review Council or the Attorney General.

R19-2-401. Definitions

For purposes of this Article, in addition to the definitions set forth in R19-2-102 and R19-2-302, and unless the context otherwise requires:

1. "Teletrack Wagering Permit" means a permit issued by the Commission authorizing an Arizona racetrack permittee to telecast a racing program to single or multiple teletrack wagering facilities within the State of Arizona for the purpose of pari-mutuel wagering.
2. "Teletrack Facility" means an additional wagering facility owned or leased by an Arizona permittee which is used for handling legal wagers.
3. "Satellite" means the receiving and retransmission space station which is in orbit with the earth.
4. "Sending Track" means the enclosure where a racing program of authorized live racing is conducted from which teletracking originates.
5. "Teletracking" means the telecast of live audio and visual signals of live or simulcast horse, mule, or greyhound racing programs conducted at an authorized enclosure within Arizona to an authorized additional wagering facility within Arizona, by a racetrack permittee for the purpose of pari-mutuel wagering.
6. "Teletrack Wagering" means pari-mutuel wagering conducted at a teletrack facility within Arizona on a racing program which is conducted at an authorized track within Arizona.
7. "Transmission" means the point-to-point sending and receiving of an audio/visual signal by any method approved by the Arizona Department of Racing.
8. "Operating Hours" means the hours in which pari-mutuel windows are open at a teletrack facility.
9. "Sales Transaction Data" means the electronic signals transmitted between totalisator ticket-issuing machines and the totalisator central processing unit for the purpose of accepting wagers and generating, canceling and cashing pari-mutuel tickets; also, the financial information resulting from processing sales transaction data, such as handle and revenues.
10. "Pari-Mutuel Output Data" means any data provided by the totalisator system other than sales transaction data including, but not limited to, odds, will pays, race results and pay-off prices.
11. "Racing Program" means the live races conducted at an authorized track, approved dark-day simulcasts and any simulcast races shown to the public in conjunction with live racing on which pari-mutuel wagering is allowed.
12. "TIM-To-Tote Linkage" means the connection in which the Ticket Issuing Machines (TIM) are directly connected to the permittee's own calculating or compiling totalisator with no intermediate totalisator systems within that connection.
13. "Tote-To-Tote Linkage" means the connection between the totalisator systems in which one of the systems is not part of the permittee's calculating system and may or may not be used for the compilation of TIM-to-tote wagers within its own wagering network that are then forwarded to the permittee's calculating totalisator system.

14. "Video Breakdown" means any failure in the receipt of a video signal at a teletrack or racetrack facility including any failure to initially acquire a signal.
15. "Video Reception" means the display of wagering information and races as offered to the general public.

Historical Note

Adopted effective April 3, 1984 (Supp. 84-2). Amended by adding paragraphs (8) and (9) effective August 21, 1985 (Supp. 85-4). Repealed effective December 14, 1994 (Supp. 94-4). R19-2-401 recodified from R4-27-401 (Supp. 95-1). New Section adopted effective February 26, 1996, pursuant to an exemption from the rulemaking process (Supp. 96-1). Amended effective July 22, 1998, pursuant to an exemption from the rulemaking process (Supp. 98-3). Amended by exempt rulemaking at 5 A.A.R. 532, effective January 29, 1999 (Supp. 99-1).

Section R19-2-402 was adopted under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to A.R.S. § 41-105(A)(18). Exemption from the rulemaking process means that the agency did not submit these rules to the Secretary of State's Office for publication in the Register as proposed rules, the agency was not required to accept public comment, and the rules were not approved by either the Governor's Regulatory Review Council or the Attorney General.

R19-2-402. Teletrack Wagering

- A. All applicable Department rules governing pari-mutuel wagering are incorporated by reference as also governing teletrack wagering. Teletrack monies wagered shall be made a part of the pool of the sending track.
- B. Sales transaction data from a teletrack facility to the sending track must be maintained as a separate account for audit purposes.
- C. Sales transaction data shall, by the use of currently approved technology, be transmitted separately from pari-mutuel data and the visual display of the races.
- D. In case of interruption of transmission of sales transaction or pari-mutuel output data to or from the teletrack facility, the designated representative of the Department may require that the amount of wagers which have been accepted be deducted from the sending track pool, the odds recalculated, and those monies bet at the teletrack facility refunded, taking into consideration time, the extent of the breakdown, and the amount of monies wagered.

Historical Note

Adopted effective April 3, 1984 (Supp. 84-2). Amended effective August 21, 1985 (Supp. 85-4). Repealed effective December 14, 1994 (Supp. 94-4). R19-2-402 recodified from R4-27-401 (Supp. 95-1). New Section adopted effective February 26, 1996, pursuant to an exemption from the rulemaking process (Supp. 96-1).

Section R19-2-403 was adopted and subsequently amended under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to A.R.S. § 41-1005(A)(18). Exemption from the rulemaking process means that the agency did not submit these rules to the Secretary of State's Office for publication in the Register as proposed rules, the agency was not required to accept public comment, and the rules were not approved by either the Governor's Regulatory Review Council or the Attorney General.

R19-2-403. General Provisions

The following rules shall apply to each teletrack facility:

1. At the Director's discretion, a Department representative may be present during all operating hours.

2. Suitable back-up or replacement tote equipment shall be available such that down time in the event of equipment failure shall be 60 minutes or less, during operating hours. At teletrack sites with multiple teller equipment installed, back-up equipment may consist of the remaining operating teller machines provided that the remaining machines are sufficient to handle the reasonably anticipated volume of sales transactions without unreasonable delays or inconvenience to patrons.
3. The permittee controlling the teletrack wagering permit is responsible during the racing program for reporting any problems or delays to the public.
4. Security requirements will be adequate to control disturbances.
5. Communications must allow the sending track and teletrack facility to communicate without delay. In a Tote-to-Tote situation, if the data transmission link between the tote systems fail, the permittee holding the teletrack permit shall decide the policy for paying off or refunding pari-mutuel tickets and all other communication failures at the teletrack site.
6. Photo finish pictures of the previous day's live races will be available for viewing upon request within 48 hours.
7. A video display showing the following information must be in operation at each teletrack facility during all operating hours:
 - a. All wagering information including pool totals, will pays, or odds as offered to the general public at the permittee racetrack location;
 - b. Each race shown live, as it is run;
 - c. Race Results;
 - d. Prices or payoff;
 - e. Minutes to post;
 - f. The corresponding race number and track for which the above information is displayed.
8. Notwithstanding subsection (7), should a video breakdown occur in the display of the race and wagering information, the permittee shall immediately contact the Director or his designee. Wagering may continue at the teletrack facility on the affected racing program for the remainder of that racing day provided the following conditions are met:
 - a. The racetrack permittee shall notify the wagering public at the affected teletrack facility of the nature of the breakdown;
 - b. The racetrack permittee shall make immediate and continuing efforts to repair the video breakdown;
 - c. The racetrack permittee shall provide the Director a written report concerning the circumstances within 48 hours of any such breakdown;
 - d. The racetrack permittee shall not accept wagers at the teletrack facility on the affected racing program for any performance on a subsequent racing day until the breakdown has been repaired. The Director may, upon written request, authorize the racetrack permittee to accept wagers at a teletrack facility despite an ongoing video breakdown;
 - e. If there is not a reasonable expectation of video reception, the racetrack permittee shall not accept wagers at the teletrack facility on the affected racing program. The Director may upon written request, authorize the racetrack permittee to accept wagers at a teletrack facility despite the lack of expectation of video reception.
9. Arizona pari-mutuel rules must be available in the wagering area.
10. Notice of any race cancellation, scratches, and other changes shall be posted conspicuously as soon as possible in the wagering area. In addition, it shall be the responsibility of the mutuel manager at the host permittee to disseminate all changes in wagering information to all teletrack wagering locations.
11. The results of each race, and the winnings therefrom, shall be posted as soon as possible at each teletrack facility and shall be available to the wagering public for 24 hours on the race day following the day of the race.
12. A permittee shall report to the Department any violation or suspected violation of law which occurs on or about the premises of the teletrack facility.
13. The permittee shall make daily handle and attendance reports for each teletrack facility as prescribed by the Department.
14. Betting Period:
 - a. Wagering may only be conducted during periods approved by the Director or Commission in respect to any race, racing card, pool or feature pool.
 - b. The Director may prescribe the closing time for pari-mutuel equipment at each facility based on the level of sophistication of the pari-mutuel equipment and transmission equipment.
15. The method used to transmit sales transaction and pari-mutuel output data shall be approved in writing by the Director, based upon the Director's determination that provisions to secure the system and transmissions are satisfactory.
16. The permittee shall provide computer reports pertaining to pari-mutuel activity as required by the Director.

Historical Note

Adopted effective April 3, 1984 (Supp. 84-2). Amended paragraphs (16) and (17) effective August 21, 1985 (Supp. 85-4). Repealed effective December 14, 1994 (Supp. 94-4). R19-2-403 recodified from R4-27-403 (Supp. 95-1). New Section adopted effective February 26, 1996, pursuant to an exemption from the rulemaking process (Supp. 96-1). Amended effective July 22, 1998, pursuant to an exemption from the rulemaking process (Supp. 98-3). Amended by exempt rulemaking at 5 A.A.R. 532, effective January 29, 1999 (Supp. 99-1).

Section R19-2-404 was adopted under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to A.R.S. § 41-105(A)(18). Exemption from the rulemaking process means that the agency did not submit these rules to the Secretary of State's Office for publication in the Register as proposed rules, the agency was not required to accept public comment, and the rules were not approved by either the Governor's Regulatory Review Council or the Attorney General.

R19-2-404. Application for Original Teletrack Wagering Permit; Plan of Operation; Renewals of Teletrack Wagering Permit

- A. An applicant must submit an Application for a Teletrack Wagering permit and a Plan of Operation to the Commission before the Commission may grant a teletrack wagering permit. The length of the permit shall not exceed three years. The Plan of Operation shall include but not be limited to the following:
 1. Feasibility and accounts. A feasibility study denoting the estimated gross revenue from the teletrack wagering operation and the estimated costs to operate. The feasibility study shall include:
 - a. The number of races to be displayed,

- b. The types of wagering to be offered and hours during which pari-mutuel windows will be in operation,
 - c. The estimated attendance at all additional wagering facilities,
 - d. The level of anticipated wagering activity,
 - e. The source and amount of estimated revenues other than pari-mutuel wagering,
 - f. The cost of operating the teletrack wagering system,
 - g. The amount and source of revenues needed for financing the teletrack wagering operation,
 - h. Proof of financial stability and assets sufficient to cover projected costs,
 - i. An estimate of the total amount of anticipated revenues to be paid to the state of Arizona resulting from teletrack wagering operations.
 2. Proof of compliance with applicable FCC regulations, and applicable FCC licensing requirements.
 3. Contracts and agreements. The following information must be submitted in relation to any groups, concessions, or contracts whether within or outside of Arizona which are related to the teletrack wagering operation unless such information is already on record with the Department as part of the permittee's original application to operate racing meet:
 - a. Copy of all contracts to provide service within Arizona;
 - b. Names and background of the individuals responsible for operating the teletrack wagering system;
 - c. Copies of proposed agreements for the transmission of audio-visual signals of racing events and transmission of sales transaction and pari-mutuel output data;
 - d. Other information which, in the Director's judgment, is or may be material, such as information pertaining to financial background and persons associated with the parties to the contract.
 4. Security.
 - a. The security measures to be employed to protect the teletrack wagering facilities,
 - b. The security measures to be employed to protect the public,
 - c. The security measures to be employed to prevent the interception of audio and video signal transmission of races,
 - d. The security measures to be employed to protect transmission of sales transaction and pari-mutuel output data.
 5. Equipment, communication, and transmission.
 - a. The type of data processing, communication, and transmission equipment to be utilized;
 - b. A description of all computer services and all other methods utilized for the transmission of any data or signal;
 - c. A description of any alternate or backup system in case of principal system failure of communications or data-processing equipment used for forwarding wagers;
 - d. Identification of satellite, if applicable;
 - e. Additional information which may be required, at the discretion of the Director, such as the names, addresses, and phone numbers of all individuals who will be involved in the delivery of the signal.
- B.** Approval and amendments. A permittee shall conduct a teletrack wagering operation only according to the provisions of an approved Plan of Operation. Any change to the Plan of Operation will be allowed only when approved in writing by the Director. A permittee shall:
1. Report to the Department any changes in ownership/management groups,
 2. Provide to the Department new contracts or amendments to existing ones,
 3. Request the approval of the Director for any change in technology used to transmit sales transaction data,
 4. Notify the Department of any change in the Plan of Operation.
- C.** Renewal. A permittee shall apply to the Racing Commission for renewal of its teletrack wagering permit at the time it makes application for a permit to operate a racing meet. The application for renewal shall provide the information required in subsections (A)(1) through (5) above.

Historical Note

Adopted effective April 3, 1984 (Supp. 84-2). Amended effective August 21, 1985 (Supp. 85-4). Repealed effective December 14, 1994 (Supp. 94-4). R19-2-404 recodified from R4-27-404 (Supp. 95-1). New Section adopted effective February 26, 1996, pursuant to an exemption from the rulemaking process (Supp. 96-1).

Section R19-2-405 was adopted under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to A.R.S. § 41-105(A)(18). Exemption from the rulemaking process means that the agency did not submit these rules to the Secretary of State's Office for publication in the Register as proposed rules, the agency was not required to accept public comment, and the rules were not approved by either the Governor's Regulatory Review Council or the Attorney General.

R19-2-405. Application for Approval of Additional Wagering Facilities; Plan of Operation; Renewal or Approval of Additional Wagering Facilities

- A.** A permittee who holds a permit for teletrack wagering shall submit an Application for Approval and a Plan of Operation for each additional teletrack wagering facility to the Racing Commission. The length of the permit for an additional wagering facility shall not exceed three years. The Plan of Operation shall include but not be limited to the following:
1. Feasibility and accounts. A feasibility study denoting the estimated gross revenue from the teletrack facility and the estimated costs to operate the facility. The feasibility study shall include:
 - a. The number of races to be displayed,
 - b. The types of wagering to be offered and the hours during which pari-mutuel windows will be in operation,
 - c. The estimated attendance at the teletrack facility,
 - d. The level of anticipated wagering activity,
 - e. The source and amount of estimated revenues from sources other than pari-mutuel wagering,
 - f. The cost of operating the facility,
 - g. The amount and source of revenues needed for financing the teletrack wagering operation,
 - h. Proof of financial stability and assets sufficient to cover projected costs,
 - i. An estimate of the total amount of anticipated revenues to be paid to the state of Arizona resulting from teletrack wagering.
 2. Contracts and agreements. The following information must be submitted in relation to any groups, concessions, or contracts, whether within or outside of Arizona, which are connected with the operation of a teletrack facility, unless such information is already on record.

- a. Listing and background of the management groups responsible for the operation of the facility;
 - b. The names of all individuals who own 10% or more of the facility;
 - c. Other information which, in the Director's judgment, is or may be material, such as information pertaining to financial background and persons associated with the parties to the contract.
3. Security. The measures to be employed to protect the facility, the employees, the public, and the wagering dollars.
 4. Location of the teletrack wagering facility.
 5. Proof that approval for use of the facility to handle pari-mutuel wagering has been given by the governing body of the city or town or by the board of supervisors, if the facility is located in an unincorporated area.
 6. Building plans and specifications. Adequate provision shall be made for areas appropriate for patrons to handicap the races and the facilities shall allow reasonable access by handicapped persons.
- B.** Approval and amendments shall be the same as provided in R19-2-404(B).
- C.** Renewal. A permittee shall apply to the Department for renewal of its additional wagering facility permits at the time it makes application to renew its Teletrack Wagering Permit. Upon receipt of a completed application, the Director may approve the:
1. Renewal of a teletrack wagering facility,
 2. A permittee's application to begin operation at a teletrack wagering facility previously approved by the Racing Commission and currently used by another permittee.
- D.** After receiving approval from the Racing Commission, a new facility may not open for business for a period of five working days or until all licensing requirements are satisfied. Should the necessary licensing requirements be completed in less than five working days, the remaining days may be waived by the Director.

Historical Note

Adopted effective April 3, 1984 (Supp. 84-2). Amended effective August 21, 1985 (Supp. 85-4). Repealed effective December 14, 1994 (Supp. 94-4). R19-2-405 recodified from R4-27-405 (Supp. 95-1). New Section adopted effective February 26, 1996, pursuant to an exemption from the rulemaking process (Supp. 96-1).

Section R19-2-406 was adopted under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to A.R.S. § 41-105(A)(18). Exemption from the rulemaking process means that the agency did not submit these rules to the Secretary of State's Office for publication in the Register as proposed rules, the agency was not required to accept public comment, and the rules were not approved by either the Governor's Regulatory Review Council or the Attorney General.

R19-2-406. Requisites for a Teletrack Wagering System

After a permit has been granted by the Commission but prior to beginning operation, if the applicant is required to utilize encoding and decoding systems, applicant will submit the following to the Director:

1. A description of the coding system used for any authorized encoding and decoding systems;
2. Number and manufacturer of any encoders and decoders;
3. Serial numbers of all encoders and decoders, updated monthly;
4. Number and location of decoders, updated monthly.

Historical Note

Adopted effective April 3, 1984 (Supp. 84-2). Amended effective August 21, 1985 (Supp. 85-4). Repealed effective December 14, 1994 (Supp. 94-4). R19-2-406 recodified from R4-27-406 (Supp. 95-1). New Section adopted effective February 26, 1996, pursuant to an exemption from the rulemaking process (Supp. 96-1).

Section R19-2-407 was adopted under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to A.R.S. § 41-105(A)(18). Exemption from the rulemaking process means that the agency did not submit these rules to the Secretary of State's Office for publication in the Register as proposed rules, the agency was not required to accept public comment, and the rules were not approved by either the Governor's Regulatory Review Council or the Attorney General.

R19-2-407. Transmission

- A.** Only persons authorized in writing by the Director will have access to the encoder and decoder. An updated list of the location of all decoders, controlled by the sending track or its designee, capable of obtaining the race signal of Arizona racetracks, shall be provided to the Department every 30 days.
- B.** Decoder authorization codes shall be changed more often than every 30 days and changes may be required more often by the Director.
- C.** The sending track or its licensed designee (who must be approved by the Director) will be the sole controller of the codes.

Historical Note

Adopted effective April 3, 1984 (Supp. 84-2). Repealed effective December 14, 1994 (Supp. 94-4). R19-2-407 recodified from R4-27-407 (Supp. 95-1). New Section adopted effective February 26, 1996, pursuant to an exemption from the rulemaking process (Supp. 96-1).

Section R19-2-408 was adopted under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to A.R.S. § 41-105(A)(18). Exemption from the rulemaking process means that the agency did not submit these rules to the Secretary of State's Office for publication in the Register as proposed rules, the agency was not required to accept public comment, and the rules were not approved by either the Governor's Regulatory Review Council or the Attorney General.

R19-2-408. Suspension of Teletrack Permit

- A.** The Director or the Director's designee may suspend any permit authorizing the operation of teletrack wagering or may suspend any permit to operate an additional wagering facility granted to a permittee if such permittee fails to conduct operations in accordance with the provisions of the applicable Plan of Operation, the applicable rules, or directives, or statutes.
- B.** If the Director finds that the public health, safety, or welfare imperatively requires emergency action, the Director may order summary suspension of a teletrack wagering permit or may order summary suspension of any permit authorizing operation of an additional wagering facility, pending a hearing.

Historical Note

Adopted effective April 3, 1984 (Supp. 84-2). Repealed effective December 14, 1994 (Supp. 94-4). R19-2-408 recodified from R4-27-408 (Supp. 95-1). New Section adopted effective February 26, 1996, pursuant to an exemption from the rulemaking process (Supp. 96-1).

Section R19-2-409 was adopted under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to A.R.S. § 41-105(A)(18). Exemption from the rulemaking process means that the agency did not submit these rules to the Secre-

tary of State's Office for publication in the Register as proposed rules, the agency was not required to accept public comment, and the rules were not approved by either the Governor's Regulatory Review Council or the Attorney General.

R19-2-409. Licensing of Employees at Teletrack Facilities

- A. A teletrack wagering facility shall not participate in teletrack wagering unless all individuals required to be licensed in subsection (B) have been licensed.
- B. The following individuals shall be licensed by the Department prior to participating in teletrack wagering:
 1. All persons employed at any teletrack facility by any permittee,
 2. All persons who own 10% or more in a teletrack facility leased be a permittee,
 3. Any individual employed by the facility who has responsibility as manager of the facility during operating (racing) hours,
 4. Any other person designated by the Director.

Historical Note

Adopted effective April 3, 1984 (Supp. 84-2). Repealed effective December 14, 1994 (Supp. 94-4). R19-2-409 recodified from R4-27-409 (Supp. 95-1). New Section adopted effective February 26, 1996, pursuant to an exemption from the rulemaking process (Supp. 96-1).

Section R19-2-410 was adopted under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to A.R.S. § 41-105(A)(18). Exemption from the rulemaking process means that the agency did not submit these rules to the Secretary of State's Office for publication in the Register as proposed rules, the agency was not required to accept public comment, and the rules were not approved by either the Governor's Regulatory Review Council or the Attorney General.

R19-2-410. Directives

Notwithstanding anything contained in this Article, decisions on other matters which arise concerning teletrack facility operations may be made by the Director, within the scope of the Director's statutory authority. The decisions shall be effective immediately upon written notification.

Historical Note

Adopted effective April 3, 1984 (Supp. 84-2). Repealed effective December 14, 1994 (Supp. 94-4). R19-2-410 recodified from R4-27-410 (Supp. 95-1). New Section adopted effective February 26, 1996, pursuant to an exemption from the rulemaking process (Supp. 96-1).

ARTICLE 5. PARI-MUTUEL WAGERING

The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act (A.R.S. Title 41, Chapter 6) pursuant to A.R.S. § 41-1005(A)(18). Exemption from A.R.S. Title 41, Chapter 6 means that the Arizona Racing Commission did not submit these rules to the Governor's Regulatory Review Council for Review; the Commission did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Commission was not required to hold public hearings on these rules; and the Attorney General did not certify these rules.

R19-2-501. General

Each permittee shall conduct wagering in accordance with applicable laws and these rules. Such wagering shall employ a pari-mutuel system approved by the Department. The totalisator shall be tested prior to and during the meeting as required by the Department.

Historical Note

Adopted effective October 21, 1993, under an exemption

from the Administrative Procedure Act pursuant to A.R.S. § 41-1005(A)(18) (Supp. 93-4). R19-2-501 recodified from R4-27-501 (Supp. 95-1).

The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act (A.R.S. Title 41, Chapter 6) pursuant to A.R.S. § 41-1005(A)(18). Exemption from A.R.S. Title 41, Chapter 6 means that the Arizona Racing Commission did not submit these rules to the Governor's Regulatory Review Council for Review; the Commission did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Commission was not required to hold public hearings on these rules; and the Attorney General did not certify these rules.

R19-2-502. Records

- A. The permittee shall maintain records of all wagering so the Department may review such records for any contest including the opening line, subsequent odds fluctuation, the amount and at which window wagers were placed on any betting, interest, and such other information as may be required. Such wagering records shall be retained by each permittee and safeguarded for a period of time specified by the Department. The Department may require that certain of these records be made available to the wagering public at the completion of each contest.
- B. The permittee shall provide the Department with a list of the licensed individuals afforded access to pari-mutuel records and equipment at the wagering facility.

Historical Note

Adopted effective October 21, 1993, under an exemption from the Administrative Procedure Act pursuant to A.R.S. § 41-1005(A)(18) (Supp. 93-4). R19-2-502 recodified from R4-27-502 (Supp. 95-1).

The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act (A.R.S. Title 41, Chapter 6) pursuant to A.R.S. § 41-1005(A)(18). Exemption from A.R.S. Title 41, Chapter 6 means that the Arizona Racing Commission did not submit these rules to the Governor's Regulatory Review Council for Review; the Commission did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Commission was not required to hold public hearings on these rules; and the Attorney General did not certify these rules.

R19-2-503. Pari-mutuel Tickets

A pari-mutuel ticket is evidence of a contribution to the pari-mutuel pool operated by the permittee and is evidence of the obligation of the permittee to pay to the holder thereof such portion of the distributable amount of the pari-mutuel pool as is represented by such valid pari-mutuel ticket. The permittee shall cash all valid winning tickets when such are presented for payment during the course of the meeting where sold, and for a one-year period after the last day of the meeting. Each pari-mutuel ticket purchaser agrees to abide by the terms and provisions of these rules, other applicable rules of the Arizona Racing Commission, and by the laws of the state of Arizona.

1. To be deemed a valid pari-mutuel ticket, such ticket shall have been issued by a pari-mutuel ticket machine operated by the permittee and recorded as a ticket entitled to a share of the pari-mutuel pool and contain imprinted information as to:
 - a. The name of the permittee operating the meeting,
 - b. A unique identifying number or code,
 - c. Identification of the terminal at which the ticket was issued,
 - d. A designation of the performance for which the wagering transaction was issued,

- e. The contest number for which the pool is conducted,
 - f. The type or types of wagers represented,
 - g. The number or numbers representing the betting interests for which the wager is recorded,
 - h. The amount or amounts of the contributions to the pari-mutuel pool or pools for which the ticket is evidence.
2. No pari-mutuel ticket recorded or reported as previously paid, cancelled, or nonexistent shall be deemed a valid pari-mutuel ticket by the permittee. The permittee may withhold payment and refuse to cash any pari-mutuel ticket deemed not valid, except as provided in R19-2-504(E) of these rules.

Historical Note

Adopted effective October 21, 1993, under an exemption from the Administrative Procedure Act pursuant to A.R.S. § 41-1005(A)(18) (Supp. 93-4). R19-2-503 recodified from R4-27-503 (Supp. 95-1).

The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act (A.R.S. Title 41, Chapter 6) pursuant to A.R.S. § 41-1005(A)(18). Exemption from A.R.S. Title 41, Chapter 6 means that the Arizona Racing Commission did not submit these rules to the Governor's Regulatory Review Council for Review; the Commission did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Commission was not required to hold public hearings on these rules; and the Attorney General did not certify these rules.

R19-2-504. Pari-mutuel Ticket Sales

- A. Pari-mutuel tickets shall not be sold by anyone other than a permittee licensed to conduct pari-mutuel wagering, and such tickets shall be sold within the enclosure in which authorized racing takes place and at all facilities pursuant to A.R.S. § 5-111 and A.R.S. § 5-112.
- B. No pari-mutuel ticket may be sold on a contest for which wagering has already been closed and no permittee shall be responsible for ticket sales entered into but not completed by issuance of a ticket before the totalisator is closed for wagering on such contest.
- C. Claims pertaining to a mistake on an issued or unissued ticket must be made by the bettor prior to leaving the seller's window.
- D. Payment on winning pari-mutuel wagers shall be made on the basis of the order of finish as purposely posted and declared "official." Any subsequent change in the order of finish or award of purse money as may result from a subsequent ruling by the stewards or Department shall in no way affect the pari-mutuel payoff. If an error in the posted order of finish or payoff figures is discovered, the official order of finish or payoff prices may be corrected and an announcement concerning the change shall be made to the public.
- E. The permittee shall not satisfy claims on lost, mutilated, or altered pari-mutuel tickets without authorization of the Department.
- F. The permittee shall have no obligation to enter a wager into a betting pool if unable to do so due to equipment failure.
- G. Pari-mutuel tickets shall neither be sold nor purchased by anyone under 18 years of age.

Historical Note

Adopted effective October 21, 1993, under an exemption from the Administrative Procedure Act pursuant to A.R.S. § 41-1005(A)(18) (Supp. 93-4). R19-2-504 recodified from R4-27-504 (Supp. 95-1).

The following Section was adopted under an exemption from

the provisions of the Administrative Procedure Act (A.R.S. Title 41, Chapter 6) pursuant to A.R.S. § 41-1005(A)(18). Exemption from A.R.S. Title 41, Chapter 6 means that the Arizona Racing Commission did not submit these rules to the Governor's Regulatory Review Council for Review; the Commission did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Commission was not required to hold public hearings on these rules; and the Attorney General did not certify these rules.

R19-2-505. Advance Performance Wagering

No permittee shall permit wagering to begin more than one day before scheduled post time of the first contest of a performance unless it has first obtained the authorization of the Department.

Historical Note

Adopted effective October 21, 1993, under an exemption from the Administrative Procedure Act pursuant to A.R.S. § 41-1005(A)(18) (Supp. 93-4). R19-2-505 recodified from R4-27-505 (Supp. 95-1).

The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act (A.R.S. Title 41, Chapter 6) pursuant to A.R.S. § 41-1005(A)(18). Exemption from A.R.S. Title 41, Chapter 6 means that the Arizona Racing Commission did not submit these rules to the Governor's Regulatory Review Council for Review; the Commission did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Commission was not required to hold public hearings on these rules; and the Attorney General did not certify these rules.

R19-2-506. Claims for Payment from Pari-mutuel Pool

At a designated location, a written, verified claim for payment from a pari-mutuel pool shall be accepted by the permittee in any case where the permittee has withheld payment or has refused to cash a pari-mutuel wager. The claim shall be made on such form as approved by the Department, and the claimant shall make such claim under penalty of perjury. The original of such claim shall be forwarded to the Department within 48 hours.

- 1. In the case of a claim made for payment of a mutilated pari-mutuel ticket which does not contain the total imprinted elements required pursuant to R19-2-503(1) of these rules, the permittee shall make a recommendation to accompany the claim forwarded to the Department as to whether or not the mutilated ticket has sufficient elements to be positively identified as a winning ticket.
- 2. In the case of a claim made for payment on a pari-mutuel wager, the Department shall adjudicate the claim and may order payment thereon from the pari-mutuel pool or by the permittee, or may deny the claim, or may make such other order as it may deem proper.

Historical Note

Adopted effective October 21, 1993, under an exemption from the Administrative Procedure Act pursuant to A.R.S. § 41-1005(A)(18) (Supp. 93-4). R19-2-506 recodified from R4-27-506 (Supp. 95-1).

The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act (A.R.S. Title 41, Chapter 6) pursuant to A.R.S. § 41-1005(A)(18). Exemption from A.R.S. Title 41, Chapter 6 means that the Arizona Racing Commission did not submit these rules to the Governor's Regulatory Review Council for Review; the Commission did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Commission was not required to hold public hearings on these rules; and the Attorney General did not certify these rules.

R19-2-507. Payment for Errors

If an error occurs in the payment amounts for pari-mutuel wagers which are cashed or entitled to be cashed and, as a result of such error, the pari-mutuel pool involved in the error is not correctly distributed among winning ticket holders, the following shall apply:

1. Verification is required to show that the amount of the commission, the amount in breakage, and the amount in payoffs is equal to the total gross pool. If the amount of the pool is more than the amount used to calculate the payoff, the underpayment shall be paid to the Department for deposit into the State Treasury.
2. Any claim not filed with the permittee within 30 days, inclusive of the date on which the underpayment was publicly announced, shall be deemed waived, and the permittee shall have no further liability therefore.
3. In the event the error results in an overpayment to winning wagers, the permittee shall be responsible for such payment.

Historical Note

Adopted effective October 21, 1993, under an exemption from the Administrative Procedure Act pursuant to A.R.S. § 41-1005(A)(18) (Supp. 93-4). R19-2-507 recodified from R4-27-507 (Supp. 95-1).

The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act (A.R.S. Title 41, Chapter 6) pursuant to A.R.S. § 41-1005(A)(18). Exemption from A.R.S. Title 41, Chapter 6 means that the Arizona Racing Commission did not submit these rules to the Governor's Regulatory Review Council for Review; the Commission did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Commission was not required to hold public hearings on these rules; and the Attorney General did not certify these rules.

R19-2-508. Betting Explanation

A summary explanation of pari-mutuel wagering and each type of betting pool offered shall be published in the program for every wagering performance. The rules of racing relative to each type of pari-mutuel pool offered must be prominently displayed on permittee grounds and available upon request through permittee representatives.

Historical Note

Adopted effective October 21, 1993, under an exemption from the Administrative Procedure Act pursuant to A.R.S. § 41-1005(A)(18) (Supp. 93-4). R19-2-508 recodified from R4-27-508 (Supp. 95-1).

The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act (A.R.S. Title 41, Chapter 6) pursuant to A.R.S. § 41-1005(A)(18). Exemption from A.R.S. Title 41, Chapter 6 means that the Arizona Racing Commission did not submit these rules to the Governor's Regulatory Review Council for Review; the Commission did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Commission was not required to hold public hearings on these rules; and the Attorney General did not certify these rules.

R19-2-509. Display of Betting Information

- A. Approximate odds for Win pool betting shall be posted on display devices within view of the wagering public and updated at intervals of not more than 90 seconds.
- B. The probable payoff or amounts wagered, in total and on each betting interest, for other pools shall be displayed to the wagering public at intervals and in a manner approved by the Department.

- C. Official results and payoffs must be displayed upon each contest being declared official.

Historical Note

Adopted effective October 21, 1993, under an exemption from the Administrative Procedure Act pursuant to A.R.S. § 41-1005(A)(18) (Supp. 93-4). R19-2-509 recodified from R4-27-509 (Supp. 95-1).

The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act (A.R.S. Title 41, Chapter 6) pursuant to A.R.S. § 41-1005(A)(18). Exemption from A.R.S. Title 41, Chapter 6 means that the Arizona Racing Commission did not submit these rules to the Governor's Regulatory Review Council for Review; the Commission did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Commission was not required to hold public hearings on these rules; and the Attorney General did not certify these rules.

R19-2-510. Cancelled Contests

- A. If a contest is cancelled or declared "no contest," refunds shall be granted on valid wagers in accordance with these rules.
- B. Should less than three contestants in a greyhound race finish, the contest shall be declared "no contest," and refunds shall be granted on valid wagers in accordance with these rules.

Historical Note

Adopted effective October 21, 1993, under an exemption from the Administrative Procedure Act pursuant to A.R.S. § 41-1005(A)(18) (Supp. 93-4). R19-2-510 recodified from R4-27-510 (Supp. 95-1).

The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act (A.R.S. Title 41, Chapter 6) pursuant to A.R.S. § 41-1005(A)(18). Exemption from A.R.S. Title 41, Chapter 6 means that the Arizona Racing Commission did not submit these rules to the Governor's Regulatory Review Council for Review; the Commission did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Commission was not required to hold public hearings on these rules; and the Attorney General did not certify these rules.

R19-2-511. Refunds

- A. Notwithstanding other provisions of these rules, refunds of the entire pool shall be made on:
 1. Win pools, Exacta pools, and first-half Double pools offered in contests in which the number of betting interests has been reduced to fewer than 2.
 2. Place pools, Quinella pools, Trifecta pools, first-half Quinella Double pools, first-half Twin Quinella pools, first-half Twin Trifecta pools, and first-half Tri-Superfecta pools offered in contests in which the number of betting interests has been reduced to fewer than 3.
 3. Show pools, Superfecta pools, and first-half Twin Superfecta pools offered in contests in which the number of betting interests has been reduced to fewer than 4.
- B. Authorized refunds shall be paid upon presentation and surrender of the affected pari-mutuel ticket.

Historical Note

Adopted effective October 21, 1993, under an exemption from the Administrative Procedure Act pursuant to A.R.S. § 41-1005(A)(18) (Supp. 93-4). R19-2-511 recodified from R4-27-511 (Supp. 95-1).

The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act (A.R.S. Title 41, Chapter 6) pursuant to A.R.S. § 41-1005(A)(18). Exemption

from A.R.S. Title 41, Chapter 6 means that the Arizona Racing Commission did not submit these rules to the Governor's Regulatory Review Council for Review; the Commission did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Commission was not required to hold public hearings on these rules; and the Attorney General did not certify these rules.

R19-2-512. Coupled Entries and Mutuel Fields

- A. Contestants coupled in wagering as a coupled entry or mutuel field shall be considered part of a single betting interest for the purpose of price calculations and distribution of pools. Should any contestant in a coupled entry or mutuel field be officially withdrawn or scratched, the remaining contestants in that coupled entry or mutuel field shall remain valid betting interests and no refunds will be granted. If all contestants within a coupled entry or mutuel field are scratched, then tickets on such betting interests shall be refunded, notwithstanding other provisions of these rules.
- B. For the purpose of price calculations only, coupled entries and mutuel fields shall be calculated as a single finisher, using the finishing position of the leading contestant in that coupled entry or mutuel field to determine order of placing. This rule shall apply to all circumstances, including situations involving a dead heat, except as otherwise provided by these rules.

Historical Note

Adopted effective October 21, 1993, under an exemption from the Administrative Procedure Act pursuant to A.R.S. § 41-1005(A)(18) (Supp. 93-4). R19-2-512 recodified from R4-27-512 (Supp. 95-1).

The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act (A.R.S. Title 41, Chapter 6) pursuant to A.R.S. § 41-1005(A)(18). Exemption from A.R.S. Title 41, Chapter 6 means that the Arizona Racing Commission did not submit these rules to the Governor's Regulatory Review Council for Review; the Commission did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Commission was not required to hold public hearings on these rules; and the Attorney General did not certify these rules.

R19-2-513. Pools Dependent upon Betting Interests

Unless the Department otherwise provides, at the time the pools are opened for wagering, the permittee:

1. May offer win, place, and show wagering on all contests with six or more betting interests.
2. May be allowed to prohibit show wagering on any contest with five or fewer betting interests scheduled to start.
3. May be allowed to prohibit place wagering on any contest with four or fewer betting interests scheduled to start.
4. May be allowed to prohibit Quinella wagering on any contest with three or fewer betting interests scheduled to start.
5. May be allowed to prohibit Quinella Double wagering on any contests with three or fewer betting interests scheduled to start.
6. May be allowed to prohibit Exacta wagering on any contest with three or fewer betting interests scheduled to start.
7. Shall prohibit Trifecta wagering on any horse racing contest with five or fewer betting interests scheduled to start. The permittee shall prohibit Trifecta wagering on any greyhound contest with five or fewer betting interests scheduled to start.
8. Shall prohibit Superfecta wagering on any contest with six or fewer betting interests scheduled to start.

9. May be allowed to prohibit Twin Quinella wagering on any contests with three or fewer betting interests scheduled to start.
10. Shall prohibit Twin Trifecta wagering on any contests with six or fewer betting interests scheduled to start.
11. Shall prohibit Tri-Superfecta wagering on any contests with seven or fewer betting interests scheduled to start.
12. Shall prohibit Twin Superfecta wagering on any contests with seven or fewer betting interests scheduled to start.
13. May prohibit wagering on any particular contestant or contestants in stakes races, if such exclusions are clearly indicated within the program.

Historical Note

Adopted effective October 21, 1993, under an exemption from the Administrative Procedure Act pursuant to A.R.S. § 41-1005(A)(18) (Supp. 93-4). R19-2-513 recodified from R4-27-513 (Supp. 95-1). Amended effective July 3, 1996 (Supp. 96-3). Amended by exempt rulemaking at 6 A.A.R. 786, effective February 1, 2000 (Supp. 00-1).

The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act (A.R.S. Title 41, Chapter 6) pursuant to A.R.S. § 41-1005(A)(18). Exemption from A.R.S. Title 41, Chapter 6 means that the Arizona Racing Commission did not submit these rules to the Governor's Regulatory Review Council for Review; the Commission did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Commission was not required to hold public hearings on these rules; and the Attorney General did not certify these rules.

R19-2-514. Prior Approval Required for Betting Pools

- A. A permittee that desires to offer new forms of wagering must apply in writing to the Department and receive written approval prior to implementing the new betting pool.
- B. The permittee may suspend previously approved forms of wagering with the prior approval of the Department. Any carryover shall be held until the suspended form of wagering is reinstated. A permittee may request approval of a form of wagering or separate wagering pool for specific performances.

Historical Note

Adopted effective October 21, 1993, under an exemption from the Administrative Procedure Act pursuant to A.R.S. § 41-1005(A)(18) (Supp. 93-4). R19-2-514 recodified from R4-27-514 (Supp. 95-1).

The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act (A.R.S. Title 41, Chapter 6) pursuant to A.R.S. § 41-1005(A)(18). Exemption from A.R.S. Title 41, Chapter 6 means that the Arizona Racing Commission did not submit these rules to the Governor's Regulatory Review Council for Review; the Commission did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Commission was not required to hold public hearings on these rules; and the Attorney General did not certify these rules.

R19-2-515. Closing of Wagering in a Contest

- A. A Department representative shall close wagering for each contest after which time no pari-mutuel tickets shall be sold for that contest.
- B. The permittee shall maintain, in good order, a system approved by the Department for closing wagering.
 1. Should the totalisator fail mechanically and become unreliable as to the amounts wagered, the payoff shall be

computed on the sums then wagered in each pool as shown by the recapitulation of the sales registered by each ticket-issuing device. If the pari-mutuel equipment renders such recapitulation impossible, all money wagered on the contest shall be refunded.

2. In the event that a breakdown of the totalisator cannot be repaired during wagering on a contest, the wagering for that contest shall be declared closed. The payoff for such a race shall be computed on the sums wagered in each pool prior to the breakdown, subject to the limitations of subsection (B)(1) of this Section.

Historical Note

Adopted effective October 21, 1993, under an exemption from the Administrative Procedure Act pursuant to A.R.S. § 41-1005(A)(18) (Supp. 93-4). R19-2-515 recodified from R4-27-515 (Supp. (5-1)).

The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act (A.R.S. Title 41, Chapter 6) pursuant to A.R.S. § 41-1005(A)(18). Exemption from A.R.S. Title 41, Chapter 6 means that the Arizona Racing Commission did not submit these rules to the Governor's Regulatory Review Council for Review; the Commission did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Commission was not required to hold public hearings on these rules; and the Attorney General did not certify these rules.

R19-2-516. Complaints Pertaining to Pari-mutuel Operations

- A. When a patron makes a complaint regarding the pari-mutuel department to a permittee, the permittee shall immediately issue a complaint report setting out:
 1. The name of the complainant;
 2. The nature of the complaint;
 3. The name of the persons, if any, against whom the complaint was made;
 4. The date of the complaint;
 5. The action taken or proposed to be taken, if any, by the permittee.
- B. The permittee shall submit every complaint report to the Department within 48 hours after the complaint was made.

Historical Note

Adopted effective October 21, 1993, under an exemption from the Administrative Procedure Act pursuant to A.R.S. § 41-1005(A)(18) (Supp. 93-4). R19-2-516 recodified from R4-27-516 (Supp. 95-1).

The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act (A.R.S. Title 41, Chapter 6) pursuant to A.R.S. § 41-1005(A)(18). Exemption from A.R.S. Title 41, Chapter 6 means that the Arizona Racing Commission did not submit these rules to the Governor's Regulatory Review Council for Review; the Commission did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Commission was not required to hold public hearings on these rules; and the Attorney General did not certify these rules.

R19-2-517. Licensed Employees

All licensees shall report any known irregularities or wrongdoings by any person involving pari-mutuel wagering immediately to the Department and cooperate in subsequent investigations.

Historical Note

Adopted effective October 21, 1993, under an exemption from the Administrative Procedure Act pursuant to A.R.S. § 41-1005(A)(18) (Supp. 93-4). R19-2-517 recod-

ified from R4-27-517 (Supp. 95-1).

The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act (A.R.S. Title 41, Chapter 6) pursuant to A.R.S. § 41-1005(A)(18). Exemption from A.R.S. Title 41, Chapter 6 means that the Arizona Racing Commission did not submit these rules to the Governor's Regulatory Review Council for Review; the Commission did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Commission was not required to hold public hearings on these rules; and the Attorney General did not certify these rules.

R19-2-518. State Mutuel Supervisor

- A. The Director shall appoint a state mutuel supervisor who shall monitor the pari-mutuel department and wagering at all race meetings and additional wagering facilities.
- B. A permittee shall grant the state mutuel supervisor and Department unrestricted access to its facilities and equipment and to all books, ledgers, accounts, documents, and records pertaining to pari-mutuel wagering.
- C. The state mutuel supervisor shall receive all requested information from a permittee's officers and employees promptly and shall receive full cooperation while carrying out the duties of that office.
- D. The state mutuel supervisor shall report to the Director and stewards any failure of the permittee, including its officers and employees, to comply with both the provisions of these rules and the laws of the state of Arizona.

Historical Note

Adopted effective October 21, 1993, under an exemption from the Administrative Procedure Act pursuant to A.R.S. § 41-1005(A)(18) (Supp. 93-4). R19-2-518 recodified from R4-27-518 (Supp. 95-1).

The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act (A.R.S. Title 41, Chapter 6) pursuant to A.R.S. § 41-1005(A)(18). Exemption from A.R.S. Title 41, Chapter 6 means that the Arizona Racing Commission did not submit these rules to the Governor's Regulatory Review Council for Review; the Commission did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Commission was not required to hold public hearings on these rules; and the Attorney General did not certify these rules.

R19-2-519. Mutuel Manager

- A. In the event of an emergency in connection with the pari-mutuel department not covered in these rules, the mutuel manager representing the permittee shall report the problem to the stewards and the permittee, and the stewards shall render a full report to the Department within 48 hours.
- B. The mutuel manager shall be responsible for the correctness of all payoff prices posted on the odds board, subject to the limitations of nonfraudulent human and mechanical errors. In the event that a payoff is both incorrectly posted and paid, the mutuel manager shall file with the Department a complete report explaining the circumstances prior to the next racing day.
- C. The mutuel manager shall provide the Department with, upon request, complete and detailed reports of each race day; including the handle of each race, the total handle and attendance, the payoffs on each race, breakage and commission, opening and closing lines, and sellers' shortages and overages.

Historical Note

Adopted effective October 21, 1993, under an exemption from the Administrative Procedure Act pursuant to

A.R.S. § 41-1005(A)(18) (Supp. 93-4). R19-2-519 recodified from R4-27-519 (Supp. 95-1).

R19-2-520. Reserved

The following Section was adopted and subsequently amended under an exemption from the provisions of the Administrative Procedure Act (A.R.S. Title 41, Chapter 6) pursuant to A.R.S. § 41-1005(A)(18). Exemption from A.R.S. Title 41, Chapter 6 means that the Arizona Racing Commission did not submit these rules to the Governor's Regulatory Review Council for Review; the Commission did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Commission was not required to hold public hearings on these rules; and the Attorney General did not certify these rules.

R19-2-521. Simulcast Wagering

- A. The Department may authorize a racetrack permittee to conduct simulcasting as defined in A.R.S. § 5-101 pursuant to A.R.S. § 5-112 and the Interstate Horse Racing Act of 1978.
- B. A racetrack permittee shall submit a request for sending or receiving of simulcasts in writing to the Director of the Department.
- C. For approval of horse simulcasts, the Department requires the following:
 - 1. A completed simulcast agreement between a racetrack permittee and out-of-state entity specifying which races will be simulcast to or from each specific track involved in the agreement.
 - 2. Written approval of the out-of-state horsemen's group, if applicable.
 - 3. Written approval of the out-of-state racing commission.
 - 4. Written approval of the local horsemen's group. For purposes of this Section, horsemen's group is the group which represents the majority of the horsemen racing at or contracted with the racetrack permittee.
- D. For approval of greyhound simulcasts, the Department requires the following:
 - 1. A completed simulcast agreement between a racetrack permittee and out-of-state entity.
 - 2. Written approval of the out-of-state racing commission.
- E. Withdrawal of any of the written approvals required in subsections (C) and (D) shall at any time constitute grounds for the Department to rescind authorization for simulcasting.
- F. Additional Wagering Facilities
 - 1. A racetrack permittee may conduct simulcasting at the racetrack enclosure and at any additional wagering facility operated by the racetrack permittee providing that the additional wagering facility is included in the simulcast agreement.
 - 2. A racetrack permittee may send its simulcast signal to an out-of-state racetrack enclosure and any additional wagering facilities operated or used by the out-of-state entity providing all locations receiving the simulcast signal are included in the simulcast agreement.
- G. Duties of Sending Racetrack Permittee
 - 1. The sending racetrack permittee is responsible for content of the simulcast and shall use all reasonable effort to present a simulcast which offers the viewers an exemplary depiction of each performance.
 - 2. Unless otherwise permitted by the Department, every simulcast will contain in its video content a digital signal of actual time of day, the name of the host facility from where it emanates, the number of the contest being displayed, and any other relevant information available to patrons at the sending facility.

- 3. The sending racetrack permittee shall maintain such security controls including encryption over its uplink and communications systems as directed or approved by the Department.

H. Duties of Receiving Racetrack Permittee

- 1. A receiving racetrack permittee conducting a live commercial racing meeting in this state may conduct and operate a pari-mutuel wagering system on the results of contests being held or conducted and simulcast from the enclosures of one or more sending racetrack permittees outside this state and with approval of the Department.
- 2. Receiving racetrack permittee shall provide:
 - a. Adequate transmitting and receiving equipment of acceptable broadcast quality, which shall not interfere with the closed-circuit TV system of the sending racetrack permittee for providing any sending facility patron information.
 - b. Pari-mutuel terminals, pari-mutuel odds displays, modems, and switching units enabling pari-mutuel data transmissions, and data communications between the sending and receiving racetrack permittees.
 - c. A voice communication system between receiving racetrack permittee and the sending racetrack permittee providing timely voice contact among the Department designees, placing judges, and pari-mutuel departments.
 - d. A monthly copy of the simulcast schedule and any amendments to that schedule to the Department.
- 3. A receiving racetrack permittee shall conduct pari-mutuel wagering pursuant to the applicable Department rules.
- 4. With the exception of the cases in subsection (I)(1), at all times the live video signal shall be shown to the wagering public.
- 5. The Department may appoint at least one designee to supervise all approved simulcast facilities and may require additional designees as is reasonably necessary for the protection of the public interest.

I. Acquisition and Subsequent Loss of Simulcast Video Signal

- 1. Should a video breakdown occur in the display of the race and wagering information, the permittee shall immediately contact the Director or the Director's designee. Wagering may continue at the permittee racetrack location on the affected racing program for the remainder of that racing day provided the following conditions are met:
 - a. The racetrack permittee shall notify the wagering public of the nature of the breakdown;
 - b. The racetrack permittee shall make immediate and continuing efforts to repair the video breakdown;
 - c. The racetrack permittee shall provide the Director a written report concerning the circumstances within 48 hours of any such breakdown;
 - d. The racetrack permittee shall not accept wagers at the racetrack enclosure on the affected racing program for any performance on a subsequent racing day until the breakdown has been repaired. The Director may, upon written request, authorize the racetrack permittee to accept wagers despite an ongoing video breakdown;
 - e. If there is not a reasonable expectation of video reception, the racetrack permittee shall not accept wagers on the affected racing program. The Director may, upon written request, authorize the racetrack permittee to accept wagers despite an ongoing video breakdown;

- f. For separate pool simulcast wagering, the racetrack permittee shall ensure that the voice communication line between the Arizona Stewards and their out-of-state counterpart remains intact;
 - g. For common pool simulcast wagering, the racetrack permittee shall ensure that the core-to-core link between the Arizona permittee's tote system and the out-of-state tote system remains intact.
2. In accordance with R19-2-505, the racetrack permittee may request in writing to the Director the authorization to conduct advance performance wagering.

Historical Note

Adopted effective October 21, 1993, under an exemption from the Administrative Procedure Act pursuant to A.R.S. § 41-1005(A)(18) (Supp. 93-4). R19-2-521 recodified from R4-27-521 (Supp. 95-1). Amended effective February 17, 1998, under an exemption from the Administrative Procedure Act pursuant to A.R.S. § 41-1005(A)(18) (Supp. 98-1). Amended effective July 22, 1998, pursuant to an exemption under the Administrative Procedure Act. (Supp. 98-3). Amended by exempt rulemaking at 5 A.A.R. 532, effective January 29, 1999 (Supp. 99-1). Amended by exempt rulemaking at 5 A.A.R. 2176, effective June 15, 1999 (Supp. 99-2).

The following Section was adopted and subsequently amended under an exemption from the provisions of the Administrative Procedure Act (A.R.S. Title 41, Chapter 6) pursuant to A.R.S. § 41-1005(A)(18). Exemption from A.R.S. Title 41, Chapter 6 means that the Arizona Racing Commission did not submit these rules to the Governor's Regulatory Review Council for Review; the Commission did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Commission was not required to hold public hearings on these rules; and the Attorney General did not certify these rules.

R19-2-522. Interstate Common Pool Wagering

A. General

- 1. All contracts governing participation by a racetrack permittee in interstate common pools shall be submitted to the Department for approval.
- 2. Individual wagering transactions are made at the point of sale in the state where placed. Pari-mutuel pools are combined solely for computing odds and calculating payoffs but will be held separate for auditing and all other purposes.
- 3. Any surcharges or withholdings in addition to the takeout shall only be applied in the jurisdiction otherwise imposing such surcharges or withholdings.
- 4. The content and format of the visual display of racing and wagering information at facilities in other jurisdictions where wagering is permitted in the interstate common pool need not be identical to the similar information permitted or required to be displayed under these rules.
- 5. A racetrack permittee may only participate in common pool wagering on the same type of racing as authorized by the permit for live racing conducted by the racetrack permittee.

B. Participation in Interstate Common Pools by Receiving Racetrack Permittee

- 1. With the prior approval of the Department, pari-mutuel wagering pools may be combined with corresponding wagering pools at the sending facility outside of this state.
- 2. The Department may permit adjustment of the takeout from the pari-mutuel pool so that the takeout rate in this

jurisdiction is identical to that at the sending track (within the limits permitted by state law).

- 3. Where takeout rates in the merged pool are not identical, the net price calculation shall be the method by which the differing takeout rates are applied.
- 4. Rules of racing as established for the contest in the sending track shall apply to the merged pool.
- 5. The Department shall approve agreements made between the racetrack permittee and other participants in interstate common pools governing the distribution of breakage between the jurisdictions.
- 6. If, for any reason, it becomes impossible to successfully merge the bets placed into the interstate common pool, the racetrack permittee shall make payoffs in accordance with payoff prices that would have been in effect if prices for the pool of bets were calculated without regard to wagers placed elsewhere; except that, with permission of the Department, the racetrack permittee may alternatively determine to either pay winning tickets at the payoff prices at the sending track or declare such accepted bets void and make refunds in accordance with the applicable rules.

C. Participation in Merged Pools by Sending Racetrack Permittee

- 1. With the prior approval of the Department, a racetrack permittee conducting a live racing meeting and conducting pari-mutuel wagering may determine that all or part of its racing program be utilized for pari-mutuel wagering by sending all or part of its racing program to facilities outside this state and may also determine that pari-mutuel pools at such facilities be combined with corresponding wagering pools established by it as the sending track.
- 2. Rules of racing established for races held in this state shall also apply to interstate common pools unless the Department shall have specifically otherwise determined.
- 3. The Department shall approve agreements made between the racetrack permittee and other participants in interstate common pools governing the distribution of breakage between the jurisdictions.
- 4. Any contract for interstate common pools entered into by the racetrack permittee shall contain a provision to the effect that if, for any reason, it becomes impossible to successfully merge the bets placed in another state into the interstate common pool formed by the racetrack permittee, or if, for any reason, the Department's or the racetrack permittee's representative determines that attempting to effect transfer of pool data from the receiving facility may endanger the racetrack permittee's wagering pool, the racetrack permittee shall have no liability for any measures taken which may result in the receiving facility's wagers not being accepted into the pool.
- 5. Amounts wagered in an interstate common pool other than amounts wagered within this state shall not be considered part of the racetrack permittee's pari-mutuel wagering pool for purposes of A.R.S. § 5-111. A racetrack permittee may charge a fee to a receiving facility or location outside this state for the privilege of conducting pari-mutuel wagering on the race and participating in the interstate common pool and for payment of costs incurred to transmit the broadcast of the race.
- 6. Should a racetrack permittee experience a breakdown in the sending of the video signal while conducting interstate common pool wagering, the racetrack permittee:
 - a. Shall notify all receiving locations of the technical difficulties being experienced;

- b. May continue to accept wagers from the receiving out-of-state locations provided there is compliance with the guest site's governing agency.

D. Takeout Rates in Interstate Common Pools. With prior approval of the Department, a racetrack permittee wishing to participate in an interstate common pool may change its takeout rate (within the limits permitted by state law) so as to achieve a common pool takeout rate with all other participants in the interstate common pool.

Historical Note

Adopted effective October 21, 1993, under an exemption from the Administrative Procedure Act pursuant to A.R.S. § 41-1005(A)(18) (Supp. 93-4). R19-2-522 recodified from R4-27-522 (Supp. 95-1). Amended effective February 17, 1998, under an exemption from the Administrative Procedure Act pursuant to A.R.S. § 41-1005(A)(18) (Supp. 98-1). Amended by exempt rulemaking at 5 A.A.R. 532, effective January 29, 1999 (Supp. 99-1).

The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act (A.R.S. Title 41, Chapter 6) pursuant to A.R.S. § 41-1005(A)(18). Exemption from A.R.S. Title 41, Chapter 6 means that the Arizona Racing Commission did not submit these rules to the Governor's Regulatory Review Council for Review; the Commission did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Commission was not required to hold public hearings on these rules; and the Attorney General did not certify these rules.

R19-2-523. Calculation of Payoffs and Distribution of Pools

A. General

1. All permitted pari-mutuel wagering pools shall be separately and independently calculated and distributed. Takeout shall be deducted from each gross pool as stipulated by law. The remainder of the monies in the pool shall constitute the net pool for distribution as payoff on winning wagers.
2. For each wagering pool, the amount wagered on the winning betting interest or betting combinations is deducted from the net pool to determine the profit; the profit is then divided by the amount wagered on the winning betting interest or combinations, such quotient being the profit per dollar.
3. Either the standard or net price calculation procedure may be used to calculate single commission pools, while the net price calculation procedure must be used to calculate multi-commission pools.

a. Standard Price Calculation Procedure

SINGLE PRICE POOL (WIN POOL)

gross pool	=	sum of wagers on all betting interests - refunds
takeout	=	gross pool x percent takeout
net pool	=	gross pool - takeout
profit	=	net pool - gross amount bet on winner
profit per dollar	=	profit / gross amount bet on winner
\$1 unbroken price	=	profit per dollar + \$1
\$1 broken price	=	\$1 unbroken price rounded down to the break point

total payout	=	\$1 broken price x gross amount bet on winner
total breakage	=	net pool - total payout

PROFIT SPLIT (PLACE POOL)

Profit is net pool less gross amount bet on all place finishers. Finishers split profit 1/2 and 1/2 (place profit), then divide by gross amount bet on each place finisher for two unique prices.

PROFIT SPLIT (SHOW POOL)

Profit is net pool less gross amount bet on all show finishers. Finishers split profit 1/3 and 1/3 and 1/3 (show profit), then divide by gross amount bet on each show finisher for three unique prices.

b. Net Price Calculation Procedure

SINGLE PRICE POOL (WIN POOL)

gross pool	=	sum of wagers on all betting interests - refunds
takeout	=	gross pool x percent takeout

* for each source:

net pool	=	gross pool - takeout
net bet on winner	=	gross amount bet on winner x (1 - percent takeout)

total net pool	=	sum of all sources net pools
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total net bet on winner	=	sum of all sources net bet on winner
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total profit	=	total net pool - total net bet on winner
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profit per dollar	=	total profit / total net bet on winner
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\$1 unbroken base price	=	profit per dollar + \$1
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* for each source:

\$1 unbroken price	=	\$1 unbroken base price x (1 - percent takeout)
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\$1 broken price	=	\$1 unbroken price rounded down to the break point
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total payout	=	\$1 broken price x gross amount bet on winner
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total breakage	=	net pool - total payout
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PROFIT SPLIT (PLACE POOL)

Total profit is the total net pool less the total net amount bet on all place finishers. Finishers split total profit 1/2 and 1/2 (place profit), then divide by total net amount bet on each place finisher for two unique unbroken base prices.

PROFIT SPLIT (SHOW POOL)

Total profit is the total net pool less the total net amount bet on all show finishers. Finishers split total profit 1/3 and 1/3 and 1/3 (show profit), then divide by total net amount bet on each show finisher for three unique unbroken base prices.

4. If a profit split results in only one covered winning betting interest or combinations, it shall be calculated the same as a single price pool.
5. Minimum payoffs and the method used for calculating breakage shall be established by the Department.

6. The individual pools outlined in these rules may be given alternative names by each permittee, provided prior approval is obtained from the Department.
- B. Win Pools**
1. The amount wagered on the betting interest which finishes first is deducted from the net pool, the balance remaining being the profit; the profit is divided by the amount wagered on the betting interest finishing first, such quotient being the profit per dollar wagered to Win on that betting interest.
 2. The net Win pool shall be distributed as a single price pool to winning wagers in the following precedence, based upon the official order of finish:
 - a. To those whose selection finished first; but if there are no such wagers, then
 - b. To those whose selection finished second; but if there are no such wagers, then
 - c. To those whose selection finished third; but if there are no such wagers, then
 - d. The entire pool shall be refunded on Win wagers for that contest.
 3. If there is a dead heat for first involving:
 - a. Contestants representing the same betting interest, the Win pool shall be distributed as if no dead heat occurred.
 - b. Contestants representing two or more betting interests, the Win pool shall be distributed as a profit split.

Table 1: WIN POOL
(Standard Price Calculation)

Sum of Wagers on All Betting Interests	=	\$194,230.00
Refunds	=	\$1,317.00
Gross Pool:		
Sum of Wagers on All Betting Interests - Refunds	=	\$192,913.00
Percent Takeout	=	18%
Takeout:		
Gross Pool x Percent Takeout	=	\$34,724.34
Net Pool:		
Gross Pool - Takeout	=	\$158,188.66
Gross Amount Bet on Winner	=	\$23,872.00
Profit:		
Net Pool - Gross Amount Bet on Winner	=	\$134,316.66
Profit Per Dollar:		
Profit / Gross Amount Bet on Winner	=	\$5.6265357
\$1 Unbroken Price:		
Profit Per Dollar + \$1	=	\$6.6265357

- C. Place Pools**
1. The amounts wagered to Place on the first two betting interests to finish are deducted from the net pool, the balance remaining being the profit; the profit is divided into two equal portions, one being assigned to each winning betting interest and divided by the amount wagered to Place on that betting interest, the resulting quotient is the profit per dollar wagered to Place on that betting interest.
 2. The net Place pool shall be distributed to winning wagers in the following precedence, based upon the official order of finish:
 - a. If contestants of a coupled entry or mutuel field finished in the first two places, as a single price pool to those who selected the coupled entry or mutuel field; otherwise
 - b. As a profit split to those whose selection is included within the first two finishers; but if there are no such wagers on one of those two finishers, then
 - c. As a single price pool to those who selected the one covered betting interest included within the first two finishers; but if there are no such wagers, then
 - d. As a single price pool to those who selected the third-place finisher, but if there are no such wagers, then
 - e. The entire pool shall be refunded on Place wagers for that contest.
 3. If there is a dead heat for first involving:
 - a. Contestants representing the same betting interest, the Place pool shall be distributed as a single price pool.
 - b. Contestants representing two or more betting interests, the Place pool shall be distributed as a profit split.
 4. If there is a dead heat for second involving:
 - a. Contestants representing the same betting interest, the Place pool shall be distributed as if no dead heat occurred.
 - b. Contestants representing two or more betting interests, the Place pool is divided with half of the profit distributed to Place wagers on the betting interest finishing first and the remainder is distributed equally amongst Place wagers on those betting interests involved in the dead heat for second.

Table 2: PLACE POOL

(Standard Price Calculation)

Sum of Wagers on All Betting Interests	=	\$194,230.00
Refunds	=	\$1,317.00
Gross Pool:		
Sum of Wagers on All Betting Interests - Refunds	=	\$192,913.00
Percent Takeout	=	18%
Takeout		
Gross Pool x Percent Takeout	=	\$34,724.34
Net Pool:		
Gross Pool - Takeout	=	\$158,188.66
Gross Amount Bet on first place finisher	=	\$23,872.00
Gross amount Bet on second place finisher	=	\$12,500.00
Profit:		
Net Pool - Gross Amount Bet on first place finisher - Gross Amount Bet on second place finisher	=	\$121,816.66
Place Profit:		
Profit / 2	=	\$60,908.33
Profit Per Dollar for first place:		
Place Profit / Gross Amount Bet on first place finisher	=	\$2.5514548
\$1 Unbroken Price for first place:		
Profit Per Dollar for first place + \$1	=	\$3.5514548
Profit Per Dollar for second place:		
Place Profit / Gross Amount Bet on second place finisher	=	\$4.8726664
\$1 Unbroken Price for second place:		
Profit Per Dollar for second place + \$1	=	\$5.8726664

D. Show Pools

1. The amounts wagered to Show on the first three betting interests to finish are deducted from the net pool, the balance remaining being the profit; the profit is divided into three equal portions, one being assigned to each winning betting interest and divided by the amount wagered to Show on that betting interest, the resulting quotient being the profit per dollar wagered to Show on that betting interest.
2. The net Show pool shall be distributed to winning wagers in the following precedence, based upon the official order of finish:
 - a. If contestants of a coupled entry or mutuel field finished in the first three places, as a single price pool to those who selected the coupled entry or mutuel field; otherwise
 - b. If contestants of a coupled entry or mutuel field finished as two of the first three finishers, the profit is divided with two-thirds distributed to those who selected the coupled entry or mutuel field and one-third distributed to those who selected the other betting interest included within the first three finishers; otherwise
 - c. As a profit split to those whose selection is included within the first three finishers; but if there are no such wagers on one of those three finishers, then
 - d. As a profit split to those who selected one of the two covered betting interests included within the first three finishers; but if there are no such wagers on two of those three finishers, then
 - e. As a single price pool to those who selected the one covered betting interest included within the first three finishers; but if there are no such wagers, then
 - f. As a single price pool to those who selected the fourth-place finisher; but if there are no such wagers, then
 - g. The entire pool shall be refunded on Show wagers for that contest.
3. If there is a dead heat for first involving:
 - a. Two contestants representing the same betting interest, the profit is divided with 2/3rds distributed to those who selected the first-place finishers and one-third distributed to those who selected the betting interest finishing third.
 - b. Three contestants representing a single betting interest, the Show pool shall be distributed as a single price pool.
 - c. Contestants representing two or more betting interests, the Show pool shall be distributed as a profit split.
4. If there is a dead heat for second involving:
 - a. Contestants representing the same betting interest, the profit is divided with one-third distributed to those who selected the betting interest finishing first and two-thirds distributed to those who selected the second-place finishers.
 - b. Contestants representing two betting interests, the Show pool shall be distributed as a profit split.
 - c. Contestants representing three betting interests, the Show pool is divided with one-third of the profit distributed to Show wagers on the betting interest finishing first and the remainder is distributed equally among Show wagers on those betting interests involved in the dead heat for second.
5. If there is a dead heat for third involving:

- a. Contestants representing the same betting interest, the Show pool shall be distributed as if no dead heat occurred.
- b. Contestants representing two or more betting interests, the Show pool is divided with 2/3rds of the profit distributed to Show wagers on the betting interests finishing first and second and the remainder is distributed equally among Show wagers on those betting interests involved in the dead heat for third.

Table 3: SHOW POOL

(Standard Price Calculation)

Sum of Wagers on All Betting Interests	=	\$194,230.00
Refunds	=	\$1,317.00
Gross Pool:		
Sum of Wagers on All Betting Interests - Refunds	=	\$192,913.00
Percent Takeout	=	18%
Takeout		
Gross Pool x Percent Takeout	=	\$34,724.34
Net Pool:		
Gross Pool - Takeout	=	\$158,188.66
Gross Amount Bet on first place finisher	=	\$23,872.00
Gross Amount Bet on second place finisher	=	\$12,500.00
Gross Amount Bet on third place finisher	=	\$4,408.00
Profit: Net Pool		
- Gross Amount Bet on first place finisher		
- Gross Amount Bet on second place finisher		
- Gross Amount Bet on third place finisher	=	\$117,408.66
Show Profit:		
Profit / 3	=	\$39,136.22
Profit Per Dollar for first place:		
Show Profit / Gross Amount Bet on first place finisher	=	\$1.6394194
\$1 Unbroken Price for first place:		
Profit Per Dollar for first place + \$1	=	\$2.6394194
Profit Per Dollar for second place:		
Show Profit / Gross Amount Bet on second place finisher	=	\$3.1308976
\$1 Unbroken Price for second place		
Profit Per Dollar for second place + \$1	=	\$4.1308976
Profit Per Dollar for third place:		
Show Profit / Gross Amount Bet on third place finisher	=	\$8.8784528
\$1 Unbroken Price for third place		
Profit Per Dollar for third place + \$1	=	\$9.8784528

Table 4: SHOW POOL

Single Takeout Rate & Single Betting Source

(Net Price Calculation)

Sum of Wagers on All Betting Interests	=	\$194,230.00
Refunds	=	\$1,317.00
Gross Pool:		
Sum of Wagers on All Betting Interests - Refunds	=	\$192,913.00
Percent Takeout	=	18%
Takeout:		
Gross Pool x Percent Takeout	=	\$34,724.34
Total Net Pool:		
Gross Pool - Takeout	=	\$158,188.66
Gross Amount Bet on first place finisher	=	\$23,872.00
Net Amount Bet on first place finisher	=	\$19,575.04
Gross Amount Bet on second place finisher	=	\$12,500.00
Net Amount bet on second place finisher	=	\$10,250.00
Gross Amount Bet on third place finisher	=	\$4,408.00
Net Amount Bet on third place finisher	=	\$3,614.56
Total Net Bet on Winners:		
Net Amount Bet on first place finisher +		
Net Amount Bet on second place finisher +		
Net Amount Bet on third place finisher	=	\$33,439.60
Total Profit:		
Total Net Pool - Total Net Bet on Winners	=	\$124,749.06
Show Profit:		
Total Profit / 3	=	\$41,583.02
Profit Per Dollar for first place:		
Show Profit / Net Amount Bet on first place finisher	=	\$2.1242879
\$1 Unbroken Base Price for first place:		
Profit Per Dollar for first place + \$1	=	\$3.1242879
\$1 Unbroken Price for first place:		
\$1 Unbroken Base Price for first place x (1 -		
percent takeout)	=	\$2.5619161
Profit Per Dollar for second place:		
Show Profit / Net Amount Bet on second place finisher	=	\$4.0568800
\$1 Unbroken Base Price for second place:		
Profit Per Dollar for second place + \$1	=	\$5.0568800
\$1 Unbroken Price for second place:		
\$1 Unbroken Base Price for second place x (1 -		
percent takeout)	=	\$4.1466416
Profit Per Dollar for third place:		
Show Profit / Net Amount Bet on third place finisher	=	\$11.504310
\$1 Unbroken Base Price for third place:		
Profit Per Dollar for third place + \$1	=	\$12.504310
Unbroken Price for third place:		
\$1 Unbroken Base Price for third place x (1 -		
percent takeout)	=	\$10.253534

E. Double Pools

1. The Double requires selection of the first-place finisher in each of two specified contests.
2. The net Double pool shall be distributed to winning wagers in the following precedence, based upon the official order of finish:
 - a. As a single price pool to those whose selection finished first in each of the two contests; but if there are no such wagers, then
 - b. As a profit split to those who selected the first-place finisher in either of the two contests; but if there are no such wagers, then
 - c. As a single price pool to those who selected the one covered first-place finisher in either contest; but if there are no such wagers, then
 - d. As a single price pool to those whose selection finished second in each of the two contests; but if there are no such wagers, then

- e. The entire pool shall be refunded on Double wagers for those contests.
3. If there is a dead heat for first in either of the two contests involving:
 - a. Contestants representing the same betting interest, the Double pool shall be distributed as if no dead heat occurred.
 - b. Contestants representing two or more betting interests, the Double pool shall be distributed as a profit split if there is more than one covered winning combination.
4. Should a betting interest in the first-half of the Double be scratched prior to the first Double contest being declared official, all money wagered on combinations including the scratched betting interest shall be deducted from the Double pool and refunded.
5. Should a betting interest in the second-half of the Double be scratched prior to the close of wagering on the first Double contest, all money wagered on combinations including the scratched betting interest shall be deducted from the Double pool and refunded.
6. Should a betting interest in the second-half of the Double be scratched after the close of wagering on the first Double contest, all wagers combining the winner of the first contest with the scratched betting interest in the second

contest shall be allocated a consolation payoff. In calculating the consolation payoff the net Double pool shall be divided by the total amount wagered on the winner of the first contest and an unbroken consolation price obtained. The broken consolation price is multiplied by the dollar value of wagers on the winner of the first contest combined with the scratched betting interest to obtain the consolation payoff. Breakage is not declared in this calculation. The consolation payoff is deducted from the net Double pool before calculation and distribution of the winning Double payoff. Dead heats including separate betting interests in the first contest shall result in a consolation payoff calculated as a profit split.

7. If either of the Double contests are cancelled prior to the first Double contest, or the first Double contest is declared "no contest," the entire Double pool shall be refunded on Double wagers for those contests.
8. If the second Double contest is cancelled or declared "no contest" after the conclusion of the first Double contest, the net Double pool shall be distributed as a single price pool to wagers selecting the winner of the first Double contest. In the event of a dead heat involving separate betting interests, the net Double pool shall be distributed as a profit split.

Table 5: DOUBLE POOL

(Standard Price Calculation)

Sum of Wagers on All Betting Interests	=	\$194,230.00
Refunds	=	\$1,317.00
Gross Pool:		
Sum of Wagers on All Betting Interests - Refunds	=	\$192,913.00
Percent Takeout	=	18%
Takeout:		
Gross Pool x Percent Takeout	=	\$34,724.34
Net Pool:		
Gross Pool - Takeout	=	\$158,188.66
Gross Amount Bet on Winning Combination	=	\$23,872.00
Profit:		
Net Pool - Gross Amount Bet on Winning Combination	=	\$134,316.66
Profit Per Dollar:		
Profit / Gross Amount Bet on Winning Combination	=	\$5.6265357
\$1 Unbroken Price:		
Profit Per Dollar + \$1	=	\$6.6265357

Table 6: DOUBLE POOL

CONSOLATION PRICING

Sum of Wagers on All Betting Interests	=	\$194,230.00
Refunds	=	\$1,317.00
Gross Pool:		
Sum of Wagers on All Betting Interests - Refunds	=	\$192,913.00
Percent Takeout	=	18%
Takeout:		
Gross Pool x Percent Takeout	=	\$34,724.34
Net Pool:		
Gross Pool - Takeout	=	\$158,188.66
Consolation Pool:		
Sum Total Amount Bet on winner of the first contest with all second contest betting interests	=	\$43,321.00
\$1 Consolation Unbroken Consolation Price:		
Net Pool / Consolation Pool	=	\$3.6515468
\$1 Consolation Broken Price	=	\$3.65
Amount Bet on winner of the first contest with scratched betting interests:	=	\$1,234.00
Consolation Liability:		
\$1 Consolation Broken Price x (Amount Bet on the winner of the first contest with scratched betting interests)	=	\$4,504.10
Adjusted Net Pool:		
Net Pool - Consolation Liability	=	\$153,684.56
Gross Amount Bet on the Winning Combination	=	\$23,872.00
Profit:		
Adjusted Net Pool - Gross Amount Bet on the Winning Combination	=	\$129,812.56
Profit Per Dollar:		
Profit / Gross Amount Bet on the Winning Combination	=	\$5.4378586
\$1 Unbroken Price:		
Profit Per Dollar + \$1	=	\$6.4378586

F. Pick 3 Pools

1. The Pick 3 requires selection of the first-place finisher in each of three specified contests.
2. The net Pick 3 pool shall be distributed to winning wagers in the following precedence, based upon the official order of finish:
 - a. As a single price pool to those whose selection finished first in each of the three contests; but if there are no such wagers, then
 - b. As a single price pool to those who selected the first-place finisher in any two of the three contests; but if there are no such wagers, then
 - c. As a single price pool to those who selected the first-place finisher in any one of the three contests; but if there are no such wagers, then
 - d. The entire pool shall be refunded on Pick 3 wagers for those contests.
3. If there is a dead heat for first in any of the three contests involving:
 - a. Contestants representing the same betting interest, the Pick 3 pool shall be distributed as if no dead heat occurred.
 - b. Contestants representing two or more betting interests, the Pick 3 pool shall be distributed as a single

price pool with each winning wager receiving an equal share of the profit.

4. Should a betting interest in any of the three Pick 3 contests be scratched, the actual favorite, as evidenced by total amounts wagered in the Win pool at the close of wagering on that contest, shall be substituted for the scratched betting interest for all purposes, including pool calculations. In the event that the Win pool total for two or more favorites is identical, the substitute selection shall be the betting interest with the lowest program number. The totalisator shall produce reports showing each of the wagering combinations with substituted betting interests which became winners as a result of the substitution, in addition to the normal winning combination.
5. If all three Pick 3 contests are cancelled or declared "no contest," the entire pool shall be refunded on Pick 3 wagers for those contests.
6. If one or two of the Pick 3 contests are cancelled or declared "no contest," the Pick 3 pool shall remain valid and shall be distributed in accordance with subsection (F)(2) of this rule.

G. Pick (n) Pools

1. The Pick (n) requires selection of the first-place finisher in each of a designated number of contests. The permittee

must obtain written approval from the Department concerning the scheduling of Pick (n) contests, the designation of one of the methods prescribed in subsection (G)(2), and the amount of any cap to be set on the carryover. Any changes to the approved Pick (n) format require prior approval from the Department.

2. The Pick (n) pool shall be apportioned under one of the following methods:

- a. *Method 1, Pick (n) with Carryover:* The net Pick (n) pool and carryover, if any, shall be distributed as a single price pool to those who selected the first-place finisher in each of the Pick (n) contests, based upon the official order of finish. If there are no such wagers, then a designated percentage of the net pool shall be distributed as a single price pool to those who selected the first-place finisher in the greatest number of Pick (n) contests; and the remainder shall be added to the carryover.
- b. *Method 2, Pick (n) with Minor Pool and Carryover:* The major share of the net Pick (n) pool and the carryover, if any, shall be distributed to those who selected the first-place finisher in each of the Pick (n) contests, based upon the official order of finish. The minor share of the net Pick (n) pool shall be distributed to those who selected the first-place finisher in the second greatest number of Pick (n) contests, based upon the official order of finish. If there are no wagers selecting the first-place finisher of all Pick (n) contests, the minor share of the net Pick (n) pool shall be distributed as a single price pool to those who selected the first-place finisher in the greatest number of Pick (n) contests; and the major share shall be added to the carryover.
- c. *Method 3, Pick (n) with No Minor Pool and No Carryover:* The net Pick (n) pool shall be distributed as the single price pool to those who selected the first-place finisher in the greatest number of Pick (n) contests, based upon the official order of finish. If there are no winning wagers, the pool is refunded.
- d. *Method 4, Pick (n) with Minor Pool and No Carryover:* The major share of the net Pick (n) pool shall be distributed to those who selected the first-place finisher in the greatest number of Pick (n) contests, based upon the official order of finish. The minor share of the net Pick (n) pool shall be distributed to those who selected the first-place finisher in the second greatest number of Pick (n) contests, based upon the official order of finish. If there are no wagers selecting the first-place finisher in a second greatest number of Pick (n) contests, the minor share of the net Pick (n) pool shall be combined with the major share for distribution as a single price pool to those who selected the first-place finisher in the greatest number of Pick (n) contests. If the greatest number of first-place finishers selected is 1, the major and minor shares are combined for distribution as a single price pool. If there are no winning wagers, the pool is refunded.
- e. *Method 5, Pick (n) with Minor Pool and No Carryover:* The major share of net Pick (n) pool shall be distributed to those who selected the first-place finisher in each of the Pick (n) contests, based upon the official order of finish. The minor share of the net Pick (n) pool shall be distributed to those who selected the first-place finisher in the second greatest number of Pick (n) contests, based upon the official

order of finish. If there are no wagers selecting the first-place finisher in all Pick (n) contests, the entire net Pick (n) pool shall be distributed as a single pool to those who selected the first-place finisher in the greatest number of Pick (n) contests. If there are no wagers selecting the first-place finisher in a second greatest number of Pick (n) contests, the minor share of the net Pick (n) pool shall be combined with the major share for distribution as a single price pool to those who selected the first-place finisher in each of the Pick (n) contests. If there are no winning wagers, the pool is refunded.

3. If there is a dead heat for first in any of the Pick (n) contests involving:
 - a. Contestants representing the same betting interest, the Pick (n) pool shall be distributed as if no dead heat occurred.
 - b. Contestants representing two or more betting interests, the Pick (n) pool shall be distributed as a single price pool with each winning wager receiving an equal share of the profit.
4. Should a betting interest in any of the Pick (n) contests be scratched, the actual favorite, as evidenced by total amounts wagered in the Win pool at the host association for the contest at the close of wagering on that contest, shall be substituted for the scratched betting interest for all purposes, including pool calculations. In the event that the Win pool total for two or more favorites is identical, the substitute selection shall be the betting interest with the lowest program number. The totalisator shall produce reports showing each of the wagering combinations with substituted betting interests which became winners as a result of the substitution, in addition to the normal winning combination.
5. The Pick (n) pool shall be cancelled and all Pick (n) wagers for the individual performance shall be refunded if:
 - a. At least two contests included as part of a Pick 3 are cancelled or declared "no contest."
 - b. At least three contests included as part of a Pick 4, Pick 5, or Pick 6 are cancelled or declared "no contest."
 - c. At least four contests included as part of a Pick 7, Pick 8, or Pick 9 are cancelled or declared "no contest."
 - d. At least five contests included as part of a Pick 10 are cancelled or declared "no contest."
6. If at least one contest included as part of a Pick (n) is cancelled or declared "no contest," but not more than the number specified in subsection (G)(5) of this rule, the net pool shall be distributed as a single price pool to those whose selection finished first in the greatest number of Pick (n) contests for that performance. Such distribution shall include the portion ordinarily retained for the Pick (n) carryover but not the carryover from previous performances.
7. The Pick (n) carryover may be capped at a designated level approved by the Department so that if, at the close of any performance, the amount in the Pick (n) carryover equals or exceeds the designated cap, the Pick (n) carryover will be frozen until it is won or distributed under other provisions of this rule. After the Pick (n) carryover is frozen, 100% of the net pool, part of which ordinarily would be added to the Pick (n) carryover, shall be distributed to those whose selection finished first in the greatest number of Pick (n) contests for that performance.

8. A written request for permission to distribute the Pick (n) carryover on a specific performance may be submitted to the Department. The request shall contain justification for the distribution, an explanation of the benefit to be derived, and the intended date and performance for the distribution.
9. Should the Pick (n) carryover be designated for distribution on the final day of the meeting or on another specified date on which there are no wagers selecting the first-place finisher in each of the Pick (n) contests, the entire pool shall be distributed as a single price pool to those whose selection finished first in the greatest number of Pick (n) contests. The Pick (n) carryover shall be designated for distribution on a specified date and performance only under the following circumstances:
 - a. Upon written approval from the Department as provided in subsection (G)(8) of this rule.
 - b. Upon written approval from the Department when there is a change in the carryover cap, a change from one type of Pick (n) wagering to another, or when the Pick (n) is discontinued.
 - c. On the closing performance of the meet or split meet.
10. If, for any reason, the Pick (n) carryover must be held over to the corresponding Pick (n) pool of a subsequent meet, the carryover shall be deposited in an interest-bearing account approved by the Department. The Pick (n) carryover plus accrued interest shall then be added to the net Pick (n) pool of the following meet on a date and performance so designated by the Department.
11. With the written approval of the Department, the permittee may contribute to the Pick (n) carryover a sum of money up to the amount of any designated cap.
12. Providing information to any person regarding covered combinations, amounts wagered on specific combinations, number of tickets sold, or number of live tickets remaining is strictly prohibited. This shall not prohibit necessary communication between totalisator and pari-mutuel department employees for processing of pool data.
13. The permittee may suspend previously approved Pick (n) wagering with the prior approval of the Department. Any carryover shall be held until the suspended Pick (n) wagering is reinstated. A permittee may request approval of a Pick (n) wager or separate wagering pool for specific performances.

Table 7: PICK 7 POOL

Multiple Takeout Rates & Multiple Betting Sources

(Net Price Calculation)

	Percent Takeout	Gross Pool	Gross Amt. Bet on Win	Net Pool	Net Amt. Bet on Win
Source 1:	16%	\$190,000.00	\$44.00	\$159,600.00	\$36.96
Source 2:	18.5%	\$10,000.00	\$18.00	\$8,150.00	\$14.67
Source 3:	21%	\$525,730.00	\$124.00	\$415,326.70	\$97.96
TOTALS:		\$725,730.00	\$186.00	\$583,076.70	\$149.59
Total Profit:					
Total Net Pool - Total Net Bet on the Winning Combination			=		\$582,927.11
Profit Per Dollar:					
Total Profit / Total Net Bet on the Winning Combination			=		\$3,896.8321
\$1 Unbroken Base Price:					
Profit Per Dollar + \$1			=		\$3,897.8321
\$1 Unbroken Price for Source 1:					
\$1 Unbroken Base Price x (1 - Percent Takeout)			=		\$3,274.1789
\$1 Unbroken Price for Source 2:					
\$1 Unbroken Base Price x (1 - Percent Takeout)			=		\$3,176.7331
\$1 Unbroken Price for Source 3:					
\$1 Unbroken Base Price x (1 - Percent Takeout)			=		\$3,079.2873

H. Place Pick (n) Pools

1. The Place Pick (n) requires selection of the first- or second-place finisher in each of a designated number of contests. The permittee must obtain written approval from the Department concerning the scheduling of Place Pick (n) contests, the designation of one of the methods prescribed in subsection (H)(2), the distinctive name identifying the pool and the amount of any cap to be set on the carryover. Any changes to the approved Place Pick (n) format require prior approval from the Department.
2. The Place Pick (n) pool shall be apportioned under one of the following methods:
 - a. *Method 1, Place Pick (n) with Carryover:* The net Place Pick (n) pool and carryover, if any, shall be distributed as a single price pool to those who selected the first- or second-place finisher in each of the Place Pick (n) contests, based upon the official order of finish. If there are no such wagers, then a designated percentage of the net pool shall be distributed as a single price pool to those who selected the first- or second-place finisher in the greatest number of Place Pick (n) contests; and the remainder shall be added to the carryover.
 - b. *Method 2, Place Pick (n) with Minor Pool and Carryover:* The major share of the net Place Pick (n)

- pool and the carryover, if any, shall be distributed to those who selected the first- or second-place finisher in each of the Place Pick (n) contests, based upon the official order of finish. The minor share of the net Place Pick (n) pool shall be distributed to those who selected the first- or second-place finisher in the second greatest number of Place Pick (n) contests, based upon the official order of finish. If there are no wagers selecting the first- or second-place finisher of all Place Pick (n) contests, the minor share of the net Place Pick (n) pool shall be distributed as a single price pool to those who selected the first- or second-place finisher in the greatest number of Place Pick (n) contests; and the major share shall be added to the carryover.
- c. *Method 3, Place (n) Pick with No Minor Pool and No Carryover:* The net Place Pick (n) pool shall be distributed as a single price pool to those who selected the first- or second-place finisher in the greatest number of Place Pick (n) contests, based upon the official order of finish. If there are no major winning wagers, the pool is refunded.
 - d. *Method 4, Place Pick (n) with Minor Pool and No Carryover:* The major share of the net Place Pick (n) pool shall be distributed to those who selected the first- or second-place finisher in the greatest number of Place Pick (n) contests, based upon the official order of finish. The minor share of the net Place Pick (n) pool shall be distributed to those who selected the first- or second-place finisher in the second greatest number of Place Pick (n) contests, based upon the official order of finish. If there are no wagers selecting the first- or second-place finisher in a second greatest number of Place Pick (n) contests, the minor share of the net Place Pick (n) pool shall be combined with the major share for distribution as a single price pool to those who selected the first- or second-place finisher in the greatest number of Place Pick (n) contests. If the greatest number of first- or second-place finishers selected is 1, the major and minor shares are combined for distribution as a single price pool. If there are no winning wagers, the pool is refunded.
 - e. *Method 5, Place Pick (n) with Minor Pool and No Carryover:* The major share of the net Place Pick (n) pool shall be distributed to those who selected the first- or second-place finisher in each of the Place Pick (n) contests, based upon the official order of finish. The minor share of the net Place Pick (n) pool shall be distributed to those who selected the first- or second-place finisher in the second greatest number of Place Pick (n) contests, based upon the official order of finish. If there are no wagers selecting the first- or second-place finisher in all Place Pick (n) contests, the entire net Place Pick (n) pool shall be distributed as a single price pool to those who selected the first- or second-place finisher in the greatest number of Place Pick (n) contests. If there are no wagers selecting the first or second-place finisher in a second greatest number of Place Pick (n) contests, the minor share of the net Place Pick (n) pool shall be combined with the major share for distribution as a single price pool to those who selected the first- or second-place finisher in each of the Place Pick (n) contests. If there are no winning wagers, the pool is refunded.
3. If there is a dead heat for first in any of the Place Pick (n) contests involving:
 - a. Contestants representing the same betting interest, the Place Pick (n) pool shall be distributed as if no dead heat occurred.
 - b. Contestants representing two or more betting interests, the Place Pick (n) pool shall be distributed as a single price pool with a winning wager including each betting interest participating in the dead heat.
 4. If there is a dead heat for second in any of the Place Pick (n) contests involving:
 - a. Contestants representing the same betting interest, the Place Pick (n) pool shall be distributed as if no dead heat occurred.
 - b. Contestants representing two or more betting interests, the Place Pick (n) pool shall be distributed as a single price pool with a winning wager including the betting interest which finished first or any betting interest involved in a dead heat for second.
 5. Should a betting interest in any Place Pick (n) contest be scratched, the actual favorite, as evidenced by total amounts wagered in the Win pool at the host association for the contest at the close of wagering on that contest, shall be substituted for the scratched betting interest for all purposes, including pool calculations. In the event that the Win pool total for two or more favorites is identical, the substitute selection shall be the betting interest with the lowest program number. The totalisator shall produce reports showing each of the wagering combinations with substituted betting interests which became winners as a result of the substitution, in addition to the normal winning combination.
 6. The Place Pick (n) pool shall be cancelled and all Place Pick (n) wagers for the individual performance shall be refunded if:
 - a. At least two contests included as part of a Place Pick 3 are cancelled or declared "no contest."
 - b. At least three contests included as part of a Place Pick 4, Place Pick 5, or Place Pick 6 are cancelled or declared "no contest."
 - c. At least four contests included as part of a Place Pick 7, Place Pick 8, or Place Pick 9 are cancelled or declared "no contest."
 - d. At least five contests included as part of a Place Pick 10 are cancelled or declared "no contest."
 7. If at least one contest included as part of a Place Pick (n) is cancelled or declared "no contest," but not more than the number specified in subsection (H)(6) of this rule, the net pool shall be distributed as a single price pool to those whose selection finished first or second in the greatest number of Place Pick (n) contests for that performance. Such distribution shall include the portion ordinarily retained for the Place Pick (n) carryover but not the carryover from previous performances.
 8. The Place Pick (n) carryover may be capped at a designated level approved by the Department so that if, at the close of any performance, the amount in the Place Pick (n) carryover equals or exceeds the designated cap, the Place Pick (n) carryover will be frozen until it is won or distributed under other provisions of this rule. After the Place Pick (n) carryover is frozen, 100% of the net pool, part of which ordinarily would be added to the Place Pick (n) carryover, shall be distributed to those whose selection finished first or second in the greatest number of Place Pick (n) contests for that performance.

9. A written request for permission to distribute the Place Pick (n) carryover on a specific performance may be submitted to the Department. The request must contain justification for the distribution, an explanation of the benefit to be derived, and the intended date and performance for the distribution.
 10. Should the Place Pick (n) carryover be designated for distribution on a specified date and performance in which there are no wagers selecting the first- or second-place finisher in each of the Place Pick (n) contests, the entire pool shall be distributed as a single price pool to those whose selection finished first or second in the greatest number of Place Pick (n) contests. The Place Pick (n) carryover shall be designated for distribution on a specified date and performance under any of the following circumstances:
 - a. Upon written approval from the Department as provided in subsection (H)(9) of this rule.
 - b. Upon written approval from the Department when there is a change in the carryover cap, a change from one type of Place Pick (n) wagering to another, or when the Place Pick (n) is discontinued.
 - c. On the closing performance of the meet or split meet.
 11. If, for any reason, the Place Pick (n) carryover must be held over to the corresponding Place Pick (n) pool of a subsequent meet, the carryover shall be deposited in an interest-bearing account approved by the Department. The Place Pick (n) carryover plus accrued interest shall then be added to the net Place Pick (n) pool of the following meet on a date and performance so designated by the Department.
 12. With the written approval of the Department, the permittee may contribute to the Place Pick (n) carryover a sum of money up to the amount of any designated cap.
 13. Providing information to any person regarding covered combinations, amounts wagered on specific combinations, number of tickets sold, or number of live tickets remaining is strictly prohibited. This shall not prohibit necessary communication between totalisator and pari-mutuel department employees for processing of pool data.
 14. The permittee may suspend previously approved Place Pick (n) wagering with the prior approval of the Department. Any carryover shall be held until the suspended Place Pick (n) wagering is reinstated. A permittee may request approval of a Place Pick (n) wager or separate wagering pool for specific performances.
- d. As a single price pool to those whose combination included the one covered betting interest included within the first two finishers; but if there are no such wagers, then
 - e. The entire pool shall be refunded on Quinella wagers for that contest.
3. If there is a dead heat for first involving:
 - a. Contestants representing the same betting interest, the Quinella pool shall be distributed to those selecting the coupled entry or mutuel field combined with the next separate betting interest in the official order of finish.
 - b. Contestants representing two betting interests, the Quinella pool shall be distributed as if no dead heat occurred.
 - c. Contestants representing three or more betting interests, the Quinella pool shall be distributed as a profit split.
 4. If there is a dead heat for second involving contestants representing the same betting interest, the Quinella pool shall be distributed as if no dead heat occurred.
 5. If there is a dead heat for second involving contestants representing two or more betting interests, the Quinella pool shall be distributed to wagers in the following precedence, based upon the official order of finish:
 - a. As a profit split to those combining the winner with any of the betting interests involved in the dead heat for second, but if there is only one covered combination, then
 - b. As a single price pool to those combining the winner with the one covered betting interest involved in the dead heat for second; but if there are no such wagers, then
 - c. As a profit split to those combining the betting interests involved in the dead heat for second; but if there are no such wagers, then
 - d. As a profit split to those whose combination included the winner and any other betting interest and wagers selecting any of the betting interests involved in the dead heat for second; but if there are no such wagers, then
 - e. The entire pool shall be refunded on Quinella wagers for that contest.

I. Quinella Pools

1. The Quinella requires selection of the first two finishers, irrespective of order, for a single contest.
2. The net Quinella pool shall be distributed to winning wagers in the following precedence, based upon the official order of finish:
 - a. If contestants of a coupled entry or mutuel field finish as the first two finishers, as a single price pool to those selecting the coupled entry or mutuel field combined with the next separate betting interest in the official order of finish; otherwise
 - b. As a single price pool to those whose combination finished as the first two betting interests; but if there are no such wagers, then
 - c. As a profit split to those whose combination included either the first- or second-place finisher; but if there are no such wagers on one of the those two finishers, then

J. Quinella Double Pools

1. The Quinella Double requires selection of the first two finishers, irrespective of order, in each of two specified contests.
2. The net Quinella Double pool shall be distributed to winning wagers in the following precedence, based upon the official order of finish:
 - a. If a coupled entry or mutuel field finishes as the first two contestants in either contest, as a single price pool to those selecting the coupled entry or mutuel field combined with the next separate betting interest in the official order of finish for that contest, as well as the first two finishers in the alternate Quinella Double contest; otherwise
 - b. As a single price pool to those who selected the first two finishers in each of the two Quinella Double contests; but if there are no such wagers, then
 - c. As a profit split to those who selected the first two finishers in either of the two Quinella Double contests; but if there are no such wagers on one of those contests, then

- d. As a single price pool to those who selected the first two finishers in the one covered Quinella Double contest; but if there were no such wagers, then
- e. The entire pool shall be refunded on Quinella Double wagers for those contests.
- 3. If there is a dead heat for first in either of the two Quinella Double contests involving:
 - a. Contestants representing the same betting interest, the Quinella Double pool shall be distributed to those selecting the coupled entry or mutuel field combined with the next separate betting interest in the official order of finish for that contest.
 - b. Contestants representing two betting interests, the Quinella Double pool shall be distributed as if no dead heat occurred.
 - c. Contestants representing three or more betting interests, the Quinella Double pool shall be distributed as a profit split.
- 4. If there is a dead heat for second in either of the Quinella Double contests involving contestants representing the same betting interest, the Quinella Double pool shall be distributed as if no dead heat occurred.
- 5. If there is a dead heat for second in either of the Quinella Double contests involving contestants representing two or more betting interests, the Quinella Double pool shall be distributed as profit split.
- 6. Should a betting interest in the first half of the Quinella Double be scratched prior to the first Quinella Double contest being declared official, all money wagered on combinations including the scratched betting interest shall deducted from the Quinella Double pool and refunded.
- 7. Should a betting interest in the second half of the Quinella Double be scratched prior to the close of wagering on the first Quinella Double contest, all money wagered on combinations including the scratched betting interest shall be deducted from the Quinella Double pool and refunded.
- 8. Should a betting interest in the second half of the Quinella Double be scratched after the close of wagering on the first Quinella Double contest, all wagers combining the winning combination in the first contest with a combination including the scratched betting interest in the second contest shall be allocated a consolation payoff. In calculating the consolation payoff, the net Quinella Double pool shall be divided by the total amount wagered on the winning combination in the first contest and an unbroken consolation price obtained. The unbroken consolation price is multiplied by the dollar value of wagers on the winning combination in the first contest combined with a combination including the scratched betting interest in the second contest to obtain the consolation payoff. Breakage is not utilized in this calculation. The consolation payoff is deducted from the net Quinella Double pool before calculation and distribution of the winning Quinella Double payoff. In the event of a dead heat involving separate betting interests, the net Quinella Double pool shall be distributed as a profit split.
- 9. If either of the Quinella Double contests is cancelled prior to the first Quinella Double contest, or the first Quinella Double contest is declared "no contest," the entire Quinella Double pool shall be refunded on Quinella Double wagers for those contests.
- 10. If the second Quinella Double contest is cancelled or declared "no contest" after the conclusion of the first

Quinella Double contest, the net Quinella Double pool shall be distributed as a single price pool to wagers selecting the winning combination in the first Quinella Double contest. If there are no wagers selecting the winning combination in the first Quinella Double contest, the entire Quinella Double pool shall be refunded on Quinella Double wagers for those contests.

K. Exacta Pools

- 1. The Exacta requires selection of the first two finishers, in their exact order, for a single contest.
- 2. The net Exacta pool shall be distributed to winning wagers in the following precedence, based upon the official order of finish:
 - a. If contestants of a coupled entry or mutuel field finish as the first two finishers, as a single price pool to those selecting the coupled entry or mutuel field combined with the next separate betting interest in the official order of finish; otherwise
 - b. As a single price pool to those whose combination finished in correct sequence as the first two betting interests; but if there are no such wagers, then
 - c. As a profit split to those whose combination included either the first-place betting interest to finish first or the second-place betting interest to finish second; but if there are no such wagers on one of those two finishers, then
 - d. As a single price pool to those whose combination included the one covered betting interest to finish first or second in the correct sequence; but if there are no such wagers, then
 - e. The entire pool shall be refunded on Exacta wagers for that contest.
- 3. If there is a dead heat for first involving:
 - a. Contestants representing the same betting interest, the Exacta pool shall be distributed as a single price pool to those selecting the coupled entry or mutuel field combined with the next separate betting interest in the official order of finish.
 - b. Contestants representing two or more betting interests, the Exacta pool shall be distributed as a profit split.
- 4. If there is a dead heat for second involving contestants representing the same betting interest, the Exacta pool shall be distributed as if no dead heat occurred.
- 5. If there is a dead heat for second involving contestants representing two or more betting interests, the Exacta pool shall be distributed to ticket holders in the following precedence, based upon the official order of finish:
 - a. As a profit split to those combining the first-place betting interest with any of the betting interests involved in the dead heat for second; but if there is only one covered combination, then
 - b. As a single price pool to those combining the first-place betting interest with the one covered betting interest involved in the dead heat for second; but if there are no such wagers, then
 - c. As a profit split to those wagers correctly selecting the winner for first place and those wagers selecting any of the dead-heated betting interests for second place; but if there are no such wagers, then
 - d. The entire pool shall be refunded on Exacta wagers for that contest.

L. Trifecta Pools

- 1. The Trifecta requires selection of the first three finishers, in their exact order, for a single contest.

2. The net Trifecta pool shall be distributed to winning wagers in the following precedence, based upon the official order of finish:
 - a. As a single price pool to those whose combination finished in correct sequence as the first three betting interests; but if there are no such wagers, then
 - b. As a single price pool to those whose combination included, in correct sequence, the first two betting interests; but if there are no such wagers, then
 - c. As a single price pool to those whose combination correctly selected the first-place betting interest only; but if there are no such wagers, then
 - d. The entire pool shall be refunded on Trifecta wagers for that contest.
 3. If less than three betting interests finish and the contest is declared official, payoffs will be made based upon the order of finish of those betting interests completing the contest. The balance of any selection beyond the number of betting interests completing the contest shall be ignored.
 4. If there is a dead heat for first involving:
 - a. Contestants representing three or more betting interests, all of the wagering combinations selecting three betting interests which correspond with any of the betting interests involved in the dead heat shall share in a profit split.
 - b. Contestants representing two betting interests, both of the wagering combinations selecting the two dead-heated betting interests, irrespective of order, along with the third-place betting interest shall share in a profit split.
 5. If there is a dead heat for second, all of the combinations correctly selecting the winner combined with any of the betting interests involved in the dead heat for second shall share in a profit split.
 6. If there is a dead heat for third, all wagering combinations correctly selecting the first two finishers, in correct sequence, along with any of the betting interests involved in the dead heat for third shall share in a profit split.
- M. Superfecta Pools**
1. The Superfecta requires selection of the first four finishers, in their exact order, for a single contest.
 2. The net Superfecta pool shall be distributed to winning wagers in the following precedence, based upon the official order of finish:
 - a. As a single price pool to those whose combination finished in correct sequence as the first four betting interests; but if there are no such wagers, then
 - b. As a single price pool to those whose combination included, in correct sequence, the first three betting interests; but if there are no such wagers, then
 - c. As a single price pool to those whose combination included, in correct sequence, the first two betting interests; but if there are no such wagers, then
 - d. As a single price pool to those whose combination correctly selected the first-place betting interest only; but if there are no such wagers, then
 - e. The entire pool shall be refunded on Superfecta wagers for that contest.
 3. If less than four betting interests finish and the contest is declared official, payoffs will be made based upon the order of finish of those betting interests completing the contest. The balance of any selection beyond the number of betting interests completing the contest shall be ignored.
 4. If there is a dead heat for first involving:
 - a. Contestants representing four or more betting interests, all of the wagering combinations selecting four betting interests which correspond with any of the betting interests involved in the dead heat shall share in a profit split.
 - b. Contestants representing three betting interests, all of the wagering combinations selecting the three dead-heated betting interests, irrespective of order, along with the fourth-place betting interest shall share in a profit split.
 - c. Contestants representing two betting interests, both of the wagering combinations selecting the two dead-heated betting interests, irrespective of order, along with the third-place and fourth-place betting interests shall share in a profit split.
 5. If there is a dead heat for second involving:
 - a. Contestants representing three or more betting interests, all of the wagering combinations correctly selecting the winner combined with any of the three betting interests involved in the dead heat for second shall share in a profit split.
 - b. Contestants representing two betting interests, all of the wagering combinations correctly selecting the winner, the two dead-heated betting interests, irrespective of order, and the fourth-place betting interest shall share in a profit split.
 6. If there is a dead heat for third, all wagering combinations correctly selecting the first two finishers, in correct sequence, along with any two of the betting interests involved in the dead heat for third shall share in a profit split.
 7. If there is a dead heat for fourth, all wagering combinations correctly selecting the first three finishers, in correct sequence, along with any of the betting interests involved in the dead heat for fourth shall share in a profit split.
- N. Twin Quinella Pools**
1. The Twin Quinella requires selection of the first two finishers, irrespective of order, in each of two designated contests. Each winning ticket for the first Twin Quinella contest must be exchanged for a free ticket on the second Twin Quinella contest in order to remain eligible for the second-half Twin Quinella pool. Such tickets may be exchanged only at attended ticket windows prior to the second Twin Quinella contest. There will be no monetary reward for winning the first Twin Quinella contest. Both of the designated Twin Quinella contests shall be included in only one Twin Quinella pool.
 2. In the first Twin Quinella contest only, winning wagers shall be determined using the following precedence, based upon the official order of finish for the first Twin Quinella contest:
 - a. If a coupled entry or mutuel field finishes as the first two finishers, those who selected the coupled entry or mutuel field combined with the next separate betting interest in the official order of finish shall be winners; otherwise
 - b. Those whose combination finished as the first two betting interests shall be winners; but if there are no such wagers, then
 - c. Those whose combination included either the first- or second-place finisher shall be winners; but if there are no such wagers on one of those two finishers, then
 - d. Those whose combination included the one covered betting interest included within the first two finish-

- ers shall be winners; but if there are no such wagers, then
- e. The entire pool shall be refunded on Twin Quinella wagers for that contest.
3. In the first Twin Quinella contest only, if there is a dead heat for first involving:
- a. Contestants representing the same betting interest, those who selected the coupled entry or mutuel field combined with the next separate betting interest in the official order of finish shall be winners.
- b. Contestants representing two betting interests, the winning Twin Quinella wagers shall be determined as if no dead heat occurred.
- c. Contestants representing three or more betting interests, those whose combination included any two of the betting interests finishing in the dead heat shall be winners.
4. In the first Twin Quinella contest only, if there is a dead heat for second involving contestants representing two or more betting interests, the Twin Quinella pool shall be distributed to wagers in the following precedence, based upon the official order of finish:
- a. As a profit split to those combining the winner with any of the betting interests involved in the dead heat for second; but if there is only one covered combination, then
- b. As a single price pool to those combining the winner with the one covered betting interest involved in the dead heat for second, but if there are no such wagers, then
- c. As a profit split to those combining the betting interests involved in the dead heat for second; but if there are no such wagers, then
- d. As a profit split to those whose combination included the winner and any other betting interest and wagers selecting any of the betting interests involved in the dead heat for second; but if there are no such wagers, then
- e. The entire pool shall be refunded on Twin Quinella wagers for the contest.
5. In the second Twin Quinella contest only, the entire net Twin Quinella pool shall be distributed to winning wagers in the following precedence, based upon the official order of finish for the second Twin Quinella contest:
- a. If a coupled entry or mutuel field finishes as the first two finishers, as a single price pool to those who selected the coupled entry or mutuel field combined with the next separate betting interest in the official order of finish; otherwise
- b. As a single price pool to those whose combination finished as the first two betting interests; but if there are no such wagers, then
- c. As a profit split to those whose combination included either the first- or second-place finisher; but if there are no such wagers on one of those two finishers, then
- d. As a single price pool to those whose combination included the one covered betting interest included within the first two finishers; but if there are no such wagers, then
- e. As a single price pool to all the exchange ticket holders for that contest; but if there are no such tickets, then
- f. In accordance with subsection (N)(2) of the Twin Quinella rules.
6. In the second Twin Quinella contest only, if there is a dead heat for first involving:
- a. Contestants representing the same betting interest, the net Twin Quinella pool shall be distributed to those selecting the coupled entry or mutuel field combined with the next separate betting interest in the official order of finish.
- b. Contestants representing two betting interests, the net Twin Quinella pool shall be distributed as if no dead heat occurred.
- c. Contestants representing three or more betting interests, the net Twin Quinella pool shall be distributed as a profit split to those whose combination included any two of the betting interests finishing in the dead heat.
7. In the second Twin Quinella contest only, if there is a dead heat for second involving contestants representing two or more betting interests, the Twin Quinella pool shall be distributed to wagers in the following precedence, based upon the official order of finish:
- a. As a profit split to those combining the winner with any of the betting interests involved in the dead heat for second; but if there is only one covered combination, then
- b. As a single price pool to those combining the winner with the one covered betting interest involved in the dead heat for second; but if there are no such wagers, then
- c. As a profit split to those combining the betting interests involved in the dead heat for second; but if there are no such wagers, then
- d. As a profit split to those whose combination included the winner and any other betting interest and wagers selecting any of the betting interests involved in the dead heat for second, then
- e. As a single price pool to all the exchange ticket holders for that contest; but if there are no such tickets, then
- f. In accordance with subsection (N)(2) of the Twin Quinella rules.
8. If a winning ticket for the first-half of the Twin Quinella is not presented for exchange prior to the close of betting on the second-half Twin Quinella contest, the ticket holder forfeits all rights to any distribution of the Twin Quinella pool resulting from the outcome of the second contest.
9. Should a betting interest in the first half of the Twin Quinella be scratched, those Twin Quinella wagers including the scratched betting interest shall be refunded.
10. Should a betting interest in the second half of the Twin Quinella be scratched, an announcement concerning the scratch shall be made and a reasonable amount of time shall be provided for exchange of tickets that include the scratched betting interest. If tickets have not been exchanged prior to the close of betting for the second Twin Quinella contest, the ticket holder forfeits all rights to the Twin Quinella pool.
11. If either of the Twin Quinella contests is cancelled prior to the first Twin Quinella contest, or the first Twin Quinella contest is declared "no contest," the entire Twin Quinella pool shall be refunded on Twin Quinella wagers for that contest.
12. If the second-half Twin Quinella contest is cancelled or declared "no contest" after the conclusion of the first Twin Quinella contest, the net Twin Quinella pool shall be distributed as a single price pool to wagers selecting

the winning combination in the first Twin Quinella contest and all valid exchange tickets. If there are no such wagers, the net Twin Quinella pool shall be distributed as described in subsection (N)(2) of the Twin Quinella rules.

O. Twin Trifecta Pools

1. The Twin Trifecta requires selection of the first three finishers, in their exact order, in each of two designated contests. Each winning ticket for the first Twin Trifecta contest must be exchanged for a free ticket on the second Twin Trifecta contest in order to remain eligible for the second-half Twin Trifecta pool. Such tickets may be exchanged only at attended ticket windows prior to the second Twin Trifecta contest. Winning first-half Twin Trifecta wagers will receive both an exchange and a monetary payoff. Both of the designated Twin Trifecta contests shall be included in only one Twin Trifecta pool.
2. After wagering closes for the first half of the Twin Trifecta and commissions have been deducted from the pool, the net pool shall then be divided into separate pools: the first-half Twin Trifecta pool and the second-half Twin Trifecta pool.
3. In the first Twin Trifecta contest only, winning wagers shall be determined using the following precedence, based upon the official order of finish for the first Twin Trifecta contest:
 - a. As a single price pool to those whose combination finished in correct sequence as the first three betting interests; but if there are no such wagers, then
 - b. As a single price pool to those whose combination included, in correct sequence, the first two betting interests; but if there are no such wagers, then
 - c. As a single price pool to those whose combination correctly selected the first-place betting interest only; but if there are no such wagers, then
 - d. The entire Twin Trifecta pool shall be refunded on Twin Trifecta wagers for that contest and the second half shall be cancelled.
4. If no first-half Twin Trifecta ticket selects the first three finishers of that contest in exact order, winning ticket holders shall not receive any exchange tickets for the second-half Twin Trifecta pool. In such case, the second-half Twin Trifecta pool shall be retained and added to any existing Twin Trifecta carryover pool.
5. Winning tickets from the first half of the Twin Trifecta shall be exchanged for tickets selecting the first three finishers of the second-half of the Twin Trifecta. The second-half Twin Trifecta pool shall be distributed to winning wagers in the following precedence, based upon the official order of finish for the second Twin Trifecta contest:
 - a. As a single price pool, including any existing carryover monies, to those whose combination finished in correct sequence as the first three betting interests; but if there are no such tickets, then
 - b. The entire second-half Twin Trifecta pool for that contest shall be added to any existing carryover monies and retained for the corresponding second-half Twin Trifecta pool of the next consecutive performance.
6. If a winning first-half Twin Trifecta ticket is not presented for cashing and exchange prior to the second-half Twin Trifecta contest, the ticket holder may still collect the monetary value associated with the first-half Twin Trifecta pool but forfeits all rights to any distribution of the second-half Twin Trifecta pool.
7. Should a betting interest in the first half of the Twin Trifecta be scratched, those Twin Trifecta wagers including the scratched betting interest shall be refunded.
8. Should a betting interest in the second-half of the Twin Trifecta be scratched, an announcement concerning the scratch shall be made and a reasonable amount of time shall be provided for exchange of tickets that include the scratched betting interest. If tickets have not been exchanged prior to the close of betting for the second Twin Trifecta contest, the ticket holder forfeits all rights to the second-half Twin Trifecta pool.
9. If, due to a late scratch, the number of betting interests in the second half of the Twin Trifecta is reduced to fewer than the minimum, all exchange tickets and outstanding first-half winning tickets shall be entitled to the second-half Twin Trifecta pool for that contest as a single price pool, but not the Twin-Trifecta carryover.
10. If there is a dead heat or multiple dead heats in either the first- or second-half of the Twin Trifecta, all Twin Trifecta wagers selecting the correct order of finish, counting a betting interest involved in a dead heat as finishing in any dead-heated position, shall be a winner. In the case of a dead heat occurring in:
 - a. The first half of the Twin Trifecta, the payoff shall be calculated as a profit split.
 - b. The second half of the Twin Trifecta, the payoff shall be calculated as a single price pool.
11. If either of the Twin Trifecta contests are cancelled prior to the first Twin Trifecta contest, or the first Twin Trifecta contest is declared "no contest," the entire Twin Trifecta pool shall be refunded on Twin Trifecta wagers for that contest and the second half shall be cancelled.
12. If the second-half Twin Trifecta contest is cancelled or declared "no contest," all exchange tickets and outstanding first-half winning Twin Trifecta tickets shall be entitled to the net Twin Trifecta pool for that contest as a single price pool, but not Twin-Trifecta carryover. If there are no such tickets, the net Twin Trifecta pool shall be distributed as described in subsection (O)(3) of the Twin Trifecta rules.
13. The Twin-Trifecta carryover may be capped at a designated level approved by the Department so that if, at the close of any performance, the amount in the Twin-Trifecta carryover equals or exceeds the designated cap, the Twin-Trifecta carryover will be frozen until it is won or distributed under other provisions of this rule. After the Twin Trifecta carryover is frozen, 100% of the net Twin Trifecta pool for each individual contest shall be distributed to carryover winners of the first half of the Twin Trifecta pool.
14. A written request for permission to distribute the Twin-Trifecta carryover on a specific performance may be submitted to the Department. The request must contain justification for the distribution, an explanation of the benefit to be derived, and the intended date and performance for the distribution.
15. Should the Twin-Trifecta carryover be designated for distribution on a specified date and performance, the following precedence will be followed in determining winning tickets for the second half of the Twin Trifecta after completion of the first half of the Twin Trifecta:
 - a. As a single price pool to those whose combination finished in correct sequence as the first three betting interests; but if there are no such wagers, then

- b. As a single price pool to those whose combination included, in correct sequence, the first two betting interests; but if there are no such wagers, then
 - c. As a single price pool to those whose combination correctly selected the first-place betting interest only; but if there are no such wagers, then
 - d. As a single price pool to holders of valid exchange tickets.
 - e. As a single price pool to holders of outstanding first-half winning tickets.
 16. Contrary to subsection (O)(4) of the Twin Trifecta rules, during a performance designated to distribute the Twin-Trifecta carryover, exchange tickets will be issued for those combinations selecting the greatest number of betting interests in their correct order of finish for the first half of the Twin Trifecta. If there are no wagers correctly selecting the first-, second-, and third-place finishers, in their exact order, then exchange tickets shall be issued for combinations correctly selecting the first- and second-place betting interests. If there are no wagers correctly selecting the first- and second-place finishers, in their exact order, then exchange tickets shall be issued for combinations correctly selecting the first-place betting interest only. If there are no wagers selecting the first-place betting interest only in the first half of the Twin Trifecta, all first-half tickets will become winners and will receive 100% of that day's net Twin Trifecta pool and any existing Twin-Trifecta carryover as a single price pool.
 17. The Twin-Trifecta carryover shall be designated for distribution on a specified date and performance only under the following circumstances:
 - a. Upon written approval from the Department as provided in subsection (O)(15) of the Twin Trifecta rules.
 - b. Upon written approval from the Department when there is a change in the carryover cap or when the Twin Trifecta is discontinued.
 - c. On the closing performance of the meet or split meet.
 18. If, for any reason, the Twin-Trifecta carryover must be held over to the corresponding Twin Trifecta pool of a subsequent meet, the carryover shall be deposited in an interest-bearing account approved by the Department. The Twin-Trifecta carryover plus accrued interest shall then be added to the second-half Twin Trifecta pool of the following meet on a date and performance so designated by the Department.
 19. Providing information to any person regarding covered combinations, amounts wagered on specific combinations, number of tickets sold, or number of valid exchange tickets is prohibited. This shall not prohibit necessary communication between totalisator and parimutuel department employees for processing of pool data.
 20. The permittee must obtain written approval from the Department concerning the scheduling of Twin Trifecta contests, the percentages of the net pool added to the first-half pool and second-half pool, and the amount of any cap to be set on the carryover. Any changes to the approved Twin Trifecta format require prior approval from the Department.
- P. Tri-Superfecta Pools**
1. The Tri-Superfecta requires selection of the first three finishers, in their exact order, in the first of two designated contests and the first four finishers, in exact order, in the second of the two designated contests. Each winning ticket for the first Tri-Superfecta contest must be exchanged for a free ticket on the second Tri-Superfecta contest in order to remain eligible for the second-half Tri-Superfecta pool. Such tickets may be exchanged only at attended ticket windows prior to the second Tri-Superfecta contest. Winning first-half Tri-Superfecta tickets will receive both an exchange and a monetary payoff. Both of the designated Tri-Superfecta contests shall be included in only one Tri-Superfecta pool.
 2. After wagering closes for the first-half of the Tri-Superfecta and commissions have been deducted from the pool, the net pool shall then be divided into two separate pools: the first-half Tri-Superfecta pool and the second-half Tri-Superfecta pool.
 3. In the first Tri-Superfecta contest only, winning tickets shall be determined using the following precedence, based upon the official order of finish for the first Tri-Superfecta contest:
 - a. As a single price pool to those whose combination finished in correct sequence as the first three betting interests; but if there are no such wagers, then
 - b. As a single price pool to those whose combination included, in correct sequence, the first two betting interests; but if there are no such wagers, then
 - c. As a single price pool to those whose combination correctly selected the first-place betting interest only; but if there are no such wagers, then
 - d. The entire Tri-Superfecta pool shall be refunded on Tri-Superfecta for that contest and the second half shall be cancelled.
 4. If no first-half Tri-Superfecta ticket selects the first three finishers of that contest in exact order, winning ticket holders shall not receive any exchange tickets for the second-half Tri-Superfecta pool. In such case, the second-half Tri-Superfecta pool shall be retained and added to any existing Tri-Superfecta carryover pool.
 5. Winning tickets from the first half of the Tri-Superfecta shall be exchanged for tickets selecting the first four finishers of the second-half of the Tri-Superfecta. The second-half Tri-Superfecta pool shall be distributed to winning wagers in the following precedence, based upon the official order of finish for the second Tri-Superfecta contest:
 - a. As a single price pool, including any existing carryover monies, to those whose combination finished in correct sequence as the first four betting interests; but if there are no such tickets, then
 - b. The entire second-half Tri-Superfecta pool for that contest shall be added to any existing carryover monies and retained for the corresponding second-half Tri-Superfecta pool of the next performance.
 6. If a winning first-half Tri-Superfecta ticket is not presented for cashing and exchange prior to the second-half Tri-Superfecta contest, the ticket holder may still collect the monetary value associated with the first-half Tri-Superfecta pool but forfeits all rights to any distribution of the second-half Tri-Superfecta pool.
 7. Coupled entries and mutuel fields shall be prohibited in Tri-Superfecta contests.
 8. Should a betting interest in the first-half of the Tri-Superfecta be scratched, those Tri-Superfecta tickets including the scratched betting interest shall be refunded.
 9. Should a betting interest in the second-half of the Tri-Superfecta be scratched, an announcement concerning the scratch shall be made and a reasonable amount of time shall be provided for exchange of tickets that include

- the scratched betting interest. If tickets have not been exchanged prior to the close of betting for the second Tri-Superfecta contest, the ticket holder forfeits all rights to the second-half Tri-Superfecta pool.
10. If, due to a late scratch, the number of betting interests in the second-half of the Tri-Superfecta is reduced to fewer than the minimum, all exchange tickets and outstanding first-half winning tickets shall be entitled to the second-half Tri-Superfecta pool for that contest as a single price pool, but not the Tri-Superfecta carryover.
 11. If there is a dead heat or multiple dead heats in either the first or second half of the Tri-Superfecta, all Tri-Superfecta tickets selecting the correct order of finish, counting a betting interest involved in a dead heat as finishing in any dead-heated position, shall be a winner. In the case of a dead heat occurring in
 - a. The first-half of the Tri-Superfecta, the payoff shall be calculated as a profit split.
 - b. The second-half of the Tri-Superfecta, the payoff shall be calculated as a single price pool.
 12. If either of the Tri-Superfecta contests are cancelled prior to the first Tri-Superfecta contest, or the first Tri-Superfecta contest is declared "no contest," the entire Tri-Superfecta pool shall be refunded on Tri-Superfecta wagers for that contest and the second half shall be cancelled.
 13. If the second-half Tri-Superfecta contest is cancelled or declared "no contest," all exchange tickets and outstanding first-half winning Tri-Superfecta tickets shall be entitled to the net Tri-Superfecta pool for that contest as a single price pool, but not the Tri-Superfecta carryover. If no there are no such tickets, the net Tri-Superfecta pool shall be distributed as described in subsection (P)(3) of the Tri-Superfecta rules.
 14. The Tri-Superfecta carryover may be capped at a designated level approved by the Department so that if, at the close of any performance, the amount in the Tri-Superfecta carryover equals or exceeds the designated cap, the Tri-Superfecta carryover will be frozen until it is won or distributed under other provisions of this rule. After the second-half Tri-Superfecta carryover is frozen, 100% of the net Tri-Superfecta pool for each individual contest shall be distributed to winners of the first-half of the Tri-Superfecta pool.
 15. A written request for permission to distribute the Tri-Superfecta carryover on a specific performance may be submitted to the Department. The request must contain justification for the distribution, an explanation of the benefit to be derived, and the intended date and performance for the distribution.
 16. Should the Tri-Superfecta carryover be designated for distribution on a specified date and performance, the following precedence will be followed in determining winning tickets for the second half of the Tri-Superfecta after completion of the first half of the Tri-Superfecta:
 - a. As a single price pool to those whose combination finished in correct sequence as the first four betting interests; but if there are no such wagers, then
 - b. As a single price pool to those whose combination included, in correct sequence, the first three betting interests; but if there are no such wagers, then
 - c. As a single price pool to those whose combination included, in correct sequence, the first two betting interests; but if there are no such wagers, then
 - d. As a single price pool to those whose combination included, in correct sequence, the first-place betting interest only; but if there are no such wagers, then
 - e. As a single price pool to holders of valid exchange tickets.
 - f. As a single price pool to holders of outstanding first-half winning tickets.
 17. Contrary to subsection (P)(4) of the Tri-Superfecta rules, during a performance designated to distribute the Tri-Superfecta carryover, exchange tickets will be issued for those combinations selecting the greatest number of betting interests in their correct order of finish for the first-half of the Tri-Superfecta. If there are no wagers correctly selecting the first-, second-, and third-place finishers, in their exact order, then exchange tickets shall be issued for combinations correctly selecting the first- and second-place betting interests. If there are no wagers correctly selecting the first- and second-place finishers, in their exact order, then exchange tickets shall be issued for combinations correctly selecting the first-place betting interest only. If there are no wagers selecting the first-place betting interest only in the first half of the Tri-Superfecta, all first-half tickets will become winners and will receive 100% of that day's net Tri-Superfecta pool and any existing Tri-Superfecta carryover as a single price pool.
 18. The Tri-Superfecta carryover shall be designated for distribution on a specified date and performance only under the following circumstances:
 - a. Upon written approval from the Department as provided in subsection (P)(15) of the Tri-Superfecta rules.
 - b. Upon written approval from the Department when there is a change in the carryover cap or when the Tri-Superfecta is discontinued.
 - c. On the closing performance of the meet or split meet.
 19. If, for any reason, the Tri-Superfecta carryover must be held over to the corresponding Tri-Superfecta pool of a subsequent meet, the carryover shall be deposited in an interest-bearing account approved by the Department. The Tri-Superfecta carryover plus accrued interest shall then be added to the second-half Tri-Superfecta pool of the following meet on a date and performance so designated by the Department.
 20. Providing information to any person regarding covered combinations, amounts wagered on specific combinations, number of tickets sold, or number of valid exchange tickets is prohibited. This shall not prohibit necessary communication between totalisator and pari-mutuel department employees for processing of pool data.
 21. The permittee must obtain written approval from the Department concerning the scheduling of Tri-Superfecta contests, the percentages of the net pool added to the first-half pool and second-half pool, and the amount of any cap to be set on the carryover. Any changes to the approved Tri-Superfecta format require prior approval from the Department.
- Q. Twin Superfecta Pools**
1. The Twin Superfecta requires selection of the first four finishers, in their exact order, in each of two designated contests. Each winning ticket for the first Twin Superfecta contest must be exchanged for a free ticket on the second Twin Superfecta contest in order to remain eligible for the second-half Twin Superfecta pool. Such tickets

- may be exchanged only at attended ticket windows prior to the second Twin Superfecta contest. Winning first-half Twin Superfecta tickets will receive both an exchange and a monetary payoff. Both of the designated Twin Superfecta contests shall be included in only one Twin Superfecta pool.
2. After wagering closes for the first half of the Twin Superfecta and commissions have been deducted from the pool, the net pool shall then be divided into two separate pools: the first-half Twin Superfecta pool and the second-half Twin Superfecta pool.
 3. In the first Twin Superfecta contest only, winning wagers shall be determined using the following precedence, based upon the official order of finish for the first Twin Superfecta contest:
 - a. As a single price pool to those whose combination finished in correct sequence as the first four betting interests; but if there are no such wagers, then
 - b. As a single price pool to those whose combination included, in correct sequence, the first three betting interests; but if there are no such wagers, then
 - c. As a single price pool to those whose combination included, in correct sequence, the first two betting interests; but if there are no such wagers, then
 - d. As a single price pool to those whose combination correctly selected the first-place betting interest only; but if there are no such wagers, then
 - e. The entire Twin Superfecta pool shall be refunded on Twin Superfecta wagers for that contest and the second half shall be cancelled.
 4. If no first-half Twin Superfecta ticket selects the first four finishers of that contest in exact order, winning ticket holders shall not receive any exchange tickets for the second-half Twin Superfecta pool. In such case, the second-half Twin Superfecta pool shall be retained and added to any existing Twin Superfecta carryover pool.
 5. Winning tickets from the first half of the Twin Superfecta shall be exchanged for tickets selecting the first four finishers of the second half of the Twin Superfecta. The second-half Twin Superfecta pool shall be distributed to winning wagers in the following precedence, based upon the official order of finish for the second Twin Superfecta contest:
 - a. As a single price pool, including any existing carryover monies, to those whose combination finished in correct sequence as the first four betting interests; but if there are no such tickets, then
 - b. The entire second-half Twin Trifecta pool for that contest shall be added to any existing carryover monies and retained for the corresponding second-half Twin Superfecta pool of the next performance.
 6. If a winning first-half Twin Superfecta ticket is not presented for cashing and exchange prior to the second-half Twin Superfecta contest, the ticket holder may still collect the monetary value associated with the first-half Twin Superfecta pool but forfeits all rights to any distribution of the second-half Twin Trifecta pool.
 7. Coupled entries and mutuel fields shall be prohibited in Twin Superfecta contests.
 8. Should a betting interest in the first half of the Twin Superfecta be scratched, those Twin Superfecta tickets including the scratched betting interest shall be refunded.
 9. Should a betting interest in the second half of the Twin Superfecta be scratched, an announcement concerning the scratch shall be made and a reasonable amount of time shall be provided for exchange of tickets that include the scratched betting interest. If tickets have not been exchanged prior to the close of betting for the second Twin Superfecta contest, the ticket holder forfeits all rights to the second-half Twin Superfecta pool.
 10. If, due to a late scratch, the number of betting interests in the second-half of the Twin Superfecta is reduced to fewer than the minimum, all exchange tickets and outstanding first-half winning tickets shall be entitled to the second-half Twin Superfecta pool for that contest as a single price pool but not the Twin Superfecta carryover.
 11. If there is a dead heat or multiple dead heats in either the first- or second-half of the Twin Superfecta, all Twin Superfecta tickets selecting the correct order of finish, counting a betting interest involved in a dead heat as finishing in any dead-heated position, shall be a winner. In the case of a dead heat occurring in:
 - a. The first half of the Twin Superfecta, the payoff shall be calculated as a profit split.
 - b. The second half of the Twin Superfecta, the payoff shall be calculated as a single price pool.
 12. If either of the Twin Superfecta contests is cancelled prior to the first Twin Superfecta contest, or the first Twin Superfecta contest is declared "no contest," the entire Twin Superfecta pool shall be refunded on Twin Superfecta wagers for that contest and the second half shall be cancelled.
 13. If the second-half Twin Superfecta contest is cancelled or declared "no contest," all exchange tickets and outstanding first-half winning Twin Superfecta tickets shall be entitled to the net Twin Superfecta pool for that contest as a single price pool but not the Twin Superfecta carryover. If there are no such tickets, the net Twin Superfecta pool shall be distributed as described in subsection (Q)(3) of the Twin Superfecta rules.
 14. The Twin Superfecta carryover may be capped at a designated level approved by the Department so that if, at the close of any performance, the amount in the Twin Superfecta carryover equals or exceeds the designated cap, the Twin Superfecta carryover will be frozen until it is won or distributed under other provisions of this rule. After the second-half Twin Superfecta carryover is frozen, 100% of the net Twin Superfecta pool for each individual contest shall be distributed to winners of the first half of the Twin Superfecta pool.
 15. A written request for permission to distribute the Twin Superfecta carryover on a specific performance may be submitted to the Department. The request must contain justification for the distribution, an explanation of the benefit to be derived, and the intended date and performance for the distribution.
 16. Should the Twin Superfecta carryover be designated for distribution on a specified date and performance, the following precedence will be followed in determining winning tickets for the second half of the Twin Superfecta after completion of the first half of the Twin Superfecta:
 - a. As a single price pool to those whose combination finished in correct sequence as the first four betting interests; but if there are no such wagers, then
 - b. As a single price pool to those whose combination included, in correct sequence, the first three betting interests; but if there are no such wagers, then
 - c. As a single price pool to those whose combination included, in correct sequence, the first two betting interests; but if there are no such wagers, then

- d. As a single price pool to those whose combination correctly selected the first-place betting interest only; but if there are no such wagers, then
 - e. As a single price pool to holders of valid exchange tickets.
 - f. As a single price pool to holders of outstanding first-half winning tickets.
17. Contrary to subsection (Q)(4) of the Twin Superfecta rules, during a performance designated to distribute the Twin Superfecta carryover, exchange tickets will be issued for those combinations selecting the greatest number of betting interests in their correct order of finish for the first-half of the Twin Superfecta. If there are no wagers correctly selecting the first-, second-, third-, and fourth-place finishers, in their exact order, then exchange tickets shall be issued for combinations correctly selecting the first-, second-, and third-place betting interests. If there are no wagers correctly selecting the first-, second-, and third-place finishers, in their exact order, then exchange tickets shall be issued for combinations correctly selecting the first- and second-place betting interests. If there are no wagers correctly selecting the first- and second-place finishers, in their exact order, then exchange tickets shall be issued for combinations correctly selecting the first-place betting interest only. If there are no wagers selecting the first-place betting interest only in the first half of the Twin Superfecta, all first-half tickets will become winners and will receive 100% of that day's net Twin Superfecta pool and any existing Twin Superfecta carryover as a single price pool.
 18. The Twin Superfecta carryover shall be designated for distribution on a specified date and performance only under the following circumstances:
 - a. Upon written approval from the Department as provided in subsection (Q)(15) of the Twin Superfecta rules.
 - b. Upon written approval from the Department when there is a change in the carryover cap or when the Twin Superfecta is discontinued.
 - c. On the closing performance of the meet or split meet.
 19. If, for any reason, the Twin Superfecta carryover must be held over to the corresponding Twin Superfecta pool of a subsequent meet, the carryover shall be deposited in an interest-bearing account approved by the Department. The Twin Superfecta carryover plus accrued interest shall then be added to the second-half Twin Superfecta pool of the following meet on a date and performance so designated by the Department.
 20. Providing information to any person regarding covered combinations, amounts wagered on specific combinations, number of tickets sold, or number of valid exchange tickets is prohibited. This shall not prohibit necessary communications between totalisator and pari-mutuel department employees for processing of pool data.
 21. The permittee must obtain written approval from the Department concerning the scheduling of Twin Superfecta contests, the percentages of the net pool added to the first-half pool and second-half pool, and the amount of any cap to be set on the carryover. Any changes to the approved Twin Superfecta format require prior approval from the Department.
- R. Grand Slam Pools**
1. The Grand Slam requires selection of the Exacta, Trifecta, and Superfecta, respectively, in three consecutive contests. Each winning ticket for the first Grand Slam contest must be exchanged for a free ticket on the second Grand Slam contest in order to remain eligible for the second contest share of the Grand Slam pool. Such tickets may be exchanged only at attended ticket windows prior to the second Grand Slam contest. Winning Grand Slam tickets on the first race shall receive both an exchange and a monetary payoff. Each winning ticket for the second Grand Slam contest must be exchanged for a free ticket on the third Grand Slam Contest in order to remain eligible for the third contest share of the Grand Slam pool. Such tickets must be exchanged only at attended ticket windows prior to the third Grand Slam contest. Winning tickets on the second race shall receive both an exchange and a monetary payoff. The three designated Grand Slam contests shall be included in only one Grand Slam pool.
 2. After wagering closes for the first contest of the Grand Slam and commissions have been deducted from the pool, the net pool shall be divided into three separate pools: the first contest pool (25%), the second contest pool (25%), and the third contest pool (50%).
 3. In the first Grand Slam contest only, winning wagers shall be determined using the following precedence, based upon the official order of finish for the first Grand Slam contest:
 - a. If contestants of a coupled entry or mutuel field finish as the first two finishers, as a single price pool to those selecting the coupled entry or mutuel field combined with the next separate betting interest in the official order of finish; otherwise
 - b. As a single price pool to those whose combination finished in correct sequence as the first two betting interests; but if there are no such wagers, then
 - c. As a profit split to those whose combination included either the first-place betting interest to finish first or the second-place betting interest to finish second; but if there are no such wagers on one of those two finishers, then
 - d. As a single price pool to those whose combination included the one covered betting interest to finish first or second.
 4. Winning tickets from the first contest of the Grand Slam shall be exchanged for tickets selecting the first three finishers of the second contest of the Grand Slam. The second contest pool shall be distributed to winning wagers in the following precedence, based upon the official order of finish for the second Grand Slam contest:
 - a. As a single price pool to those whose combination finished in correct sequence as the first three betting interests; but if there are no such wagers, then
 - b. The entire pool for the second and third contests shall be added to any existing carryover monies and retained for the third contest pool of the next performance.
 5. Winning tickets for the second contest of the Grand Slam shall be exchanged for tickets selecting the first four finishers of the third contest of the Grand Slam. The third contest pool and any existing carryover monies shall be distributed to winning wagers in the following precedence, based upon the official order of finish for the third Grand Slam contest:
 - a. As a single price pool to those whose combination finished in correct sequence as the first four betting interests; but if there are no such wagers, then

- b. The entire pool for the third contest shall be added to any existing carryover monies and retained for the corresponding third contest pool of the next performance.
6. If a winning Grand Slam ticket is not presented for cashing and exchange prior to the next Grand Slam contest, the ticket holder may still collect the monetary value associated with the corresponding pool but forfeits all rights to any distribution of subsequent Grand Slam pools.
7. Coupled entries and mutuel fields shall be prohibited in the second and third races of the Grand Slam.
8. Should a betting interest in the first contest of the Grand Slam be scratched, those Grand Slam wagers including the scratched betting interest shall be refunded.
9. Should a betting interest in the second or third contests of the Grand Slam be scratched, an announcement concerning the scratch shall be made and a reasonable amount of time shall be provided for exchange of tickets that include the scratched betting interest. If tickets have not been exchanged prior to the close of betting for the corresponding contest, the ticket holder forfeits all rights to the remainder of the Grand Slam pool.
10. If there is a dead heat or multiple dead heats in any of the contests of the Grand Slam, all Grand Slam wagers selecting the correct order of finish, counting a betting interest involved in a dead heat as finishing in any dead-heated position, shall be winners. Contrary to the usual practice, the aggregate number of winning tickets shall be divided into the net pool and paid the same price.
11. If any of the Grand Slam contests are cancelled prior to the first Grand Slam contest, or the first Grand Slam contest is declared "no contest," the entire Grand Slam pool shall be refunded on Grand Slam wagers for that contest and the remaining Grand Slam contests shall be cancelled. Any existing carryover monies pursuant to subsections (R)(4) and (5) of this rule shall carryover to the next consecutive racing program of that meeting.
12. If the second contest of the Grand Slam is canceled or declared "no contest," or if less than three contestants finish, the second contest pool of the Grand Slam shall be distributed equally among holders of second contest Grand Slam exchange tickets, and the third-contest pool of the Grand Slam shall carryover to the third-contest pool of the next performance.
13. If the third contest of the Grand Slam is canceled or declared "no contest" before the second contest has been made official but after the first contest (pursuant to subsection (R)(11) of this rule), that racing day's third-contest pool shall be distributed equally among holders of second-contest Grand Slam exchange tickets. If the third contest of the Grand Slam is cancelled or declared "no contest" after the second contest has been made official, that racing day's third contest shall be distributed equally among holders of the third-contest Grand Slam exchange tickets. In such instance, no carryover pool would be generated from that racing day.
14. If no distribution is made pursuant to subsection (R)(5)(a) of this rule, on the last day of the race meeting the permittee shall distribute the third-race pool and any existing carryover monies equally among the holders of exchange tickets selecting the finishing contestants in the third race. The net pool shall be distributed to winning wagers in the following precedence, based upon the official order of finish:
 - a. As a single price pool to those whose combination finished in correct sequence as the first three betting interests; but if there are no such wagers, then
 - b. As a single price pool to those whose combination included, in correct sequence, the first two betting interests; but if there are no such wagers, then
 - c. As a single price pool to those whose combination correctly selected the first-place betting interest only; but if there are no such wagers, then
 - d. As a single price pool to all holders of third-race tickets.
15. If there were no winning wagers in the second race of the Grand Slam on the last day of the race meeting, the permittee shall distribute the second-race pool and any existing carryover monies equally among the holders of exchange tickets selecting the finishing contestants in the second race. The net pool shall be distributed to winning wagers in the following precedence, based upon the official order of finish:
 - a. As a single price pool to those whose combination included, in correct sequence, the first two betting interests; but if there are no such wagers, then
 - b. As a single price pool to those whose combination correctly selected the first-place betting interest only; but if there are no such wagers, then
 - c. As a single price pool to all holders of second-race tickets.
16. If there were no winning wagers in the first race of the Grand Slam on the last day of the race meeting, the permittee shall distribute the first-race pool and any existing carryover monies as a profit split to the holders of tickets selecting either the first-place finisher to finish first or the second-place finisher to finish second. If there were still no winning wagers in the first race of the Grand Slam, such monies shall be distributed to all ticket holders.
17. Grand Slam tickets shall be issued in multiples of \$1.00.

Historical Note

Adopted effective October 21, 1993, under an exemption from the Administrative Procedure Act pursuant to A.R.S. § 41-1005(A)(18) (Supp. 93-4). Amended effective November 16, 1993, under an exemption from the Administrative Procedure Act pursuant to A.R.S. § 41-1005(A)(18); inadvertently omitted from Supp. 93-4 (Supp. 94-2). Typographical corrections made to subsections (F)(6), (P)(3)(d), and (P)(21) (Supp. 94-4). R19-2-523 recodified from R4-27-523 (Supp. 95-1). Amended effective July 3, 1996 (Supp. 96-3). Amended effective September 17, 1997, under an exemption from the Administrative Procedure Act pursuant to A.R.S. § 41-1005(A)(18) (Supp. 97-3). Amended by exempt rulemaking at 6 A.A.R. 786, effective February 1, 2000 (Supp. 00-1).

ARTICLE 6. STATE BOXING ADMINISTRATION

R19-2-601. Definitions

The following terms apply to this Article:

1. "Annual bond" means the cash or surety bond, required under A.R.S. § 5-228(E), to be deposited with the Department by a promoter as a prerequisite for a promoter's license.
2. "Commission" means the Arizona State Boxing Commission.
3. "Department" means the Arizona Department of Racing.
4. "Event bond" means the cash or surety bond, authorized under A.R.S. § 5-229(B), which the Commission may

require a promoter to deposit with the Department before each contest.

5. "Gross receipts" means all receipts from the face value of tickets sold. A.R.S. § 5-104.02(E)
6. "Ticket agent" means a person authorized by a promoter to print tickets.
7. "Ticket vendor" means a person authorized by a promoter to sell tickets.
8. "Tickets issued" means all tickets printed for an event.

Historical Note

New Section recodified from Section R4-3-415 at 5 A.A.R. 1175, April 23, 1999 (Supp. 99-2). Amended by final rulemaking at 7 A.A.R. 805, effective January 18, 2001 (Supp. 01-1).

R19-2-602. Notice to the Department

- A. The Commission shall notify the Department in writing not more than two business days after approving the date of a event. The Commission shall also notify the Department immediately if any change in the scheduled event occurs.
- B. The Commission shall provide copies of all contracts to the Department, if requested.

Historical Note

New Section recodified from Section R4-3-416 at 5 A.A.R. 1175, April 23, 1999 (Supp. 99-2). Amended by final rulemaking at 7 A.A.R. 805, effective January 18, 2001 (Supp. 01-1).

R19-2-603. Ticket Manifest, Collection, Accounting

- A. General requirements.
 1. A promoter shall provide the Department with:
 - a. A ticket manifest from each ticket agent no later than weigh-in. The manifest shall be accompanied by a signed affidavit from the ticket agent or the ticket agent's designee, certifying that the manifest is accurate and complete. The manifest shall list the total number of tickets issued and the number of tickets in each price category.
 - b. If tickets issued are sold through a computerized system that does not lend itself to a manifest, an accounting from each ticket agent of the total number of tickets in each price category. The accounting shall be accompanied by a signed affidavit from the ticket agent or the ticket agent's designee, certifying that the accounting is accurate and complete.
 2. The ticket price shall be clearly printed on each ticket and ticket stub.
 3. A promoter shall ensure that tickets are distributed only through ticket vendors specified by the promoter.
 4. The Commission shall, upon request, provide the Department with the names and contract information for all ticket agents and vendors.
- B. Reduced price tickets. A promoter shall ensure that tickets sold for less than the printed price are plainly over stamped with the actual price charged on the printed face of the ticket and ticket stub.
- C. Complimentary tickets. A promoter shall ensure that:
 1. The total number of complimentary tickets does not exceed 2% of the total number of tickets issued for the event or 75 whichever is greater, as specified under A.R.S. § 5-104.02(D).
 2. Complimentary tickets in excess of the greater value of 2% or 75 are treated as noncomplimentary.
 3. Complimentary tickets and ticket stubs are punched or stamped "complimentary."

- D. Ticket accounting and fee payment. Representatives of the promoter and Department shall meet within 10 days of an event to account for all tickets sold and pay the required tax. If required by the Department, the promoter shall provide an accounting by each ticket vendor.

1. The promoter shall provide the Department with the following information on a Department form:
 - a. The number of tickets sold and unsold in each price category;
 - b. The amount of the gross receipts calculated using the printed price on each ticket sold;
 - c. The signature of the promoter, certifying that the information is true and correct.
2. The Department shall consider as sold any tickets listed on a manifest as issued and not physically presented to the Department by the promoter as unsold.
3. The promoter shall pay the Department 4% of the gross receipts after the deduction of city, state, and federal taxes, of the match or exhibition.

Historical Note

New Section recodified from Section R4-3-417 at 5 A.A.R. 1175, April 23, 1999 (Supp. 99-2). Amended by final rulemaking at 7 A.A.R. 805, effective January 18, 2001 (Supp. 01-1).

R19-2-604. Annual Bond, Event Bond, Claims

- A. Annual bond.
 1. A promoter shall deposit the annual bond with the Department no later than weigh-in for the first event promoted.
 2. Upon receipt of written notice from the Commission that a promoter's obligations for all events during the calendar year are satisfied, the Department shall release the promoter from the annual bond responsibility for that year.
- B. Event bond.
 1. The Commission shall notify the Department in writing of the amount of an event bond and deposit the bond with the Department no later than the weigh-in for the event. The Department shall retain the event bond until notice is received from the Commission that the promoter has satisfied all obligations concerning the bond guarantee.
 2. Upon receipt of written notice from the Commission that the promoter's obligations for an event are satisfied, the Department shall return the bond to the promoter.
 3. If an event is not held, the Commission shall notify the Department, not later than 22 business days after the scheduled event, whether the promoter's obligations for the event have been satisfied and whether the promoter's event bond can be returned.
- C. Department claim. The Department shall notify:
 1. A promoter by registered or certified mail, return receipt requested, that:
 - a. The unpaid tax on gross receipts shall be paid within 10 business days from receipt of the notice; and
 - b. If the payment is not received within the 10 business days, forfeiture proceedings against the bond may be initiated based on the Department's determination of whether a promoter's obligations have been faithfully performed.
 2. The Commission if a promoter fails to pay the required tax on gross receipts.
- D. The Department shall not release any bond for which a claim is pending.

Historical Note

New Section recodified from Section R4-3-418 at 5 A.A.R. 1175, April 23, 1999 (Supp. 99-2). Section

repealed; new Section adopted by final rulemaking at 7 A.A.R. 805, effective January 18, 2001 (Supp. 01-1).

R19-2-605. License Fees

- A. The Commission shall forward license fees to the Department within five business days of receipt with the following information:
1. The type of license issued;
 2. The name and date of birth of the licensee;
 3. The license number; and
 4. The date and amount of payment received.
- B. The Commission shall retain a current list of the licenses issued and the additional applicable licensing information and make the information available to the Department.

Historical Note

New Section recodified from Section R4-3-419 at 5 A.A.R. 1175, April 23, 1999 (Supp. 99-2). Former Section R19-2-605 repealed; new Section R19-2-605 renumbered from R19-2-609 and amended by final rulemaking at 7 A.A.R. 805, effective January 18, 2001 (Supp. 01-1).

R19-2-606. Fines

- A. The Commission shall notify the Department in writing if a licensee is issued a fine.
- B. The Commission shall immediately forward the fine payment to the Department.

Historical Note

New Section recodified from Section R4-3-420 at 5 A.A.R. 1175, April 23, 1999 (Supp. 99-2). Former Section R19-2-606 repealed; new Section R19-2-606 renum-

bered from R19-2-610 and amended by final rulemaking at 7 A.A.R. 805, effective January 18, 2001 (Supp. 01-1).

R19-2-607. Repealed**Historical Note**

New Section recodified from Section R4-3-421 at 5 A.A.R. 1175, April 23, 1999 (Supp. 99-2). Section repealed by final rulemaking at 7 A.A.R. 805, effective January 18, 2001 (Supp. 01-1).

R19-2-608. Repealed**Historical Note**

New Section recodified from Section R4-3-422 at 5 A.A.R. 1175, April 23, 1999 (Supp. 99-2). Section repealed by final rulemaking at 7 A.A.R. 805, effective January 18, 2001 (Supp. 01-1).

R19-2-609. Renumbered**Historical Note**

New Section recodified from Section R4-3-423 at 5 A.A.R. 1175, April 23, 1999 (Supp. 99-2). Section renumbered to R19-2-605 by final rulemaking at 7 A.A.R. 805, effective January 18, 2001 (Supp. 01-1).

R19-2-610. Renumbered**Historical Note**

New Section recodified from Section R4-3-424 at 5 A.A.R. 1175, April 23, 1999 (Supp. 99-2). Section renumbered to R19-2-606 by final rulemaking at 7 A.A.R. 805, effective January 18, 2001 (Supp. 01-1).

Supplement to the

Arizona Administrative Code

The official compilation of Arizona Rules

Arizona Secretary of State's Office

Public Services Division

1700 W. Washington Street, Fl 7.

Phoenix, AZ 85007

Replacement Check List

For rules filed within the

4th Calendar Quarter

October 1 - December 31, 2012

Code Release Number: Supp. 12-4

Within the stated calendar quarter, this Title contains all rules made, amended, repealed, renumbered, and recodified, or rules that have expired or were terminated due to an agency being eliminated under sunset law. These rules were either certified by the Governor's Regulatory Review Council or the Attorney General's Office, or exempt from the rulemaking process, and filed with the Office of the Secretary of State. Refer to the historical notes for more information. Please note that some rules you are about to remove may still be in effect after the publication date of this Supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

Follow the instructions to replace the updated Chapters.

TITLE 20. COMMERCE BANKING AND INSURANCE

Chapter 4. Department of Financial Institutions

Sections, Parts, Exhibits, Tables or Appendices modified

R20-4-102, Table A, R20-4-927, R20-4-928, R20-4-1813

REMOVE Supp. 10-4

Pages: 1 - 55

REPLACE with Supp. 12-4

Pages: 1 - 56

Chapter 5. Industrial Commission of Arizona

Sections, Parts, Exhibits, Tables or Appendices modified

R20-5-601 and R20-5-602

REMOVE Supp. 12-2

Pages: 1 - 106

REPLACE with Supp. 12-4

Pages: 1 - 106

Chapter 6. Department of Insurance

Sections, Parts, Exhibits, Tables or Appendices modified

R20-6-2301 through R20-6-2305

REMOVE Supp. 11-3

Pages: 1 - 115

REPLACE with Supp. 12-4

Pages: 1 - 117

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE**CHAPTER 4. DEPARTMENT OF FINANCIAL INSTITUTIONS**

(Authority: A.R.S. § 6-101 et seq.)

Editor's Note: The Banking Department's name was changed to the Arizona Department of Financial Institutions under the authority of A.R.S. § 6-110, originally enacted as Laws 2004, Ch. 188, effective January 1, 2006 (Supp. 06-1).

Editor's Note: Title 20, formerly Commerce, Banking, and Insurance, is now Commerce, Financial Institutions, and Insurance. This change became effective when the Banking Department changed its name to the Department of Financial Institutions, effective January 1, 2006 (Supp. 06-1).

20 A.A.C. 4, consisting of R20-4-101 through R20-4-106, R20-4-201 through R20-4-215, R20-4-301 through R20-4-331, R20-4-401 through R20-4-402, R20-4-501 through R20-4-536, R20-4-601 through R20-4-620, R20-4-701 through R20-4-707, R20-4-801 through R20-4-816, R20-4-901 through R20-4-924, R20-4-1001, R20-4-1101 through R20-4-1102, R20-4-1201 through R20-4-1220, R20-4-1401 through R20-4-1410, R20-4-1501 through R20-4-1530, R20-4-1601 through R20-4-1604, and R20-4-1701 through R20-4-1706, recodified from 4 A.A.C. 4, consisting of R4-4-101 through R4-4-106, R4-4-201 through R4-4-215, R4-4-301 through R4-4-331, R4-4-401 through R4-4-402, R4-4-501 through R4-4-536, R4-4-601 through R4-4-620, R4-4-701 through R4-4-707, R4-4-801 through R4-4-816, R4-4-901 through R4-4-924, R4-4-1001, R4-4-1101 through R4-4-1102, R4-4-1201 through R4-4-1220, R4-4-1401 through R4-4-1410, R4-4-1501 through R4-4-1530, R4-4-1601 through R4-4-1604, and R4-4-1701 through R4-4-1706, pursuant to R1-1-102 (Supp. 95-1).

ARTICLE 1. GENERAL

R20-4-101 through R4-4-106 recodified from R4-4-101 through R4-4-106 (Supp. 95-1).

Article 1, consisting of Sections R4-4-101 through R4-4-106 adopted effective August 16, 1991 (Supp. 91-3).

Article 1, consisting of Sections R4-4-101 through R4-4-104, repealed effective August 16, 1991 (Supp. 91-3).

Section

R20-4-101.	Scope of Article
R20-4-102.	Definitions
R20-4-103.	Fingerprints
R20-4-104.	Acceptance of Other Forms
R20-4-105.	Claims Against a Deposit in Place of Bond
R20-4-106.	Bankruptcy
R20-4-107.	Licensing Time-frames
Table A.	Licensing Time-frames

ARTICLE 2. BANK ORGANIZATION AND REGULATION**Section**

R20-4-201.	Articles of Incorporation
R20-4-202.	Bylaws
R20-4-203.	Repealed
R20-4-204.	Repealed
R20-4-205.	Repealed
R20-4-206.	Bankers Blanket Bond Coverage -- A.R.S. § 6-188
R20-4-207.	Capital Obligations
R20-4-208.	Repealed
R20-4-209.	Notice of Permanent Closing of Banking Office
R20-4-210.	Repealed
R20-4-211.	Application for a Banking Permit
R20-4-212.	Repealed
R20-4-213.	Repealed
R20-4-214.	Preservation of Records
R20-4-215.	Trust Business

ARTICLE 3. SAVINGS AND LOAN ASSOCIATIONS**Section**

R20-4-301.	Fidelity Bond -- A.R.S. § 6-420
R20-4-302.	Repealed
R20-4-303.	Separate Trust Account -- A.R.S. § 6-449(C)(3)
R20-4-304.	Publication of Intent to Organize -- A.R.S. § 6-123
R20-4-305.	Repealed
R20-4-306.	Repealed
R20-4-307.	Repealed
R20-4-308.	Repealed

R20-4-309.	Sale and Servicing of Loans -- A.R.S. §§ 6-451, 6-402
R20-4-310.	Reserved
R20-4-311.	Repealed
R20-4-312.	Repealed
R20-4-313.	Reserved
R20-4-314.	Repealed
R20-4-315.	Repealed
R20-4-316.	Repealed
R20-4-317.	Repealed
R20-4-318.	Service Corporations -- A.R.S. § 6-446(5)
R20-4-319.	Repealed
R20-4-320.	Repealed
R20-4-321.	Repealed
R20-4-322.	Repealed
R20-4-323.	Repealed
R20-4-324.	Give-aways -- A.R.S. § 6-444
R20-4-325.	Appraisal Requirements -- A.R.S. § 6-457
R20-4-326.	Capital Notes and Debentures -- A.R.S. § 6-405.01
R20-4-327.	Application for Permit to Organize a New Association -- A.R.S. § 6-408
R20-4-328.	Application for Approval to Establish a Branch Office -- A.R.S. § 6-475
R20-4-329.	Repealed
R20-4-330.	First Payment Date on Loans -- A.R.S. § 6-449(E)
R20-4-331.	Repealed

ARTICLE 4. CREDIT UNIONS**Section**

R20-4-401.	Fidelity Bond Coverage
R20-4-402.	Repealed

ARTICLE 5. SMALL LOANS**Section**

R20-4-501.	Repealed
R20-4-502.	Repealed
R20-4-503.	Adjustments in Precomputed Charges
R20-4-504.	Repealed
R20-4-505.	Repealed
R20-4-506.	Repealed
R20-4-507.	Repealed
R20-4-508.	Cut-off Date for Computing Refunds upon Early Repayment in Full
R20-4-509.	Repealed
R20-4-510.	Repealed
R20-4-511.	Repealed
R20-4-512.	Reserved
R20-4-513.	Repealed

R20-4-514.	Repealed
R20-4-515.	Repealed
R20-4-516.	Repealed
R20-4-517.	Repealed
R20-4-518.	Deferral Fee
R20-4-519.	Deferment Statement
R20-4-520.	Repealed
R20-4-521.	Repealed
R20-4-522.	Repealed
R20-4-523.	Repealed
R20-4-524.	Books, Accounts, and Records
R20-4-525.	Repealed
R20-4-526.	Repealed
R20-4-527.	Repealed
R20-4-528.	Repealed
R20-4-529.	Repealed
R20-4-530.	Repealed
R20-4-531.	Repealed
R20-4-532.	Repealed
R20-4-533.	Reserved
R20-4-534.	Insurance
R20-4-535.	Reserved
R20-4-536.	Repealed

ARTICLE 6. DEBT MANAGEMENT COMPANIES

Article 6, consisting of Sections R4-4-601 through R4-4-620, adopted effective October 26, 1978, except that Sections R4-4-603, R4-4-604 and R4-4-607 shall become effective January 1, 1979. R20-4-601 through R20-4-620 recodified from R4-4-601 through R4-4-620 (Supp. 95-1).

Former Article 6, consisting of Section R4-4-601, repealed effective October 26, 1978. R20-4-601 recodified from R4-4-601 (Supp. 95-1).

Section	
R20-4-601.	Repealed
R20-4-602.	Applications
R20-4-603.	Reports
R20-4-604.	Records
R20-4-605.	Reserved
R20-4-606.	Reserved
R20-4-607.	Budget Analysis
R20-4-608.	Reserved
R20-4-609.	Repealed
R20-4-610.	Repealed
R20-4-611.	Advertising
R20-4-612.	Solvency and Minimum Liquid Assets
R20-4-613.	Reserved
R20-4-614.	Reserved
R20-4-615.	Reserved
R20-4-616.	Reserved
R20-4-617.	Reserved
R20-4-618.	Reserved
R20-4-619.	Reserved
R20-4-620.	Repealed

ARTICLE 7. ESCROW AGENTS

Section	
R20-4-701.	Change in Location of Business
R20-4-702.	Account Practices and Records
R20-4-703.	Preservation of Records
R20-4-704.	Subsidiary Account Records
R20-4-705.	Reserved
R20-4-706.	Repealed
R20-4-707.	Payment to the All Other Escrow Agents Account of the Arizona Escrow Guaranty Fund
R20-4-708.	Financial Condition and Resources

ARTICLE 8. TRUST COMPANIES

Section	
R20-4-801.	Definitions
R20-4-802.	Reserved
R20-4-803.	Reserved
R20-4-804.	Repealed
R20-4-805.	Reports
R20-4-806.	Records
R20-4-807.	Unsafe or Unsound Condition
R20-4-808.	Administration of Fiduciary Powers
R20-4-809.	Fiduciary Duties
R20-4-810.	Funds Awaiting Investment or Distribution
R20-4-811.	Investment of Trust Funds
R20-4-812.	Self-dealing
R20-4-813.	Custody of Investments
R20-4-814.	Compensation
R20-4-815.	Collective Investments
R20-4-816.	Termination of Trust or Fiduciary Powers and Duties
App. A.	Repealed
App. B.	Repealed

ARTICLE 9. MORTGAGE BROKERS

Section	
R20-4-901.	Reserved
R20-4-902.	Reserved
R20-4-903.	Exemption for an Entity Regulated by an Agency of this State, Other States, or by the United States
R20-4-904.	Reserved
R20-4-905.	Repealed
R20-4-906.	Equivalent and Related Experience
R20-4-907.	Course of Study
R20-4-908.	Reserved
R20-4-909.	Reserved
R20-4-910.	Reserved
R20-4-911.	Qualified Replacement Responsible Individual
R20-4-912.	Restrictions on the Term of a Cash Alternative
R20-4-913.	Reserved
R20-4-914.	Reserved
R20-4-915.	Requirements for a Person Intended to Oversee a Branch Office
R20-4-916.	Notification of Change of Address
R20-4-917.	Recordkeeping Requirements
R20-4-918.	Repealed
R20-4-919.	Deposit of Monies Received by a Mortgage Broker
R20-4-920.	Requirements for the Testing Committee
R20-4-921.	Authorizations to Complete Blank Spaces
R20-4-922.	Determining Loan Amounts
R20-4-923.	Delay or Cause Delay
R20-4-924.	Receipt and Disbursement of Monies
R20-4-925.	Waiver of Examination and Course of Study
R20-4-926.	Acquisition of Additional Interest in Licensee by Majority Owner
R20-4-927.	Conversion to Commercial Mortgage Broker License
R20-4-928.	Certificate of Exemption Application and Renewal

ARTICLE 10. SAFE DEPOSIT AND SAFEKEEPING CODE

Section	
R20-4-1001.	Notice of Change of Location of Safe Deposit Repository

ARTICLE 11. PUBLIC DEPOSITORIES FOR PUBLIC MONIES

Section	
R20-4-1101.	Capital structure of banks; defined
R20-4-1102.	Capital structure of savings and loan associations;

defined

**ARTICLE 12. RULES OF PRACTICE AND PROCEDURE
BEFORE THE SUPERINTENDENT**

Section

- R20-4-1201. Scope of Article
- R20-4-1202. Definitions
- R20-4-1203. Repealed
- R20-4-1204. Filing; Service
- R20-4-1205. Repealed
- R20-4-1206. Repealed
- R20-4-1207. Repealed
- R20-4-1208. Commencement of Proceedings; Notice of Hearing
- R20-4-1209. Answer to Notice of Hearing
- R20-4-1210. Stays
- R20-4-1211. Intervention
- R20-4-1212. Repealed
- R20-4-1213. Repealed
- R20-4-1214. Repealed
- R20-4-1215. Repealed
- R20-4-1216. Repealed
- R20-4-1217. Repealed
- R20-4-1218. Repealed
- R20-4-1219. Rehearing
- R20-4-1220. Consent Agreements

EMERGENCY RULEMAKING

ARTICLE 13. LOAN ORIGINATORS

Article 13, consisting of Sections R20-4-1301 through R20-4-1305, emergency rulemaking renewed at 16 A.A.R. 2165, effective October 24, 2010 for an additional 180 days (Supp. 10-4).

Article 13, consisting of Sections R20-4-1301 through R20-4-1305, made by emergency rulemaking at 16 A.A.R. 839, effective April 27, 2010 for 180 days (Supp. 10-2).

Section

- EMERGENCY RULEMAKING
- R20-4-1301. Scope of Article
- EMERGENCY RULEMAKING
- R20-4-1302. Course of Study to Qualify for Licensure
- EMERGENCY RULEMAKING
- R20-4-1303. Financial Responsibility
- EMERGENCY RULEMAKING
- R20-4-1304. Fees
- EMERGENCY RULEMAKING
- R20-4-1305. Practice and Procedure

ARTICLE 13. LOAN ORIGINATORS

Article 13, consisting of Sections R20-4-1301 through R20-4-1305, emergency expired April 21, 2011; new Article consisting of Sections R20-4-1301 through R20-4-1305, made by final rulemaking at 16 A.A.R. 2401, effective April 22, 2011 (Supp. 10-4).

Article 13, consisting of Sections R20-4-1301 through R20-4-1305, emergency rulemaking renewed at 16 A.A.R. 2165, effective October 24, 2010 for an additional 180 days (Supp. 10-4).

Article 13, consisting of Sections R20-4-1301 through R20-4-1305, made by emergency rulemaking at 16 A.A.R. 839, effective April 27, 2010 for 180 days (Supp. 10-2).

Section

- R20-4-1301. Scope of Article
- R20-4-1302. Course of Study to Qualify for Licensure
- R20-4-1303. Financial Responsibility
- R20-4-1304. Fees
- R20-4-1305. Practice and Procedure

ARTICLE 14. INVESTIGATIONS

Section

- R20-4-1401. Definitions
- R20-4-1402. Repealed
- R20-4-1403. Subpoenas: Service; Amendment; Investigation or Examination not a Condition of the Superintendent's Subpoena Power
- R20-4-1404. Repealed
- R20-4-1405. Fingerprints; Background Information
- R20-4-1406. Repealed
- R20-4-1407. Renumbered
- R20-4-1408. Repealed
- R20-4-1409. Renumbered
- R20-4-1410. Repealed

ARTICLE 15. COLLECTION AGENCIES

Section

- R20-4-1501. Definitions
- R20-4-1502. Applications
- R20-4-1503. Reports
- R20-4-1504. Records
- R20-4-1505. Trust Account
- R20-4-1506. Articles of Incorporation; Bylaws; Organizing Documents
- R20-4-1507. Representations of Collection Agency's Identity
- R20-4-1508. Representations of the Law
- R20-4-1509. Representations as to Fees, Costs, and Legal Proceedings; Disinterested Counsel Required
- R20-4-1510. Representations as to Rights Waived or Remedies Available
- R20-4-1511. Prohibition of Harassment
- R20-4-1512. Contacts with Debtors and Others
- R20-4-1513. Cessation of Communication with the Debtor
- R20-4-1514. Disclosure of Information to Debtor
- R20-4-1515. Aiding and Abetting
- R20-4-1516. Advertising
- R20-4-1517. Repealed
- R20-4-1518. Agreements with Clients
- R20-4-1519. Licensee Names and Control
- R20-4-1520. Representations of Collection Agency Employees' Identity or Position
- R20-4-1521. Duty of Investigation
- R20-4-1522. Reserved
- R20-4-1523. Reserved
- R20-4-1524. Reserved
- R20-4-1525. Reserved
- R20-4-1526. Reserved
- R20-4-1527. Reserved
- R20-4-1528. Reserved
- R20-4-1529. Reserved
- R20-4-1530. Repealed

ARTICLE 16. ACQUIRING CONTROL OF FINANCIAL INSTITUTIONS

Section

- R20-4-1601. Definitions
- R20-4-1602. Application for Approval to Acquire Control of Financial Institution
- R20-4-1603. Repealed
- R20-4-1604. Repealed

ARTICLE 17. ARIZONA INTERSTATE BANK AND SAVINGS AND LOAN ASSOCIATION ACT

Section

- R20-4-1701. Definitions
- R20-4-1702. Notice to the Superintendent of Intent to Acquire

Control of an In-state Financial Institution; Surrender of an Acquired Financial Institution's Charter

- R20-4-1703. Repealed
- R20-4-1704. Public Notice
- R20-4-1705. Repealed
- R20-4-1706. Repealed

ARTICLE 18. MORTGAGE BANKERS

Article 18, consisting of Sections R20-4-1801 through R20-4-1812, adopted by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

Section

- R20-4-1801. Exemption for an Entity Regulated by an Agency of this State, Other States, or by the United States
- R20-4-1802. Equivalent and Related Experience
- R20-4-1803. Restrictions on the Term of a Cash Alternative to a Surety Bond
- R20-4-1804. Requirements for a Person Intended to Oversee a Branch Office
- R20-4-1805. Notification of Change of Address
- R20-4-1806. Recordkeeping Requirements
- R20-4-1807. Providing Copies of Records
- R20-4-1808. Authorizations to Complete Blank Spaces
- R20-4-1809. Determining Loan Amounts
- R20-4-1810. Delay or Cause Delay
- R20-4-1811. Impound Account
- R20-4-1812. Acquisition of Additional Interest in Licensee by Majority Owner
- R20-4-1813. Conversion to Mortgage Broker License

ARTICLE 19. COMMERCIAL MORTGAGE BANKERS

Article 19, consisting of Sections R20-4-1901 through R20-4-1911, adopted by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

Section

- R20-4-1901. Exemption for an Institutional Investor
- R20-4-1902. Exemption for an Entity Regulated by an Agency of this State, Other States, or by the United States
- R20-4-1903. Equivalent and Related Experience
- R20-4-1904. Restrictions on the Term of a Cash Alternative to a Surety Bond
- R20-4-1905. Requirements for a Person Intended to Oversee a Branch Office
- R20-4-1906. Notification of Change of Address
- R20-4-1907. Recordkeeping Requirements
- R20-4-1908. Impound Accounts
- R20-4-1909. Authorization to Complete Blank Spaces
- R20-4-1910. Delay or Cause Delay
- R20-4-1911. Acquisition of Additional Interest in Licensee by Majority Owner

ARTICLE 1. GENERAL

R20-4-101. Scope of Article

The rules in this Article apply to all activities of the Superintendent and to the interpretation of all Arizona statutes and rules administered by the Superintendent.

Historical Note

Former Rule 1. Former R4-4-101 repealed, new R4-4-101 adopted effective August 16, 1991 (Supp. 91-3).
R20-4-101 recodified from R4-4-101 (Supp. 95-1).

R20-4-102. Definitions

In this Chapter, unless otherwise specified:

1. "Active management" means directing a licensee's activities by a responsible individual, who:

- a. Is knowledgeable about the licensee's Arizona activities;
 - b. Supervises compliance with:
 - i. The laws enforced by the Department of Financial Institutions as they relate to the licensee, and
 - ii. Other applicable laws and rules; and
 - c. Has sufficient authority to ensure compliance.
2. "Affiliate" has the meaning stated at A.R.S. § 6-901.
 3. "Attorney General" means the Attorney General or an assistant Attorney General of the state of Arizona.
 4. "Branch office" means any location within or outside Arizona, including a personal residence, but not including a licensee's principal place of business in Arizona, where the licensee holds out to the public that the licensee acts as a licensee.
 5. "Business of a savings and loan association or savings bank" means receiving money on deposit subject to payment by check or any other form of order or request or on presentation of a certificate of deposit or other evidence of debt.
 6. "Compensation" means, in applying that term's definition in A.R.S. §§ 6-901, 6-941, and 6-971, anything received in advance, after repayment, or at any time during a loan's life. This subsection expressly excludes the following items from those definitions of compensation:
 - a. Charges or fees customarily received after a loan's closing including prepayment penalties, termination fees, reinvestment fees, late fees, default interest, transfer fees, impound account interest and fees, extension fees, and modification fees. However, extension fees and modification fees are compensation if the lender advances additional funds or increases the credit limit on an open-end mortgage as part of the extension or modification;
 - b. Out-of-pocket expenses paid to independent third parties including appraisal fees, credit report fees, legal fees, document preparation fees, title insurance premiums, recording, filing, and statutory fees, collection fees, servicing fees, escrow fees, and trustee's fees;
 - c. Insurance commissions;
 - d. Contingent or additional interest, including interest based on net operating income; or
 - e. Equity participation.
 7. "Commercial finance transaction," as that term is used in this Section's definitions of the terms "Engaged in the business of making mortgage loans" and "Engaged in the business of making mortgage loans or mortgage banking loans," means a loan made primarily for other than personal, family, or household purposes.
 8. "Control of a licensee," as used in A.R.S. §§ 6-903, 6-944, or 6-978, does not include acquiring additional fractional equity interests in a licensee by any person who already has the power to vote 51% or more of the licensee's outstanding voting equity interests.
 9. "Correspondent contract," as that term is used in A.R.S. §§ 6-941, 6-943, 6-971, or 6-973, means an agreement between a lender and a funding source under which the funding source may fund, or is required to fund, loans originated by the lender.
 10. "Cushion," as that term is used in R20-4-1811 or R20-4-1908, means funds that a servicer or lender may require a borrower to pay into an escrow or impound account before the borrower's periodic payments are available in the account to cover unanticipated disbursements.

11. "Directly or indirectly makes, negotiates, or offers to make or negotiate" and "Directly or indirectly making, negotiating, or offering to make or negotiate," as those phrases are used in A.R.S. §§ 6-901, 6-941, or 6-971, mean:
 - a. Providing consulting or advisory services in connection with a mortgage loan transaction, mortgage banking loan transaction, or commercial mortgage loan transaction;
 - i. To an investor, concerning the location or identity of potential borrowers, regardless of whether the person providing consulting or advisory services directly contacts any potential borrowers; or
 - ii. To a borrower, concerning the location or identity of potential investors or lenders; or
 - b. Providing assistance in preparing an application for a mortgage loan transaction, mortgage banking loan transaction, or commercial mortgage banking loan transaction, regardless of whether the person providing assistance directly contacts any potential investor or lender; and
 - c. Processing a loan; but
 - d. "Directly or indirectly makes, negotiates, or offers to make or negotiate" and "Directly or indirectly making, negotiating, or offering to make or negotiate" do not include:
 - i. Providing clerical, mechanical, or word processing services to prepare papers or documents associated with a mortgage loan transaction, mortgage banking loan transaction, or commercial mortgage banking loan transaction;
 - ii. Purchasing, selling, negotiating to purchase or sell, or offering to purchase or sell a mortgage loan, mortgage banking loan, or commercial mortgage banking loan already funded;
 - iii. Making, negotiating, or offering to make additional advances on an existing open-ended mortgage loan, mortgage banking loan, or commercial mortgage loan including revolving credit lines;
 - iv. Modifying, renewing, or replacing a mortgage loan, a mortgage banking loan, or a commercial mortgage loan already funded, if the parties to and security for the loan are the same as the original loan immediately before the modification, renewal, or replacement, and if no additional funds are advanced and no increase is made in the credit limit on an open-ended loan. Replacing a loan means making a new loan simultaneously with terminating an existing loan.
12. "Electronic record" has the meaning stated at A.R.S. § 44-7002(7).
13. "Employee" means a natural person who has an employment relationship with a licensee that is acknowledged by both the person and the licensee, and:
 - a. The person is entitled to payment, or is paid, by the licensee;
 - b. The licensee withholds and remits, or is liable for withholding and remitting, payroll deductions for all applicable federal and state payroll taxes;
 - c. The licensee has the right to hire and fire the employee and the employee's assistants;
 - d. The licensee directs the methods and procedures for performing the employee's job;
 - e. The licensee supervises the employee's business conduct and the employee's compliance with applicable laws and rules; and
 - f. The rights and duties under subsections (13)(a) through (e) belong to the licensee regardless of whether another person also shares those rights and duties.
14. "Engaged in the business of making mortgage loans," as that phrase is used in A.R.S. § 6-902, and "engaged in the business of making mortgage loans or mortgage banking loans," as that phrase is used in A.R.S. § 6-942, mean the direct or indirect making of a total of more than five mortgage banking loans or mortgage loans, or both in a calendar year. Each loan counts only once as of its closing date. A person is not "engaged in the business of making mortgage loans or mortgage banking loans" if the person makes loans solely in commercial finance transactions in which no more than 35% of the aggregate value of all security taken by the investor on the closing date is a lien, or liens, on real property.
15. "Exclusive contract," as that term is used in A.R.S. §§ 6-912 and 6-991.02, means a written agreement in which a loan originator agrees to perform services as a loan originator subject to supervision and control by a person holding a certificate of exemption issued under A.R.S. § 6-912 on an exclusive basis. The agreement provides that the loan originator is expressly prohibited from performing loan origination or modification services for any other person during the time the agreement is in effect.
16. "Generally accepted accounting principles" has the meaning used by the Financial Accounting Standards Board or the American Institute of Certified Public Accountants.
17. "Holds out to the public," as used in this Section's definition of "branch office," means advertising or otherwise informing the public that mortgage banking loans, commercial mortgage loans, or mortgage loans are made or negotiated at a location. "Holds out to the public" includes listing a location on business cards, stationery, brochures, rate lists, or other promotional items. "Holds out to the public" does not include a clearly identified home or mobile telephone number on a business card or stationery.
18. "Loan," as that term is used in A.R.S. §§ 6-126(C)(6) and (8), means all loans negotiated or closed, without regard to the location of the real property collateral or type of loan.
19. "Loan Processing" means obtaining a loan application's supporting documents for use in underwriting.
20. "Person" means a natural person or any legal or commercial entity including a corporation, business trust, estate, trust, partnership, limited partnership, joint venture, association, limited liability company, limited liability partnership, or limited liability limited partnership.
21. "Property insurance," as that term is used in A.R.S. §§ 6-909 and 6-947, does not include flood insurance as that term is used in the Flood Disaster Protection Act of 1973, as modified by the National Flood Insurance Reform Act of 1994. 42 U.S.C. 4001, et seq.
22. "Reasonable investigation of the background," as that term is used in A.R.S. §§ 6-903, 6-943, or 6-976 means a licensee, at a minimum:

- a. Collects and reviews all the documents authorized by the Immigration Reform and Control Act of 1986, 8 U.S.C. 1324a;
 - b. Obtains a completed Employment Eligibility Verification (Form I-9);
 - c. Obtains a completed and signed employment application;
 - d. Obtains a signed statement attesting to all of an applicant's felony convictions, including detailed information regarding each conviction;
 - e. Consults with the applicant's most recent or next most recent employer, if any;
 - f. Inquiries regarding the applicant's qualifications and competence for the position;
 - g. If for a loan officer, loan originator, loan processor, branch manager, supervisor, or similar position, obtains a current credit report from a credit reporting agency; and
 - h. Investigates further if any information received in the above inquiries raises questions as to the applicant's honesty, truthfulness, integrity, or competence. An inquiry is sufficient after two attempts to contact a person, including at least one written inquiry.
23. "Record" has the meaning stated at A.R.S. § 44-7002(13).
24. "Registered to do business in this state" means:
- a. If an Arizona corporation, it is incorporated under A.R.S. Title 10, Chapter 2, Article 1;
 - b. If a foreign corporation, it either transfers its domicile under A.R.S. Title 10, Chapter 2, Article 2, or obtains authority to transact business in Arizona under A.R.S. Title 10, Chapter 15, Article 1;
 - c. If a business trust, it obtains authority to transact business in Arizona under A.R.S. Title 10, Chapter 18, Article 4;
 - d. If an estate, it acts through a personal representative duly appointed by this state's Superior Court, under the provisions of A.R.S. Title 14, Chapter 3 or 4;
 - e. If a trust, it delivers to the Superintendent an executed copy of the trust instrument creating the trust together with:
 - All the current amendments, or
 - A true copy of the trust instrument certified accurate and complete by a trustee of the trust before a notary public;
 - f. If a general partnership, limited partnership, limited liability company, limited liability partnership, or limited liability limited partnership, it is organized under A.R.S. Title 29;
 - g. If a foreign general partnership, limited partnership, limited liability company, limited liability partnership, or limited liability limited partnership, it is registered with the Arizona Secretary of State's office under A.R.S. Title 29;
 - h. If a joint venture, association, or any entity not specified in this subsection, it is organized and conducts its business in compliance with Arizona law; or
 - i. The entity is exempt from registration.
25. "Registered Exempt Person" means a person who is exempt from licensure pursuant to A.R.S. § 6-912 and A.R.S. Title 6, Chapter 9, Articles 1, 2 and 3 as a federally chartered savings bank that is registered with the nationwide mortgage licensing system and registry and holds a certificate of exemption.
26. "Resident of this state" means a natural person domiciled in Arizona.
27. "Responsible individual" or "responsible person", as those terms are used in A.R.S. §§ 6-903, 6-943, 6-973, and 6-976, means a resident of this state who:
- a. Lives in Arizona during the entire period of designation as the responsible individual on a license;
 - b. Is in active management of a licensee's affairs;
 - c. Meets the qualifications listed in A.R.S. §§ 6-903, 6-943, or 6-973; and
 - d. Is an officer, director, member, partner, employee, or trustee of a licensed entity.
- Historical Note**
- Former Rule 2. Former R4-4-102 repealed, new R4-4-102 adopted effective August 16, 1991 (Supp. 91-3).
R20-4-102 recodified from R4-4-102 (Supp. 95-1).
Amended by final rulemaking at 5 A.A.R. 2094, effective June 10 (Supp. 99-2). Amended by final rulemaking at 7 A.A.R. 668, effective January 10, 2001 (Supp. 01-1).
Amended by final rulemaking at 8 A.A.R. 145, effective December 10, 2001 (Supp. 01-4). Amended by final rulemaking at 18 A.A.R. 2622, effective December 2, 2012 (Supp. 12-4).
- R20-4-103. Fingerprints**
- A. A licensee or applicant shall deliver fingerprints requested or required by the Superintendent on fingerprint cards provided by the Superintendent.
 - B. A licensee or applicant shall bear any costs incurred in obtaining or submitting fingerprints.
 - C. A licensee or applicant shall arrange to have fingerprints taken, signed, and dated by:
 1. A municipal police department,
 2. A local sheriff's office, or
 3. Another law enforcement authority recognized by the Superintendent.
- Historical Note**
- Former Rule 3. Former R4-4-103 repealed, new R4-4-103 adopted effective August 16, 1991 (Supp. 91-3).
R20-4-103 recodified from R4-4-103 (Supp. 95-1).
Amended by final rulemaking at 6 A.A.R. 4670, effective November 14, 2000 (Supp. 00-4).
- R20-4-104. Acceptance of Other Forms**
- If another entity's applications and forms provide all the information required by Arizona law, the Superintendent has the discretion to accept them, even if another provision of this Chapter requires use of a specific Department of Financial Institutions form. The Superintendent's exercise of the discretion to accept alternative forms does not limit the Superintendent's power to require additional information necessary to complete an application or other form.
- Historical Note**
- Former Rule 4. Former R4-4-104 repealed, new R4-4-104 adopted effective August 16, 1991 (Supp. 91-3).
R20-4-104 recodified from R4-4-104 (Supp. 95-1).
Amended by final rulemaking at 6 A.A.R. 4670, effective November 14, 2000 (Supp. 00-4).
- R20-4-105. Claims Against a Deposit in Place of Bond**
- A. As used in this Section:
 1. "Deposit" means cash or alternatives to cash deposited by a licensee with the Superintendent in place of a bond.
 2. "Depositor" means licensee or an employee of the licensee who makes a deposit with the Superintendent.

3. "Verified claim" means a claim filed with the Superintendent under subsection (B).
 4. "Award" means an amount of money granted under subsection (F).
- B.** A person may file a claim against a deposit by delivering documentation of the claim to the Superintendent. The claim shall be based on a final judgment in favor of the claimant, entered by a court of competent jurisdiction. To support a claim, the judgment shall be:
1. Against a depositor;
 2. For injury caused by the depositor's wrongful act, default, fraud, or misrepresentation committed in the course of the depositor's licensed business activity; and
 3. Documented by:
 - a. A certified copy of the complaint in the action;
 - b. A certified copy of the judgment in the action;
 - c. A statement that execution of the judgment has not been stayed, or an explanation of the terms and reason for any stay;
 - d. A statement of any amounts recovered on the judgment; and
 - e. A sworn and notarized statement that the claim is true and correct to the best of the claimant's knowledge and belief.
- C.** A claimant shall file a claim with the Superintendent, and all required supporting documentation, not more than six months after entry of the judgment asserted in the claim. However, if execution of the asserted judgment is stayed during the first six months after its entry, the claimant may file a verified claim only during the six months after the stay is lifted. The Department shall process a timely-filed verified claim as a request for hearing under R20-4-1208.
- D.** The claimant shall notify the depositor of the filing of a verified claim under this Section, and make the depositor a party to all proceedings on the claim. To do so, the claimant shall send the depositor a copy of all documents filed under subsection (B). The claimant shall make this delivery no more than 10 days after the original filing with the Superintendent under subsection (B). The Department considers a proceeding on a verified claim to be a contested case, governed by the provisions of 20 A.A.C. 4, Article 12.
- E.** The Superintendent shall, after a hearing, deny a verified claim if the hearing produces evidence of any of the following circumstances:
1. The judgment is not for an injury caused by the depositor and described in subsection (B)(2);
 2. The judgment was awarded by default, stipulation, or consent, and no showing is made in the hearing of an injury caused by the depositor and described in subsection (B)(2);
 3. The judgment's execution has been stayed for any reason;
 4. The judgment was procured through fraud or collusion;
 5. The judgment has been satisfied from other sources; or
 6. The action that produced the judgment was barred by the applicable statute of limitations at the time it was commenced.
- F.** If the Superintendent grants a verified claim, the Superintendent shall do so in the amount of the compensatory damages awarded against the depositor in the judgment, exclusive of:
1. Attorney's fees, and
 2. Amounts previously paid on the judgment.
- G.** A person injured by a depositor shall give the Superintendent written notice at the time of filing a civil action if the claims alleged could be made as a verified claim under this Section. The written notice shall include a statement of the amount of compensatory damages sought against the depositor. The injured person shall provide further information about the civil action to the Superintendent upon request.
- H.** If the Superintendent grants a verified claim under subsection (F), the Superintendent shall authorize the State Treasurer, in writing, to release the deposit to the claimant in the amount stated in subsection (F) if the Superintendent has not received notice of another pending civil action under subsection (G).
- I.** If given notice under subsection (G), the Superintendent shall determine whether the deposit is sufficient to satisfy all claims under subsection (F). The Superintendent shall determine award amounts for each claim of which the Superintendent has notice, and authorize payment, as follows:
1. If the deposit is sufficient to satisfy all claims under subsection (F), the Superintendent shall authorize its release as described in subsection (H).
 2. If the deposit is not sufficient to satisfy all claims under subsection (F), the Superintendent shall calculate the award on each claim as follows:
 - a. Each granted claim shall receive a pro rata share of the total deposit.
 - b. Each pro rata share shall be a dollar amount calculated by multiplying the total deposit by a fraction.
 - i. The numerator of the fraction is the amount of the Superintendent's award for the verified claim.
 - ii. The denominator of the fraction is the sum of the amount of the Superintendent's award for the verified claim plus the total compensatory damages sought in all other civil actions against the same depositor disclosed to the Superintendent under subsection (G).
 - c. The Superintendent shall authorize the State Treasurer to release the pro rata portion of the deposit calculated for each verified claim.
- J.** A depositor or former licensee may request return of its deposit if it substitutes a bond for the deposit, or if its license is surrendered, revoked, or expired, and if all statutory conditions for release of the deposit have been satisfied. The Superintendent shall not release any part of a deposit to a depositor or former licensee until the Superintendent determines whether there are any awards on verified claims unsatisfied because of an apportionment under subsection (I). The Superintendent shall use the deposit amount to pay any unsatisfied portion of those awards. If the deposit amount is not sufficient to pay in full all unsatisfied awards, the Superintendent shall pay the remaining amount of the deposit to claimants in the ratio their awards bear to the total of all awards granted against the deposit.
- K.** The court supervising a licensee in receivership may order the release of a deposit to persons injured by conduct described in subsection (B). In that event, the receiver shall deliver a certified copy of the court's order to the Superintendent. The copy may be uncertified if the receiver is the Superintendent or any other officer or agency of the state of Arizona. The Superintendent shall then authorize the State Treasurer, in writing, to release the deposit to the receiver. The receiver shall distribute the deposit as ordered by the receivership court, rather than under this Section.

Historical Note

Adopted effective August 16, 1991 (Supp. 91-3). R20-4-105 recodified from R4-4-105 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 4670, effective November 14, 2000 (Supp. 00-4).

R20-4-106. Bankruptcy

An enterprise licensee or consumer lender licensee shall immediately deliver written notice to the Superintendent if it files a voluntary bankruptcy petition, or if its creditors name the licensee a debtor in an involuntary bankruptcy petition. On the date of each of the following documents' filing with the bankruptcy court, the licensee shall deliver to the Superintendent a copy of the:

1. Petition for relief,
2. Schedule of assets and liabilities,
3. Statement of financial affairs,
4. List of creditors, and
5. Plan of reorganization.

Historical Note

Adopted effective August 16, 1991 (Supp. 91-3). R20-4-106 recodified from R4-4-106 (Supp. 95-1). Amended by final rulemaking at 8 A.A.R. 145, effective December 10, 2001 (Supp. 01-4).

R20-4-107. Licensing Time-frames

- A.** As used in this Section, "application" means a document specified or described in this Title, or in any statute enforced by the Department, requesting any permit, certificate, approval, registration, charter, or similar permission described in Table A, together with all supporting documentation required by statute or rule.
- B.** The time-frames in Table A apply solely to applications received by the Department after the effective date of this Section. Each overall time-frame consists of an administrative completeness review time-frame, and a substantive review time-frame. The administrative completeness review time-frame begins to run upon receipt of an application by the Department.
1. Within the administrative completeness review time-frame in Table A, the Department shall notify the applicant in writing whether the application is complete. If the application is incomplete, the notice shall specify the missing information or component.

2. An applicant whose application is incomplete shall supply the missing information within 60 days after the date of the notice. If an applicant shows good cause in writing before the expiration of the 60 day time limit, the Superintendent shall extend the period for administrative completion of an application. The administrative completeness review time-frame stops running on the postmark date of the Department's written notice of an incomplete application, and resumes when the Department receives a complete application. If the applicant fails to submit a complete application within the specified time limit, the Department shall reject the application and close the file. An applicant may reapply.
 3. The substantive review time-frame begins to run on the postmark date of the Department's written notice that the application is administratively complete.
 4. Within the overall time-frame set forth in Table A the Department shall send the applicant written notice of its decision to approve, conditionally approve, or deny a license, unless the time-frame is extended by mutual agreement under A.R.S. § 41-1075. If the Department denies an application, it shall provide written justification for the denial and a written explanation of the applicant's right to a hearing or appeal in the form required by A.R.S. § 41-1076.
 5. The Department shall calculate time limits prescribed in this Section under R2-19-107.
- C.** The time-frames in this Section apply solely to actions taken by the Department. Nothing in this Section relieves a licensee or applicant of a duty to fulfill any other legal or regulatory requirement that is a condition of its power and authority to engage in business.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 8 A.A.R. 145, effective December 10, 2001 (Supp. 01-4).

Table A. Licensing Time-frames

No.	License Type	Legal Authority	Administrative Completeness Review (Days)	Substantive Review (Days)	Overall Time-Frame (Days)
1	<i>Bank</i>	A.R.S. § 6-203, et seq.			
	Initial Application	R20-4-211	45	45	90
2	<i>Bank Trust Dept.</i>	A.R.S. § 6-381			
	Initial Application	A.R.S. § 6-203, A.R.S. § 6-204(C)	45	45	90
3	<i>Savings & Loan</i>	A.R.S. § 6-401, et seq.			
	Initial Application	A.R.S. § 6-408, R20-4-327	75	75	150
4	<i>Credit Union</i>	A.R.S. § 6-501, et seq.			
	Initial Application	A.R.S. § 6-506(A)	60	60	120
5	<i>Trust Company</i>	A.R.S. § 6-851, et seq.			
	Initial Application	A.R.S. § 6-854(A)	75	75	150

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6	<i>Consumer Lender</i>	A.R.S. § 6-601, et seq.			
	Initial Application	A.R.S. § 6-603(C)	60	60	120
7	<i>Debt Management</i>	A.R.S. § 6-701, et seq.			
	Initial Application	A.R.S. § 6-704(A), R20-4-602(A)	30	30	60
8	<i>Escrow Agent</i>	A.R.S. § 6-801, et seq.			
	Initial Application	A.R.S. § 6-814	60	60	120
9	<i>Mortgage Broker or Commercial Mortgage Broker</i>	A.R.S. § 6-901, et seq.			
	Initial Application	A.R.S. § 6-903(C) & (D)	60	60	120
10	<i>Mortgage Banker</i>	A.R.S. § 6-941, et seq.			
	Initial Application	A.R.S. § 6-943(D)	60	60	120
11	<i>Commercial Mortgage Banker</i>	A.R.S. § 6-971, et seq.			
	Initial Application	A.R.S. § 6-974(A)	60	60	120
12	<i>Acquisition of Control of Financial Institution</i>	R20-4-1602, R20-4-1702			
	Initial Application	A.R.S. 6-1104	30	30	60
13	<i>Money Transmitter</i>	A.R.S. § 6-1201, et seq.			
	Initial Application	A.R.S. § 6-1204(A)	60	60	120
14	<i>Advance Fee Loan Broker</i>	A.R.S. § 6-1301, et seq.			
	Initial Application	A.R.S. § 6-1303(A)	30	30	60
15	<i>Premium Finance Co.</i>	A.R.S. § 6-1401, et seq.			
	Initial Application	A.R.S. § 6-1402(C)	60	60	120
16	<i>Collection Agency</i>	A.R.S. § 32-1001, et seq.			
	Initial Application	A.R.S. § 32-1021, R20-4-1502	30	15	45
17	<i>Motor Vehicle Dealer</i>	A.R.S. § 44-281, et seq.			
	Initial Application	A.R.S. § 44-282(B)	30	15	45
18	<i>Sales Finance Co.</i>	A.R.S. § 44-281, et seq.			
	Initial Application	A.R.S. § 44-282(B)	30	15	45
19	<i>Certificate of Exemption</i>	A.R.S. § 6-912			
	Initial Application	A.R.S. § 6-912(B)	45	45	90
20	<i>Loan Originators</i>	A.R.S. § 6-991, et seq.			
	Initial Application	A.R.S. § 6-991.04(A)	60	60	120

Historical Note

Table A adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 8 A.A.R. 145, effective December 10, 2001 (Supp. 01-4). Amended by final rulemaking at 18 A.A.R. 2622, effective December 2, 2012 (Supp. 12-4).

ARTICLE 2. BANK ORGANIZATION AND REGULATION**R20-4-201. Articles of Incorporation**

A licensee shall deliver to the Superintendent a copy of each amendment to the licensee's articles of incorporation within 30 days after the amendment is filed with the Arizona Corporation Commission. Before delivery to the Superintendent, an officer of the licensee shall:

1. Certify the copy delivered in compliance with this Section, in writing, signed by the certifying officer, attesting to the completeness, accuracy, and authenticity of the certified copy; and
2. Ensure the copy bears a stamp affixed by the Arizona Corporation Commission to evidence filing with the Commission.

Historical Note

Former Rule 1. R20-4-201 recodified from R4-4-201 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 811, effective January 10, 2001 (Supp. 01-1).

R20-4-202. Bylaws

A licensee shall deliver to the Superintendent a copy of each amendment to the licensee's bylaws within 30 days after the amendment is adopted. An officer of the licensee shall certify the copy delivered in compliance with this Section, in writing, attesting to the completeness, accuracy, and authenticity of the certified copy.

Historical Note

Former Rule 2. R20-4-202 recodified from R4-4-202 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 811, effective January 10, 2001 (Supp. 01-1).

R20-4-203. Repealed**Historical Note**

Former Rule 3; Amended subsection (C) effective September 4, 1981 (Supp. 81-5). R20-4-203 recodified from R4-4-203 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-204. Repealed**Historical Note**

Former Rule 4. R20-4-204 recodified from R4-4-204 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-205. Repealed**Historical Note**

Former Rule 5. R20-4-205 recodified from R4-4-205 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 3188, effective August 3, 2000 (Supp. 00-3).

R20-4-206. Bankers Blanket Bond Coverage -- A.R.S. § 6-188

- A.** Each bank shall carry at least the following basic blanket bond coverage:

Banks with Deposits of:			Amounts:
Less than \$750,000			\$25,000
\$ 750,000	to	1,500,000	50,000
1,500,000	to	2,000,000	75,000
2,000,000	to	3,000,000	90,000
3,000,000	to	5,000,000	120,000
5,000,000	to	7,500,000	150,000
7,500,000	to	10,000,000	175,000
10,000,000	to	15,000,000	200,000
15,000,000	to	20,000,000	250,000
20,000,000	to	25,000,000	300,000

25,000,000	to	35,000,000	350,000
35,000,000	to	50,000,000	450,000
50,000,000	to	75,000,000	550,000
75,000,000	to	100,000,000	700,000
100,000,000	to	150,000,000	850,000
150,000,000	to	250,000,000	1,200,000
250,000,000	to	500,000,000	1,700,000
500,000,000	to	1,000,000,000	2,500,000
1,000,000,000	to	2,000,000,000	4,000,000
Over 2,000,000,000			6,000,000

- B.** Each bank shall supplement the bankers blanket bond coverage with at least a \$1,000,000 excess fidelity bond.

Effective 8-8-73.

Historical Note

Former Rule 6. R20-4-206 recodified from R4-4-206 (Supp. 95-1).

R20-4-207. Capital Obligations

- A.** An applicant for a Superintendent's order of approval to issue a capital obligation shall submit the following documents to the Superintendent, and shall not issue any capital obligation before the Superintendent issues the order of approval. The required documents are:

1. A certified copy of the resolution adopted by the Board of Directors, or a certified copy of the unanimous written consent of the Board of Directors, authorizing the sale of the capital obligation;
2. A copy of the agreement underlying the capital obligation;
3. A copy of the note or debenture intended to represent the capital obligation; and
4. A copy of the prospectus, if any, proposed for use in the sale of the capital obligation.

- B.** Each document evidencing a capital obligation shall:

1. Bear on its face, in bold face type, the following: This obligation is not a deposit and is not insured by the Federal Deposit Insurance Corporation.
2. Have a maturity provision that either:
 - a. Gives the obligation a maturity of at least five years, or
 - b. In the case of an obligation or issue that provides for scheduled repayments of principal, gives an average maturity of at least five years. The restriction on maturity stated in this subsection does not apply to any obligation that otherwise meets all the requirements of this rule if the Superintendent determines that exigent circumstances require the issuance of the obligation without regard to any restriction on maturity. The provisions of this subsection do not apply to mandatory convertible debt obligations or issues.
3. State expressly on its face that the obligation:
 - a. Is subordinated and junior in right of payment to the issuing bank's obligations to its depositors and to the bank's other obligations to its general and secured creditors, and
 - b. Is ineligible as collateral for a loan by the issuing bank, except as provided in A.R.S. § 6-354.
4. Be unsecured.
5. State expressly on its face that the issuing bank may not retire any part of its capital obligation without the Superintendent's prior written order of approval, and the prior written consent of the Federal Deposit Insurance Corporation.

6. Include, if the obligation is issued to a depository institution, a specific waiver of the right of offset by the lending depository institution.
 7. State that, in the event of liquidation, all depositors and other creditors of the bank are to be paid in full before any payment of principal or interest is made on a capital obligation.
- C. No payment shall be made under an optional right of payment reserved to the bank without the separate authorization of the Superintendent. The Superintendent may grant that authority in the initial order of approval or in a later order of approval.

Historical Note

Former Rule 7. R20-4-207 recodified from R4-4-207 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 2155, effective May 4, 2001 (Supp. 01-2).

R20-4-208. Repealed

Historical Note

Former Rule 8. R20-4-208 recodified from R4-4-208 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 3188, effective August 3, 2000 (Supp. 00-3).

R20-4-209. Notice of Permanent Closing of Banking Office

A bank may close fewer than all of its banking offices. Before closing any office, a bank shall deliver a letter to the Superintendent specifying the banking office it plans to close and the closing date. The bank shall ensure that the Superintendent receives the letter at least 10 days before the closing date. Closing the banking office shall terminate the bank's authority to maintain that banking office on the date of the actual closure.

Historical Note

Former Rule 9. R20-4-209 recodified from R4-4-209 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 5388, effective November 9, 2001 (Supp. 01-4).

R20-4-210. Repealed

Historical Note

Former Rule 10. R20-4-210 recodified from R4-4-210 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 3188, effective August 3, 2000 (Supp. 00-3).

R20-4-211. Application for a Banking Permit

- A. Before an application is filed, the representatives of the potential applicant shall meet with the Superintendent of Banks to discuss capitalization, location, and management of the proposed bank.
- B. After the meeting required by subsection (A), persons who wish to proceed with the application process shall submit an application in the form the Superintendent prescribes. The applicant shall support the application with sufficient information to enable the Superintendent to make a determination.

Historical Note

Former Rule 11. R20-4-211 recodified from R4-4-211 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 3188, effective August 3, 2000 (Supp. 00-3).

R20-4-212. Repealed

Historical Note

Former Rule 12. Amended effective September 4, 1981 (Supp. 81-4). R20-4-212 recodified from R4-4-212 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-213. Repealed

Historical Note

Former Rule 13. Repealed effective September 13, 1981 (Supp. 81-5). R20-4-213 recodified from R4-4-213 (Supp. 95-1).

R20-4-214. Preservation of Records

- A. Every bank shall keep its corporate and business records as originals or as copies of the originals made by reproduction methods that accurately and permanently preserve the records. Copies complying with this subsection, when satisfactorily identified, have the same evidentiary status as an original. A bank may use an electronic recordkeeping system. The Department shall not require a bank to keep a written copy of its records if the bank can generate all information and copies required by this Section in a timely manner for examination or other purposes.
- B. A bank shall keep its corporate and business records for the period required by this Section. These periods are measured from the date of the last entry or final action date. A bank shall have and comply with its own record retention schedule that is consistent with this Section. A bank may comply with this Section by complying with a preemptive federal regulation, even if the federal regulation requires a shorter retention period than is listed in this Section. This Section does not prohibit record retention for longer periods than these state-required minimums for any reason, including a retention period established by preemptive federal law or regulation. Likewise, this Section does not prohibit a bank from keeping any type of record not required in subsection (D).
- C. Beginning on the effective date of this Section, corporate and business records of a bank operating in the state of Arizona are classified, and their retention periods are prescribed, according to the schedule in subsection (D). Retention periods are listed in subsection (D) using the notations, acronyms, and abbreviations listed in this Section.
 1. A numerical designation refers to a period of years unless a shorter period of time is specified in the schedule.
 2. "AC" means after closure.
 3. "ACH" means automated clearing house.
 4. "AE" means after expiration.
 5. "ALC" means after last contact.
 6. "AP" means after paid.
 7. "ATD" means after termination date.
 8. "CTR" means a cash transaction report required by the Federal Bank Secrecy Act.
 9. "FDIC" means the Federal Deposit Insurance Corporation.
 10. "FHA" means the Federal Housing Administration.
 11. "FHLMC" means the Federal Home Loan Mortgage Corporation.
 12. "FNMA" means the Federal National Mortgage Association.
 13. "GNMA" means the Government National Mortgage Association.
 14. "IRS" means the United States Department of the Treasury's Internal Revenue Service.
 15. "M" means months.
 16. "P" means the bank shall keep the record permanently.
 17. "PMI" means private mortgage insurance.
 18. "SAR" means a suspicious activity report required by the federal Bank Secrecy Act.
 19. "TTL" means a treasury, tax, and loan account maintained by a bank.
 20. "UCC" means the Uniform Commercial Code as it is in effect in Arizona.

D. Retention Schedule

1. Accounting and Auditing		e. E-Bond application	2
a. Accrual and bond amortization	3	f. E-Bond sold or redeemed-record	2
b. Audit report	6	g. E-Bond transmittal letter	2
c. Audit work papers	3	h. Lock box daily receipts	1
d. Bank call, income and dividend report	5	i. Night depository agreement	1 AC
e. Bill, statement, or invoice - paid	7	j. Night depository daily record	1
f. Budget work papers	2	k. Safekeeping record and receipt	5
g. Collateral vault "in-and-out" ticket	1	l. Securities buy order and sell order	3
h. Daily reserve computation	1	5. Data processing (management information systems)	
i. Earnings report	7	a. Back-up data (for reconstruction) daily, end of month, quarter, or year	1
j. Expense voucher or invoice		b. Disaster recovery program	P
k. Financial statement	7	c. Film copy of every IRS financial reporting form	6
l. Interoffice reconciliation	1	d. Program change	P
m. Interoffice transaction	1	e. System, program and procedure manual	P
n. Periodic statement for account owned by the bank	2	6. Deposits	
o. Reconcilement of deposits-due to bank	2	a. Account opened and account closed report	1
p. Reconcilement register-due from bank	2	b. Certificate of deposit purchase record	7
q. Return and cash item register	1	c. Check paid, withdrawal slip, and other debits to account	7
r. Service contract	2	d. Club account check register	1
s. Treasury tax and loan account	2	e. Club account coupon	1
t. Unclaimed property record	7	f. SAR - for suspicious transaction under \$10,000	5
2. Administration		g. CTR - for transaction exceeding \$10,000	5
a. Articles of incorporation or association, bylaws, or other record of organization	P	h. Customer authorization, resolution, and signature card	6 AC
b. Bankers blanket bond-record showing compliance	5 AE	i. Deposit account record needed to reconstruct	7
c. Bank examiner's report	7	j. Deposit and other credits	7
d. Capital note issuance and transfer record	P	k. Dormant account - after closed or escheated	7 ALC
e. Depreciation record-office equipment	3	l. Form 1096, and 1099 reports to IRS	7
f. Dividend check and register	7	m. Individual retirement account record	7
g. Dividend check-outstanding	P	n. Interest check or other record of interest payment and reports	7
h. Expired policy insuring the bank	3 AE	o. Internal management reports:	
i. FDIC assessment base, record	5	i. Large balance	1
j. FDIC certificate	P	ii. Overdraft	1
k. Insurance policy number, record of premium paid and amount recovered	3 AE	iii. Public funds	1
l. Legal proceedings when completed	5	iv. Service charges	1
m. Minute book of:		v. Stop payment	1
i. Meetings of the board of directors	P	vi. Uncollected funds	1
ii. Meetings of committees of the board of directors	P	vii. Unposted item	1
iii. Shareholders' meetings	P	viii. Zero balance	1
n. Postage meter record book (from date of final entry)	1	p. Ledger card	5 AC
o. Real estate documentation	5 ATD	q. Power of attorney document	7 ATD
p. Report to directors	3	r. Receipt for statement held at customer's request	1
q. Stock issuance and transfer record	P	s. Record showing compliance with the following federal regulations. The stated retention period applies unless, and until, it is preempted by federal law:	
r. Required report to supervisory agency	3	i. Regulation CC, Expedited Funds Availability Act	2
s. Tax controversy or proceeding when completed	7	ii. Regulation DD, Truth in Savings Act	2
t. Tax record not material to any controversy	7	iii. Regulation E, Electronic Funds Transfer Act	2
u. Voting list and proxies	3	t. Returned statement and cancelled checks	6
3. Collections		u. Statement	6
a. Collection payment record	1	v. Stop payment order	6 AE
b. Collection receipt-carbon	1	w. Document used to request and receive Tax Identification Number	6
c. Collection register	1	x. Transaction journal	6
d. Coupon cash letter-outgoing	1	y. Trial balance	6
e. Coupon envelope	1	7. Due from banks	
f. Customer file copy	1	a. Advice from correspondent bank	1
g. Incoming collection letter	1	b. Bank statement	1
h. Incoming contract or note letter	1	c. Draft-original	7
4. Customer service		d. Draft register or copy	1 AP
a. Broker account holder-identification	5		
b. Broker's confirmation	3		
c. Broker's invoice	3		
d. Broker's statement	3		

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e.	Duplicate check-information and documentation pertaining to issuance	7	iii.	Report of lost or stolen securities	3
f.	Reconcilement register	1	iv.	Safekeeping advice	2
8.	Due to banks		v.	Taxpayer identification number	5
a.	Account opened and account closed-reports	1	c.	Commercial paper	
b.	Advice-copy	1	i.	Broker's advice	2
c.	Incoming cash letter memo for credit	1	ii.	Purchase order	2
d.	Incoming cash letter for remittance	1	iii.	Remittance advice	2
e.	Reconcilement register (TTL)	2	d.	Mortgage-backed securities	
f.	Reconcilement verification	1	i.	Buy-and-sell agreement	3
g.	Resolution	2 AC	ii.	Commitment letter	7
h.	Signature card	6 AC	iii.	FHLMC and FNMA loan file	7
i.	Trial balance (fiche)	7	iv.	GNMA certificate	7
j.	Undelivered statement, reconstruction available from bank records	1	v.	Interest accrual record	7
k.	Undelivered statement, reconstruction not possible	7	vi.	Monthly remittance report	7
9.	General		13.	Loans. A bank shall keep each loan record listed for the period required by this subsection. These periods are measured from the date of final activity. A bank shall have and comply with its own record retention schedule that is consistent with this subsection. A bank may comply with this subsection by complying with a preemptive federal regulation, even if the federal regulation requires a shorter retention period than is listed in this subsection. This subsection does not prohibit record retention for longer periods than these state-required minimums for any reason, including a retention period established by preemptive federal law or regulation. Likewise, this Section does not prohibit a bank from keeping any type of record not required by this subsection.	
a.	Address change order	1	a.	All Loans - general	
b.	Affidavit from customer including affidavit of loss, forgery, or non-use of cashier's check	1	i.	Application for loan approved	6
c.	Writ of attachment or garnishment	5	ii.	Appraisal	6
d.	Attachment, release	5	iii.	Borrower's financial statement	6
e.	Armored car receipt	1	iv.	Charge-off record	10
f.	Check book order	1	v.	Charged off note	10
g.	Check book-receipt	1	vi.	Collateral file	6
h.	Court order memorandum record	5	vii.	Correspondence	6
i.	Notice of Protest	1	viii.	Credit file - all documentation	6
j.	Travelers check-application	2	ix.	Credit report	6
k.	Vault record-opening and closing	1	x.	Daily proof and record	6
l.	Wire transfer debit entry and credit entry	7	xi.	Loan committee minutes	P
10.	General ledger		xii.	Miscellaneous loan reports including new loan journal, paid loan journal, past due report, and transaction journal as original entry	6
a.	Daily statement of condition	3	xiii.	Other documentation for reconstruction of loan	2
b.	General journal-if byproduct of posting the general ledger	3	b.	Commercial loans	
c.	General journal-if used as book of original entry with description	3	i.	Application for loan denied	12 M
d.	General ledger	5	ii.	Bill of sale	6
e.	General ledger ticket-debit and credit	2	iii.	Borrowing resolution	3
11.	International department		iv.	Business annual report (fiscal or year end) - after date of report	3
a.	Broker account holder-identification	5	v.	Business cash-flow analysis report - after date of report	3
b.	Cable copy	7	vi.	Business tax return - after date of return	6
c.	Cable requisition	7	vii.	Commitment letter	6
d.	Collection paid	1	viii.	Copy of mortgage note or deed of trust	6
e.	Correspondence	2	ix.	Evidence of insurance	6
f.	Draft	7	x.	Guaranty	6
g.	Foreign collection register	6	xi.	Letter of credit	6
h.	Foreign draft application	6	xii.	Participation agreement	6
i.	Foreign draft-carbon	2 ATD	xiii.	Promissory note	6
j.	Foreign exchange remittance sheet or book	6	xiv.	Purchase and sale agreement	6
k.	Foreign financial account-record	7	xv.	Security agreement	6
l.	Foreign mail transfer application	6	xvi.	Title documentation	6
m.	Foreign mail transfer-carbon	2 ATD	xvii.	UCC filing	6
n.	Foreign outstanding cash	2	c.	Consumer loans	
o.	Foreign payment-incoming	2			
p.	Letter of credit application	2			
q.	Letter of credit ledger sheet	7			
r.	Transfer outside of the United States in excess of \$10,000 - record	5			
12.	Investments				
a.	Bonds				
i.	Amortization record	6			
ii.	Confirmation	3			
iii.	Safekeeping receipt	2			
b.	Broker's securities				
i.	Broker's invoice	3			
ii.	Broker's statement	3			

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i.	Application for loan denied, including adverse action notice	25 M	n.	W-3 reconciliation of income tax withheld from wages	3
ii.	Collateral record	6	o.	W-4 withholding exemption certificate	3
iii.	Hazard insurance record	6	p.	Wage and tax statement record (W-2)	7
iv.	Invoice	6	q.	Wage differential documentation (Fair Labor Standards Act)	3
v.	Life and disability insurance record	6	16.	Registered mail	
vi.	Overdraft loan agreement	6	a.	Marine insurance book	3
vii.	Promissory note and modification agreement - copy	6	b.	Record of incoming and outgoing registered mail	1
viii.	Title documentation	6	c.	Return receipt card	3
ix.	UCC filing - copy	6	17.	Safe deposit vault	
d.	Real estate loans		a.	Access ticket or card	6
i.	Assignment of escrow	6	b.	Court order and correspondence	6
ii.	Assumption	6	c.	Delivery of will, burial plot deed, insurance policy-receipt	6
iii.	Commitment letter	6	d.	Forced entry record	6
iv.	Copy of deed of trust or mortgage note, as it may have been modified	6	e.	Lease or contract-closed account	2 AC
v.	Escrow analysis and record	6	f.	Ledger record of account	1
vi.	Evidence of any FHA or PMI insurance required	6	g.	Opened box contents-record and report	7
vii.	Hazard insurance	life of loan	h.	Rent receipt-copy	1
viii.	Proof of insurance excluding hazard	6	i.	Sale to satisfy lien-record	7
ix.	Sales contract	6	j.	Signature card, authorization, and resolution	6 AC
x.	Settlement sheet	6	18.	Tellers	
xi.	Survey	6	a.	Mail teller envelope	3 M
xii.	Title documentation	6	b.	Teller's balancing recap or recap book	1
e.	Construction loans. In addition to the documents specified in subsection (d), a bank shall keep a record for a construction loan as specified in this subsection:		c.	Teller's cash ticket-original and carbons	1
i.	Certificate of occupancy	6	d.	Teller's cash shipment record	1
ii.	Construction progress report	6	e.	Teller's exchange ticket	1
iii.	Contractor's cost breakdown	6	f.	Teller's machine tape	1
iv.	Disbursement documentation	6	19.	Transit, proof, and clearing	
v.	Inspection report	6	a.	ACH entry	6
vi.	Residential construction specifications and material list	6	b.	Advice of correction to deposit	2
14.	Official checks and drafts		c.	Clearinghouse settlement sheet - recapitulation of checks delivered to the clearinghouse or federal reserve	2
a.	Affidavit, bond, indemnity agreement, other documentation supporting the issuance of a duplicate check or draft	7	d.	Record of items processed	6
b.	Bank draft	3	e.	Proof machine tape or other record	2
c.	Cashier's check-cancelled	7	f.	Receipt for transit letter	1
d.	Cashier's check register-copy	7	g.	Return item letter	5
e.	Expense check-cancelled	7	20.	Trust department administration	
f.	Expense check register-copy	7	a.	Appraisal of real or personal property held as a trust asset	3 AC
g.	Expense voucher or invoice	7	b.	Correspondence	3 AC
h.	Money order-bank or personal	7	c.	Decree or receipt and release	3 AC
i.	Money order register-copy	7	d.	Fee record and supporting data	3 AC
j.	Official check outstanding	P	e.	Intermediate and final account	3 AC
15.	Personnel Records		f.	Legal documentation including judgment, court order, and legal opinion	3 AC
a.	Attendance record, and time card	3	g.	Paid bill	3 AP
b.	Authorization for payroll deduction	2	h.	Real estate insurance policy	1 AE
c.	Department of labor report	5	i.	Real estate and mortgage document	3 AC
d.	Disability record	5	j.	Receipt for asset received or delivered	3 AC
e.	Employee record and personnel folder	5	k.	Record of asset tax cost	3 AC
f.	Employment application	3 AT	l.	Summary card, original instrument, agreement and amendment, and letters of appointment	3 AC
g.	Insurance record	2	m.	Synopsis sheet	3 AC
h.	Payroll check	2	21.	Corporate trust	
i.	Pension fund record	10	a.	Bond registration journal	3 AC
j.	Profit sharing fund record	10	b.	Bond-cancelled	7
k.	Rejected employee application	2	c.	Indemnity bond	P
l.	Salary ledger or electronic data processing printout	4	d.	Certification	2
m.	Salary receipt	2	e.	Coupon envelope	6 M
			f.	Coupon-cancelled	6 M
			g.	Customer receipt	7
			h.	Dividend and coupon record	3 AC

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i.	Dividend and interest disbursement check and list	3 AC	d.	Review and recommendation	3 AC
j.	General ledger ticket	2	e.	Safekeeping record and receipt	3 AC
k.	Legal paper	P	f.	Security ledger sheet	P
l.	Copy of cancelled stock certificate, original returned to customer	1	g.	Trust check	10
m.	Stock registration journal	3 AC	h.	Trust entry-original	3 AC
n.	Stock transfer memo	1	i.	Trust or agency agreement-original	3 AC
o.	Stock transfer receipt	1	j.	Vault withdrawal and deposit ticket	7
p.	Tax return	3 AC	k.	Will-certified copy	P
q.	Transfer-supporting papers	3 AC	l.	Work papers supporting tax return	7
r.	Transfer journal	3 AC	24.	Trust Investments	
s.	Transfer tax waiver	3 AC	a.	Annual report	
t.	Trust ledger-corporate	7	i.	Common trust fund	10
22.	Personal trust		ii.	Pooled fund	10
a.	Record of previously discharged fiduciary		b.	Valuation	
i.	Accounting	3 AC	i.	Common trust fund	10
ii.	Decree	3 AC	ii.	Pooled fund	10
iii.	Receipt and release	3 AC	c.	Minutes	
b.	Accounting - recorded	3 AC	i.	Investment committee	P
c.	Advice of payment - securities department regarding bond and coupon collection	3 AC	ii.	Administrative committee	P
d.	Appraisal		d.	Investment order and broker's confirmation	3 AC
i.	Real property	3 AC	e.	investment review and related material	3 AC
ii.	Personal property	3 AC	f.	Correspondence	3 AC
e.	Asset delivery receipt	3 AC	g.	Summary of annual account activity	3 AC
f.	Authorization		25.	Wire transfer	
i.	By co-fiduciary	P	a.	Incoming wire log	1
ii.	By consultant	P	b.	Outgoing wire log	1
g.	Approval		c.	Transmission record	7
i.	By co-fiduciary	P	d.	Wire transfer request	7
ii.	By consultant	P			
h.	Broker's statement	7			
i.	Buy and sell order	7			
j.	Cash documentation				
i.	Customer cash and asset statement	7			
ii.	Cash and security journal	7			
iii.	Cash trial balance	1			
k.	Common trust fund annual report	10			
l.	Correspondence				
i.	Transfer letter	3 AC			
ii.	Claim letter	3 AC			
m.	Coupon collection record	7			
n.	Court accounting and petition	7			
o.	Daily transaction journal	6 M			
p.	Debits and credits-daily	1			
q.	Documentation necessary to support account decision	3 AC			
r.	Tax Documentation				
i.	Federal estate tax return	10			
ii.	State estate tax return	10			
iii.	Tax-related work papers	10			
iv.	Federal gift tax return	10			
s.	Fee calculations and supporting data	1			
t.	Income tax return				
i.	Federal	3 AC			
ii.	State	3 AC			
u.	Inventory	3 AC			
v.	Investment review and related material	3 AC			
w.	Minutes				
i.	Investment committee	P			
ii.	Trust committee	P			
23.	Other personal trust records				
a.	Legal opinion	3 AC			
b.	Correspondence related to legal opinion	3 AC			
c.	Paid bill	7			

Historical Note

Former Rule 14. R20-4-214 recodified from R4-4-214 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 4142, effective September 12, 2001 (Supp. 01-3).

R20-4-215. Trust Business

All banks authorized to conduct trust business under their banking permit shall comply with the applicable requirements of R20-4-808 through R20-4-816.

Historical Note

Adopted effective June 30, 1977 (Supp. 77-3). R20-4-215 recodified from R4-4-215 (Supp. 95-1).

ARTICLE 3. SAVINGS AND LOAN ASSOCIATIONS**R20-4-301. Fidelity Bond -- A.R.S. § 6-420**

Fidelity bonds of officers and employees shall be in an amount to meet the requirements of the Federal Savings and Loan Insurance Corporation and shall be approved by the filing of a copy or a certificate of issuance thereof with the Superintendent. Associations shall immediately notify the Superintendent of any change in liability or a default arising on or by said bond.

Historical Note

Former Rule 1. R20-4-301 recodified from R4-4-301 (Supp. 95-1).

R20-4-302. Repealed**Historical Note**

Former Rule 2; Repealed effective January 19, 1984 (Supp. 84-1). R20-4-302 recodified from R4-4-302 (Supp. 95-1).

R20-4-303. Separate Trust Account -- A.R.S. § 6-449(C)(3)

A separate trust bank account required by A.R.S. § 6-449(C)(3) may be established in one or more banks provided that the same are consolidated for accounting purpose, deposits thereto are made promptly, and that individual member records are maintained clearly indicating the equity of the member therein.

Historical Note

Former Rule 3. R20-4-303 recodified from R4-4-303 (Supp. 95-1).

R20-4-304. Publication of Intent to Organize -- A.R.S. § 6-123

If the Superintendent does not deny the application for permit to organize a new association on the basis of the data submitted in the application and any other information in his possession, he shall instruct the applicants to publish the following notice once each week for two successive weeks in the English language in a newspaper of general circulation published in the community in which the proposed association would be located, or if no such newspaper exists in said community, then in the county in which the proposed association would be located:

NOTICE OF INTENT TO ORGANIZE THE

_____ Savings and Loan Association. Notice is hereby given that, pursuant to the provisions of Title 6, Chapter 3 of the Arizona Revised Statutes and Rule No. 4327 of the Superintendent of Banks, _____ (fill in names of applicants) have filed an application for a permit to organize a savings and loan association to be located at, or in the immediate vicinity of _____

_____ (Street Address) _____ (City)

Arizona. A hearing will be held before the Superintendent of Banks at _____

_____ on _____, 19 _____, in Room _____ (Time) _____ (Date)

101, Commerce Building, 1601 West Jefferson, Phoenix, Arizona, at which time any person may appear, or in advance of that time any person may file communications, including briefs, with the Superintendent of Banks, in favor of or in protest of the application. Two copies of any such communication shall be filed.

The publisher's affidavits of publication of the notice shall be filed with the Superintendent prior to the hearing date. Effective 8-8-73

Historical Note

Former Rule 4. R20-4-304 recodified from R4-4-304 (Supp. 95-1).

R20-4-305. Repealed**Historical Note**

Former Rule 5. R20-4-305 recodified from R4-4-305 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-306. Repealed**Historical Note**

Former Rule 6. R20-4-306 recodified from R4-4-306 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-307. Repealed**Historical Note**

Former Rule 7. R20-4-307 recodified from R4-4-307 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-308. Repealed**Historical Note**

Former Rule 8. R20-4-308 recodified from R4-4-308 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-309. Sale and Servicing of Loans -- A.R.S. §§ 6-451, 6-402

- A. The total dollar amount of loans and/or participating interest of loans sold in any calendar year shall not, without prior written approval of the Superintendent of Banks, exceed 20% of the total amount of all loans held by the association at the beginning of such calendar year.
- B. All loans and/or participating interest of loans sold shall be sold without recourse.
- C. If the loans or participating interests sold are to be serviced by the seller, no such loans shall be sold except under the terms of a service agreement contract form. A sample service agreement contract form, in blank, shall have been filed in advance with an approval requested from the Superintendent of Banks. Any future changes in the approved form shall be handled in a similar manner.
- D. The selling association shall report to the Superintendent of Banks within 30 days of the date of any sale:
 1. Name and address of the purchaser.
 2. Gross amount of mortgage loans involved in sale.
 3. Amount of participation sold.
 4. Percentage of amount of sale to gross amount of loans involved in sale.
 5. Number of loans sold in whole or part.
 6. Service fee rate.

Historical Note

Former Rule 9. R20-4-309 recodified from R4-4-309 (Supp. 95-1).

R20-4-310. Reserved**R20-4-311. Repealed****Historical Note**

Former Rule 11; Repealed effective January 19, 1984 (Supp. 84-1). R20-4-311 recodified from R4-4-311 (Supp. 95-1).

R20-4-312. Repealed**Historical Note**

Former Rule 12. R20-4-312 recodified from R4-4-312 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-313. Reserved**R20-4-314. Repealed****Historical Note**

Former Rule 14. R20-4-314 recodified from R4-4-314 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-315. Repealed**Historical Note**

Former Rule 15. R20-4-315 recodified from R4-4-315 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-316. Repealed**Historical Note**

Former Rule 16. R20-4-316 recodified from R4-4-316 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-317. Repealed**Historical Note**

Former Rule 17; Repealed effective January 19, 1984
(Supp. 84-1). R20-4-317 recodified from R4-4-317
(Supp. 95-1).

R20-4-318. Service Corporations -- A.R.S. § 6-446(5)

A. General service corporations. An association may, if permitted by the terms of its articles of incorporation, invest in the capital stock, obligations or other securities of any service corporation organized under the laws of this state, if:

1. The entire capital stock of such service corporation is available for purchase by, and only by, any and all savings and loan associations with a home office in this state, and the capital stock is owned by more than one savings and loan association;
2. Not more than 33 1/3% of the outstanding capital stock of such service corporation is, or may be, owned by any savings and loan association;
3. Every eligible savings and loan association is permitted to own an equal amount of the capital stock of such service corporation or on such uniform basis as may be fixed by such corporation, each such association is permitted to own an amount of capital stock that is a stated percentage of its assets or savings capital at the time of any purchase by it of such stock; and
4. Substantially all of the activities of such service corporation, performed directly or through one or more wholly-owned subsidiaries or joint ventures, consist of one or more of the following:
 - a. Originating, purchasing, selling, and servicing any of the following:
 - i. Loans and participations in loans on a prudent basis and secured by real estate, including brokerage and warehousing of such real estate loans;
 - ii. Loans, and participations in loans, secured by first liens upon mobile homes, including brokerage and warehousing of such mobile home loans;
 - iii. Loans, with or without security, for the altering, repairing, improving, equipping or furnishing of any residential real estate;
 - b. Making any investment of the types specified in Sections 545.9 and 545.9-3 of the regulations of the Federal Home Loan Bank Board;
 - c. Making investments in the accounts of associations holding capital stock in the corporation;
 - d. Performing the following services, primarily for savings and loan associations with home offices in Arizona:
 - i. Clerical services, accounting, data processing and internal auditing;
 - ii. Credit information, appraising, construction loan inspection, and abstracting;
 - iii. Development and administration of personnel benefit programs including life insurance, health insurance, and pension or retirement plans;
 - iv. Research, studies and surveys;
 - v. Purchasing of office supplies, furniture and equipment;
 - vi. Development and operation of storage facilities for microfilm or other duplicate records;
 - vii. Advertising and other services to procure and retain both savings accounts and loans;

- e. Acquisition of unimproved real estate lots and other unimproved real estate for the purpose of prompt development and subdivision, principally for construction of housing or for resale to others for such construction, or for use as mobile home sites;
- f. Development and subdivision of and construction of improvements (including improvements to be used for commercial or community purposes when incidental to a housing project) for sale or for rental on, real estate referred to in subsection (A)(4)(e);
- g. Acquisition of improved residential real estate and mobile homes to be held for rental;
- h. Acquisition of improved residential real estate for remodeling, rehabilitation, modernization, renovation, or demolition and rebuilding for sale or for rental;
- i. Maintenance and management of rental real estate referred to in subsections (A)(4)(f), (g), and (h), and any real estate owned by holders of its capital stock;
- j. Serving as insurance broker or agent primarily dealing in policies for savings and loan associations, their borrowers and accountholders which provide protection such as homeowners', fire, theft, automobile, life, health, accident, and title, excluding private mortgage insurance;
- k. Serving in the capacity of trustee under deeds of trust, or escrow agent;
- l. Activities reasonably incidental to the activities described in the foregoing subparagraphs of subsection (A)(4); and
- m. Such other activities, reasonably related to the activities of savings and loan associations as the Superintendent may approve upon application therefor by any such service corporation.

B. Other service corporations. In addition to investment in a service corporation which meets the requirements of subsection (A) of this rule, an association may invest in the capital stock, obligations, or other securities of any service corporation organized under the laws of Arizona, if:

1. The entire capital stock of such corporation is held by one or more savings and loan associations or federal associations with a home office in Arizona;
2. The activities of such corporation, performed directly or through one or more wholly-owned subsidiaries or joint ventures, consist solely of one or more of the activities specified in subparagraphs (a) through (l), of subsection (A), paragraph (4) of this rule, and such other activities, reasonably related to the activities of a savings and loan association, as the Superintendent may approve upon application therefor by such corporation; and
3. The following limitations are complied with:
 - a. if less than five savings and loan associations (including any federal association) hold capital stock in such corporation or one such association holds more than 40% of such stock, such corporation, including any subsidiary, does not incur or have outstanding at any time debt in excess of the following limitations:
 - (1) in the case of all unsecured debt (to holders of its capital stock and to others), an amount equal to two times its net worth;
 - (2) in the case of all debt (secured and unsecured, to holders of its capital stock and to others), except as permitted by subdivision 3(a)(3) in an amount equal to ten times its net worth;

- (3) in the case of all debt (secured and unsecured, to a holder of its capital stock and others) engaged solely in the activities specified in subsection (A), paragraph (4), subdivision (a)(i) of this rule, an amount equal to 20 times its net worth;
 - (4) secured debt will be deemed to be unsecured for the purposes of this subsection (B), paragraph (3), subdivision (a) to the extent that such debt exceeds the market value of any security at the time the loan is made;
 - b. the approval of the Superintendent is obtained for any investment by such service corporation in a joint venture or the acquisition of a going business if a director, officer or controlling person of any savings and loan association owning any of the service corporation's capital stock has a direct or indirect beneficial interest in the joint venture or going business.
- C. Amount of investment**
- 1. Except as provided in subsection (C), paragraph (2), an association may not make any investment under this Section if its aggregate outstanding investment in the capital stock, obligations or other securities of service corporations would thereupon exceed 1% of assets. The limitation in the preceding sentence includes all loans, secured and unsecured, and all guarantees of such loans, to service corporations, or any subsidiaries thereof, and to joint ventures of such service corporations or subsidiaries, whether or not such association is a stockholder therein.
 - 2. In addition to amounts which may be invested within the limitation set forth in subsection (C), paragraph (1), an association which has a net worth of at least 5% of withdrawable accounts may loan additional amounts to service corporations, or any subsidiaries thereof, and to joint ventures of such service corporations or subsidiaries, as follows:
 - a. an aggregate outstanding amount not to exceed 20% of such associations net worth may be invested in loans made to service corporations, or any subsidiaries thereof, and to joint ventures of such service corporations or subsidiaries; and
 - b. the limitation set forth in subsection (C), paragraph (1) shall not be applicable to loans to any service corporation which qualifies as a service corporation under subsection (A) of this rule, or to any service corporation in which the lending association does not have any investment made under the authority of this rule.
- D.** No association may invest in the capital stock, obligations, or other securities of any service corporation unless said service corporation has filed with the Superintendent a certified copy of a resolution of its board of directors that:
- 1. In the case of a service corporation described in subsection (A) of this rule, such corporation will permit and pay the cost of such examination of the corporation by the Superintendent as the Superintendent from time to time deems necessary to determine the propriety of any investment by an association under this rule; and
 - 2. In the case of a service corporation described in subsection (B) of this rule, such corporation will permit and pay the cost of such examination and/or audit by the Superintendent as the Superintendent may from time to time deem necessary.
- E.** Whenever a service corporation engages in an activity which is not permissible for, or exceeds the limitations on, a service corporation in which an association may invest, or whenever the capital stock ownership requirements of this rule are not met, an association having an investment in such corporation, including any subsidiary thereof, shall dispose of such investment promptly unless, within 90 days following the date of mailing of written notice by the Superintendent to such investing association, the impermissible activity is discontinued, the limitation is complied with, or the capital stock ownership requirement is met.
- F.** A service corporation may establish and maintain one or more branch offices within the state of Arizona for the purpose of carrying on the functions of the service corporation. No service corporation may establish or maintain a branch office outside of the state of Arizona except with the specific approval of the Superintendent upon application therefor by such service corporation.
- G.** In the case of any investment by an association in a service corporation which was specifically approved by the Superintendent prior to September 26, 1974, said approval is hereby deemed to apply to such investment on and after September 26, 1974, if the activities of such corporation consist only of those activities approved by the Superintendent and any activities described in subsection (B), paragraph (2) of this rule, and if the limitations of this rule are complied with.
- H.** The term "joint venture" means any joint undertaking by a service corporation or a wholly-owned subsidiary thereof with one or more persons or legal entities in any form, including a joint tenancy, tenancy in common, or partnership and including investment in a corporation other than a wholly-owned subsidiary.
- I.** The term "aggregate outstanding investment" means the sum of amounts paid for the acquisition of capital stock or securities and amounts invested in obligations of service corporations less amounts received for the sale of capital stock or securities of service corporations and amounts paid to an association to retire obligations of service corporations.
- J.** The terms "unsecured debt" and "unsecured loan" exclude accounts payable incurred in the ordinary course of business and paid within 60 days.
- Effective 9-26-74
- Historical Note**
Former Rule 18. R20-4-318 recodified from R4-4-318 (Supp. 95-1).
- R20-4-319. Repealed**
- Historical Note**
Former Rule 19. R20-4-319 recodified from R4-4-319 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).
- R20-4-320. Repealed**
- Historical Note**
Former Rule 20. R20-4-320 recodified from R4-4-320 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).
- R20-4-321. Repealed**
- Historical Note**
Former Rule 21. R20-4-321 recodified from R4-4-321 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).
- R20-4-322. Repealed**
- Historical Note**
Former Rule 22; Repealed effective January 19, 1984 (Supp. 84-1). R20-4-322 recodified from R4-4-322 (Supp. 95-1).

R20-4-323. Repealed

Historical Note

Former Rule 23. R20-4-323 recodified from R4-4-323 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-324. Give-aways -- A.R.S. § 6-444

A give-away may be given by an association if:

1. The give-away is given in connection with a promotional campaign for the opening of or increasing the amount of savings accounts and not on a recurring basis;
2. The value of the give-away does not exceed:
 - a. \$5.00 for the opening of a new account, or for an addition to an existing account of less than \$5,000.00;
 - b. \$10.00 for the opening of a new account, or for an addition to an existing account, of \$5,000.00 or more.

Effective 8-13-72

Historical Note

Former Rule 24. R20-4-324 recodified from R4-4-324 (Supp. 95-1).

R20-4-325. Appraisal Requirements -- A.R.S. § 6-457

No association shall grant, make, disburse any portion of, or invest its funds in, any loan on the security of real estate, until:

1. At least one qualified person, whose qualifications have been approved by the board of directors of the association, and whose compensation shall not in any way be affected by the approval or declining of the loan, has appraised the real property security; and
2. Each such appraisal shall be in writing with a certificate signed by the appraiser, under oath, stating that he has personally examined the described property, setting forth the value of the land and, separately, the nature, condition, and value of the improvement, or improvements to be made, if any; and
3. Notwithstanding the provisions hereof, an association may make any insured or guaranteed loan on the basis of a valuation of the real estate security furnished to such association by any lending, insuring or guaranteeing agency of the United States or of the state of Arizona which shall insure or guarantee such loan, wholly or in part.

Effective 8-13-72

Historical Note

Former Rule 25. R20-4-325 recodified from R4-4-325 (Supp. 95-1).

R20-4-326. Capital Notes and Debentures -- A.R.S. § 6-405.01

All capital notes and debentures must be authorized by the articles of incorporation of the association and approved by the Superintendent prior to issuance and sale. In the event offering circulars or subscription agreements are used in connection with the sale of notes or debentures, the offering circular and subscription agreement must be approved by the Superintendent.

1. The following, when applicable, shall be submitted with any request for approval of capital notes or debentures:
 - a. Proposed form of note or debenture;
 - b. Proposed form of offering circular;
 - c. Proposed form of subscription agreement;
 - d. Certified copy of resolution adopted by the board of directors;

- e. Certified copy of resolution by stockholders owning a majority of the issued and outstanding shares entitled to vote; and
- f. Such other material as required by the Superintendent.

2. Capital notes and debentures shall:

- a. Have an original maturity of seven years or more, provided that this restriction on maturity shall not apply to any obligation which otherwise meets all the requirements of this rule and with respect to which the Superintendent has determined that exigent circumstances require the issuance of such obligation without regard to the restriction on maturity;
- b. Have a principal amount of at least \$500.00.

3. Capital notes and debentures shall:

- a. State expressly on its face in bold face type:
 "THIS SECURITY IS NOT A SAVINGS ACCOUNT OR DEPOSIT AND IT IS NOT INSURED BY THE FEDERAL SAVINGS AND LOAN INSURANCE CORPORATION."
- b. State expressly that it is unsecured;
- c. State expressly that it is subordinate to the claims of depositors, account holders, members other than holders of shares of guaranty capital stock, and all other creditors of the association, regardless of whether such claims arose before or after the issuance of the capital note or debenture. That, in the event of liquidation, all depositors, account holders, members other than holders of shares of guaranty capital stock and all other creditors of the association shall be entitled to be paid in full before any payment shall be made on account of principal or interest on such capital note or debenture;
- d. State expressly that no payment shall at any time be made on account of the principal thereof unless following such payment the aggregate of the guaranty capital stock, surplus, undivided profits and capital notes or debentures thereafter outstanding shall be equal to such aggregate immediately before the original issue of such capital note or debenture and the association is in compliance with the capital requirements of A.R.S. § 6-425, subsection (D), or as may be otherwise authorized by the Superintendent; and
- e. State expressly that it is ineligible as collateral for a loan from the issuing savings and loan association.

Effective 8-8-73

Historical Note

Former Rule 26. R20-4-326 recodified from R4-4-326 (Supp. 95-1).

R20-4-327. Application for Permit to Organize a New Association -- A.R.S. § 6-408

- A. Before an application is filed, the applicants shall meet with the Superintendent of Banks to discuss capitalization, location and management of the proposed savings and loan association.
- B. Applicants shall submit, upon the original filing, sufficient information in support of the application to enable the Superintendent to make a determination without further amendments and additions thereto.
- C. The application shall be in the following form on legal size paper securely fastened at the top:

-----, 19--

Superintendent of Banks
 101 Commerce Building
 1601 West Jefferson
 Phoenix, Arizona 85007

Sir:

We, the undersigned residents of the state of Arizona, do hereby make application for a permit to organize a savings and loan association under the provisions of Title 6, Chapter 3, Arizona Revised Statutes, to be located at -----, -----, Arizona and to be known as ----- Savings and Loan Association. In support of said application, we submit the following information:

1. The capital stock will be divided into ----- shares at the par value of \$----- per share. Total \$-----
2. Paid-in Surplus -----
3. Undivided Profits -----
- Total =====

4. Attached as Exhibit A is a copy of a statement from the Corporation Commission indicating the reservation of the name for the proposed association.

5. Names, addresses and length of residence in Arizona of the applicants:

NameAddress

Resident of
Arizona Since

6. Attached as Exhibit B is a brief resume, current financial statement and credit report for each applicant.
7. None of the applicants has been convicted of any criminal offense involving dishonesty or a breach of trust.
8. Population of town or city in which the proposed association is to be located is ----- as of ----- 19--. Source:

9. Population of trade area to be served by the proposed association is ----- as of -----, 19--. Source:

10. Savings and loan association offices located within the trade area and distance from proposed association office site:

AssociationAddressDistance

11. Bank offices located within the trade area:

BankAddress

12. Attached as Exhibit C is a map delineating the trade area to be served by the proposed association.
13. Attached as Exhibit D is a report in which is set forth pertinent economic data, lending needs, nature and characteristics of the trade area to be served by the proposed association.
14. Known prospective stockholders:

NameAddressShares

15. Proposed staff:

PositionSalary

16. Statement of the estimated assets, liabilities and net worth of the proposed association, as of the beginning of business, is as follows:

17. Statement of estimated deposits at the close of the first, second and third year of operations of the proposed association is as follows:

18. Statement of estimated loans to be made during the first year of operations of the proposed association is as follows:

NumberTypeAmount

19. Statement of estimated operating earnings and expenses for the first year of operations of the proposed association, with supporting data stated in notes to the statement, is as follows:

20. Statement of estimated assets, liabilities, reserves and net worth at the end of the first year of operations of the proposed association is as follows:

21. Itemized statement of estimated expenses in connection with the organization of the proposed association is as follows:

22. The organization expenses will be paid out of funds from the following sources:

23. Statement that a need does exist for a new savings and loan association, and that the public convenience and advantage will be promoted by the proposed association, in the trade area to be served by the proposed association is as follows:

24. The name of the proposed association is not the same as, or deceptively similar to, the name of any other financial institution located in the state of Arizona.

25. Other information deemed pertinent to this application is as follows:

Department of Financial Institutions

Enclosed herewith is a check in the amount of \$1,000.00 representing payment of the filing fee for this application.

Signature of applicants:

State of Arizona)
) ss
County of -----)

Before me, a Notary Public in and for the County and State above named, personally appeared ----- and that each of them stated under oath that all the matters herein contained are true and correct to their best knowledge and belief.

Subscribed and sworn to before me this ----- day of -----, 19--.

(Notary Public)

(Seal)

My commission expires: -----, 19--.

Effective 8-8-73.

Historical Note

Former Rule 27. R20-4-327 recodified from R4-4-327 (Supp. 95-1).

R20-4-328. Application for Approval to Establish a Branch Office -- A.R.S. § 6-475

- A. Applicants shall submit, upon the original filing, a complete application incorporating all the pertinent information required by law and the superintendent.
- B. Approval of the application will be granted only upon a strong showing in the application and during the hearing required by law that the establishment and maintenance of the proposed

branch office will not unduly injure any existing association located in the same county as the proposed branch office and is advisable and in the public interest, that the current earnings of the association are sufficient to support the proposed branch office operation, and that the association will have qualified personnel available to staff the proposed branch office when it is opened.

- C. The application shall be in the following form:

Superintendent of Banks
101 Commerce Building
1601 West Jefferson
Phoenix, Arizona 85007

-----, 19--

Sir:

The -----
(Applicant) (Street Address) (City)

hereby makes application for approval to establish and maintain a branch office at -----
(Street Address) (City) (County)

to be known as ----- office.

The functions to be performed in the proposed branch office are as follows:

In support of this application, we submit the following information:

1. Attached as Exhibit A is a certified copy of the resolution of the Board of Directors authorizing the filing of this application:
2. The association opened for business on -----, 19--.
3. Attached as Exhibit B (confidential) is a statement showing the number and amount of loans and deposits held in each of the ----- association offices as of the end of the last calendar year and the end of the last quarter.
4. The following ----- branch offices have been approved but not opened:

<u>Street Address</u>	<u>City</u>	<u>Date Approved</u>	<u>Anticipated Opening Date</u>
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5. The following branch office applications are pending approval:

<u>Street Address</u>	<u>City</u>	<u>Application Date</u>
-----------------------	-------------	-------------------------
6. Attached as Exhibit C is a statement of condition of the association as of -----, 19--.
7. The capital structure of the association as of the application date -----, 19-- .
 - a. Capital stock (----- shares, \$ ----- par value) \$-----
 - b. Paid-in surplus -----
 - c. Capital notes and debentures -----
 - d. Reserves for losses -----
 - e. Earned surplus (including undivided profits) -----
 - Total Capital =====
8. The total deposits in the association as of the application date -----, 19-- is \$-----.
9. The ratio of total capital to total deposits as of the application date -----, 19-- is -----%.
10. The capital structure will be increased as follows prior to the establishment of the proposed branch office (confidential):
11. The estimated cost and description of the premises to be occupied by the proposed branch office is as follows:
12. The investment in land and building or leasehold improvements for the proposed branch office will not result in the association exceeding the limitation imposed in A.R.S. § 6-453.
13. The estimated cost of furniture, fixtures and equipment in the proposed branch office is \$-----.
14. Attached as Exhibit D is a statement of estimated income and expenses for the first year of operation of the proposed branch office.
15. Estimated number and amount of deposits and loans as of the end of the first year of operations of the proposed branch office is as follows:
16. It is estimated that \$----- of deposits and \$----- of loans will be transferred to the proposed branch office from other offices of the association.
17. Attached as Exhibit E (confidential) is a budget of the association for the current dividend period and for the next succeeding semi-annual period which reflects the estimated additional income and expense of the maintenance of the proposed branch office.
18. The gross assets, deposits and loans of the association at the end of the three calendar years last past and at the end of the last quarter were as follows:
19. The name, duties, salary and brief resume of the managing officer of the proposed branch office is as follows:
20. Officers of the proposed branch office will have the following authority in connection with extension of credit:

21. The following is a summary of the supervision and control which will be exercised by the officials of the association over the activities of the proposed branch office:
22. The association maintains fidelity bond coverage on its directors, officers, employees and agents as follows:
23. The approximate population of the city in which the proposed branch office is to be located is ----- as of -----, 19--.
Source:
24. The approximate population of the trade area to be served by the proposed branch office is ----- as of -----, 19--.
Source:
25. Existing and approved associations and branch offices located within a three mile radius of the proposed branch office are as follows:

<u>Name</u>	<u>Location</u>	<u>Distance</u>
-------------	-----------------	-----------------

26. Attached as Exhibit F is a map delineating the trade area and indicating the location of each of the above associations and branch offices in the trade area and the proposed branch office.
27. Relative information regarding the trade area in which the proposed branch office is to be located is as follows:
28. The establishment and maintenance of the proposed branch office will not unduly injure any existing association located in the same county as the proposed branch office for the following reasons:
29. The establishment and maintenance of the proposed branch office is advisable and in the public interest for the following reasons:
30. Attached is a copy of (contract, lease, option or letter of intent) covering the purchase or lease of the property. If no copy is attached state the reason:

Attached is our check in the amount of \$375.00 representing payment of the filing fee for this application.

The undersigned does hereby certify and state that he has read this application and all statements, representation and information contained therein are true and correct to the best of his knowledge and belief.

(President or Vice President)

Attest:

(Secretary)

Effective 8-8-73.

Historical Note

Former Rule 28. R20-4-328 recodified from R4-4-328 (Supp. 95-1).

R20-4-329. Repealed

Historical Note

Former Rule 29. R20-4-329 recodified from R4-4-329 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-330. First Payment Date on Loans -- A.R.S. § 6-449(E)

The first payment date on loans shall not be later than as follows:

1. Regular installment loans, other than (2), (3) and (4) hereof, six months from the date of the note;
2. Construction loans:
Property Improvement - 12 months from date of note;
One to Four Family Dwellings - 18 months from date of note;
All other construction loans - 36 months from date of note;
3. Insured loans, not later than as acceptable to the insurer; and
4. Guaranteed loans, not later than as acceptable to the guarantor.

Effective 9-27-74.

Historical Note

Original Rule. R20-4-330 recodified from R4-4-330 (Supp. 95-1).

R20-4-331. Repealed

Historical Note

Original Rule. R20-4-331 recodified from R4-4-331 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

ARTICLE 4. CREDIT UNIONS

R20-4-401. Fidelity Bond Coverage

- A. A credit union shall have a fidelity bond in the form and in the amount required to maintain federal insurance on its accounts.
- B. A fidelity bond purchased by a credit union to comply with this Section shall include faithful-performance-of-duty coverage.
- C. A credit union shall purchase its fidelity bond from an insurer that holds a certificate of authority from the Arizona Director of Insurance to transact surety business in Arizona.

Historical Note

Former Rule 1. R20-4-401 recodified from R4-4-401 (Supp. 95-1). Amended effective April 21, 1995 (Supp. 95-2). Amended by final rulemaking at 7 A.A.R. 2229, effective May 3, 2001 (Supp. 01-2).

R20-4-402. Repealed**Historical Note**

Former Rule 2. R20-4-402 recodified from R4-4-402 (Supp. 95-1). Repealed effective April 21, 1995 (Supp. 95-2).

ARTICLE 5. SMALL LOANS**R20-4-501. Repealed****Historical Note**

Former Rule 1. R20-4-501 recodified from R4-4-501 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-502. Repealed**Historical Note**

Former Rule 2. R20-4-502 recodified from R4-4-502 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 3380, effective August 3, 2000 (Supp. 00-3).

R20-4-503. Adjustments in Precomputed Charges

A licensee shall adjust the total precomputed charges if the first installment period is more or less than one month long. The licensee's records shall reflect the adjustment's collection in one of three ways.

1. In the first installment payment,
2. Amortized over the life of the contract, or
3. As part of the final payment.

Historical Note

Former Rule 3. R20-4-503 recodified from R4-4-503 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 4605, effective November 14, 2000 (Supp. 00-4).

R20-4-504. Repealed**Historical Note**

Former Rule 4. R20-4-504 recodified from R4-4-504 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 4605, effective November 14, 2000 (Supp. 00-4).

R20-4-505. Repealed**Historical Note**

Former Rule 5. R20-4-505 recodified from R4-4-505 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-506. Repealed**Historical Note**

Former Rule 6. R20-4-506 recodified from R4-4-506 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 3380, effective August 3, 2000 (Supp. 00-3).

R20-4-507. Repealed**Historical Note**

Former Rule 7. R20-4-507 recodified from R4-4-507 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-508. Cut-off Date for Computing Refunds upon Early Repayment in Full

If a borrower repays a loan before the due date of the final installment, a licensee shall calculate any refund or credit due on the pre-computed loan using the following rules:

1. A licensee shall credit any full repayment, made on or before the 15th day following an installment date, as if received on the last previous installment date.
2. A licensee shall credit any full repayment, made on or after the 16th day following an installment date, as if received on the next installment date.

Historical Note

Former Rule 8. R20-4-508 recodified from R4-4-508 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 4605, November 14, 2000 (Supp. 00-4).

R20-4-509. Repealed**Historical Note**

Former Rule 9. R20-4-509 recodified from R4-4-509 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-510. Repealed**Historical Note**

Former Rule 10. R20-4-510 recodified from R4-4-510 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-511. Repealed**Historical Note**

Former Rule 11. R20-4-511 recodified from R4-4-511 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-512. Reserved**R20-4-513. Repealed****Historical Note**

Former Rule 13. R20-4-513 recodified from R4-4-513 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-514. Repealed**Historical Note**

Former Rule 14. R20-4-514 recodified from R4-4-514 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-515. Repealed**Historical Note**

Former Rule 15. R20-4-515 recodified from R4-4-515 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-516. Repealed**Historical Note**

Former Rule 16. R20-4-516 recodified from R4-4-516 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 4605, effective November 14, 2000 (Supp. 00-4).

R20-4-517. Repealed**Historical Note**

Former Rule 17. R20-4-517 recodified from R4-4-517 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-518. Deferral Fee

- A.** A licensee may collect a deferral fee at the time it agrees to a deferment or at any time after the assessment of a deferral fee. If a licensee receives a payment when it agrees to the deferment, it may apply the payment first to the deferral fee. Any remainder of the payment shall be applied to the balance of the loan.
- B.** If a licensee receives a payment that is large enough to pay in full a delinquent installment and all allowable delinquency fees, the licensee shall apply the payment first to the delinquent installment and fees. The licensee shall not show the paid installment as deferred, and shall not collect a deferral fee.

Historical Note

Former Rule 18. R20-4-518 recodified from R4-4-518 (Supp. 95-1). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 4605, effective November 14, 2000 (Supp. 00-4).

R20-4-519. Deferment Statement

A licensee shall give the borrower a statement at the time a deferment is made, and shall retain a copy of the statement in the borrower's credit file. The statement shall contain the following information:

1. The amount of the deferral fee,
2. The date of the borrower's next scheduled payment,
3. The amount of the borrower's next scheduled payment, and
4. The extended maturity date of the loan.

Historical Note

Former Rule 19. R20-4-519 recodified from R4-4-519 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 4605, effective November 14, 2000 (Supp. 00-4).

R20-4-520. Repealed**Historical Note**

Former Rule 20. R20-4-520 recodified from R4-4-520 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 3380, effective August 3, 2000 (Supp. 00-3).

R20-4-521. Repealed**Historical Note**

Former Rule 21. R20-4-521 recodified from R4-4-521 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 3380, effective August 3, 2000 (Supp. 00-3).

R20-4-522. Repealed**Historical Note**

Former Rule 22. R20-4-522 recodified from R4-4-522 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-523. Repealed**Historical Note**

Former Rule 23. R20-4-523 recodified from R4-4-523 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-524. Books, Accounts, and Records

- A.** A licensee may use a computer recordkeeping system if the licensee gives the Superintendent advanced written notice that it intends to do so. The Department shall not require a licensee to keep a written copy of its books, accounts, and records if the licensee can generate all information required by this Section in a timely manner for examination or other purposes. A licensee may modify a computer recordkeeping system's hard-

ware or software components. When requested, or in response to a written notice of an examination, a licensee shall report to the Superintendent any modification that changes a computer system back to a paper-based recordkeeping system;

- B.** A licensee shall keep its books, accounts, and records of operations licensed under A.R.S. Title 6, Chapter 5 separate from the books, accounts, and records of its other business activities.
- C.** In addition to any statutory requirements, the books, accounts, and records maintained by a Small Loan Company shall include the following:
1. A file containing a record of all legal actions brought during the fiscal year. A licensee shall keep the file until the Department of Financial Institutions conducts its examination of the licensee.
 2. An itemized record of disbursing the proceeds of each loan. The itemized record shall include the amount of refund on each loan that is renewed or refinanced if the licensee makes precomputed loans.
 3. A record of the receipt of all allowable fees.
 4. A record for each borrower and each loan that contains documentary evidence of filing or recording each instrument of record for the loan.
 5. A record of the borrower's voluntary election to purchase any insurance in connection with a loan, if that insurance is sold by the licensee.

Historical Note

Former Rule 24. R20-4-524 recodified from R4-4-524 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 4605, effective November 14, 2000 (Supp. 00-4).

R20-4-525. Repealed**Historical Note**

Former Rule 25. R20-4-525 recodified from R4-4-525 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 4605, effective November 14, 2000 (Supp. 00-4).

R20-4-526. Repealed**Historical Note**

Former Rule 26. R20-4-526 recodified from R4-4-526 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 4605, effective November 14, 2000 (Supp. 00-4).

R20-4-527. Repealed**Historical Note**

Former Rule 27. R20-4-527 recodified from R4-4-527 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-528. Repealed**Historical Note**

Former Rule 28. R20-4-528 recodified from R4-4-528 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-529. Repealed**Historical Note**

Former Rule 29. R20-4-529 recodified from R4-4-529 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 4605, effective November 14, 2000 (Supp. 00-4).

R20-4-530. Repealed**Historical Note**

Former Rule 30. R20-4-530 recodified from R4-4-530 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 4605, effective November 14, 2000 (Supp. 00-4).

R20-4-531. Repealed**Historical Note**

Former Rule 31. R20-4-531 recodified from R4-4-531 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-532. Repealed**Historical Note**

Former Rule 32. R20-4-532 recodified from R4-4-532 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 3380, effective August 3, 2000 (Supp. 00-3).

R20-4-533. Reserved**R20-4-534. Insurance**

- A.** A licensee shall obtain written evidence of the borrower's voluntary election to purchase insurance in connection with a loan if the licensee's sale of insurance to the borrower is intended to secure repayment of a loan. The licensee shall retain this evidence of voluntary election in its records as required by statute. A document sufficient to comply with this Section shall read as follows:

TO SECURE REPAYMENT OF MY LOAN, I ELECT TO PURCHASE INSURANCE IN THE AMOUNT OF \$ _____.
I UNDERSTAND THAT MY TOTAL LOAN OBLIGATION IS THE SUM OF \$ _____.

- B.** A licensee shall obtain written evidence of the borrower's voluntary election to purchase property insurance in connection with a loan if the licensee's sale of property insurance to the borrower is intended to secure repayment of a loan. The licensee shall retain this evidence of voluntary election in its records as required by statute. A document sufficient to comply with this Section shall read as follows:

TO SECURE REPAYMENT OF MY LOAN, I ELECT TO PURCHASE PROPERTY INSURANCE IN THE AMOUNT OF \$ _____.
I UNDERSTAND THAT MY TOTAL LOAN OBLIGATION IS THE SUM OF \$ _____.
I ATTEST THAT THE VALUE OF MY PROPERTY INSURED IN CONNECTION WITH THIS LOAN IS THE SUM OF \$ _____.

Historical Note

Former Rule 34. R20-4-534 recodified from R4-4-534 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 4605, effective November 14, 2000 (Supp. 00-4).

R20-4-535. Reserved**R20-4-536. Repealed****Historical Note**

Former Rule 36. R20-4-536 recodified from R4-4-536 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 3380, effective August 3, 2000 (Supp. 00-3).

ARTICLE 6. DEBT MANAGEMENT COMPANIES

Article 6, consisting of Sections R4-4-601 through R4-4-620, adopted effective October 26, 1978, except that Sections R4-4-603, R4-4-604 and R4-4-607 shall become effective January 1, 1979. R20-4-601 through R20-4-620 recodified from R4-4-601 through R4-4-620 (Supp. 95-1).

Former Article 6 consisting of Section R4-4-601 repealed effective October 26, 1978. R20-4-601 recodified from R4-4-601 (Supp. 95-1).

R20-4-601. Repealed**Historical Note**

Former Rule 1; Former Section R4-4-601 repealed, new Section R4-4-601 adopted effective October 26, 1978 (Supp. 78-5). R20-4-601 recodified from R4-4-601 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-602. Applications

- A.** An applicant for a debt management company license shall send the Department an application on the form required by the Superintendent. The Department shall order a credit report from a local credit reporting agency disclosing the credit history of the applicant's principals or managing agents. The Department shall direct the credit reporting agency to send the credit report directly to the Superintendent. The applicant shall pay the cost of obtaining the credit report. A complete application shall include the credit report required by this Section and all of the following:

1. The surety bond required by A.R.S. § 6-704(B);
2. The fidelity bond required by A.R.S. § 6-704(D);
3. The nonrefundable application fee and original license fee described in A.R.S. § 6-706, and specified in A.R.S. § 6-126(A)(14);
4. A sample of the contract intended to be used by the applicant;
5. Current financial statements as described in R20-4-604(A)(5);
6. A certified copy of the current articles of incorporation, by-laws, partnership agreement or other organizing documents used to form the applicant business entity; and
7. Statements of personal history, on the form required by the Superintendent, for each of the applicant's principals, principal officers, trustees, partners, and managing agents.

- B.** A debt management company applying to operate a branch office or use an agency shall send the Department an application on the form required by the Superintendent.

- C.** A debt management company applying to renew a license shall deliver, on or before June 15 of each year, an application to the Department on the form required by the Superintendent. A debt management company shall apply separately to renew the license of each authorized business location. With each application for renewal, a debt management company shall include the renewal fee described in A.R.S. § 6-706 and specified in A.R.S. § 6-126(C)(2).

- D.** The Department may require additional information the Superintendent considers necessary in connection with an application under this Section.

Historical Note

Adopted effective October 26, 1978 (Supp. 78-5). R20-4-602 recodified from R4-4-602 (Supp. 95-1). Amended by final rulemaking at 8 A.A.R. 2708, effective June 6, 2002 (Supp. 02-2).

R20-4-603. Reports

- A.** Each debt management company and each nonprofit corporation or association exempt from licensure under A.R.S. § 6-702(4) and (5), shall send the Department an annual report of its business and operations for each place of business during the previous year beginning July 1 and ending June 30, using the form required by the Superintendent. A debt management company shall deliver its report to the Department on or before August 15.
- B.** Each debt management company organized as a corporation shall send the Department a copy, date-stamped by the Ari-

zona Corporation Commission, of each annual report and certificate of disclosure filed under the authority of A.R.S. § 10-202 or 10-1622 within ten days of filing the report and certificate with the Arizona Corporation Commission.

- C. Each debt management company shall notify the Department of any change in its ownership or in the names of its officers, directors, trustees, partners, or managing agents within ten days of the change.

Historical Note

Adopted effective January 1, 1979 (Supp. 78-5). R20-4-603 recodified from R4-4-603 (Supp. 95-1). Amended by final rulemaking at 8 A.A.R. 2708, effective June 6, 2002 (Supp. 02-2).

R20-4-604. Records

- A. A debt management company shall keep books, accounts, and records adequate to provide a clear and readily understandable record of all its business activity. A debt management company may use an electronic recordkeeping system. The Department shall not require a debt management company to keep a written copy of its books, accounts, and records if the debt management company can generate all information and documentation required by this Section within three days of the Department's request for production of the records for examination or other purposes. A debt management company's books, accounts, and records shall include:

1. A file for each account containing:
 - a. A copy of all correspondence concerning the account;
 - b. Evidence of the notice given to creditors of the debt management contract;
 - c. A subsidiary ledger disclosing all financial transactions concerning the account;
 - d. A copy of each written statement of account given to the debtor;
 - e. The original budget analysis required under R20-4-607; and
 - f. The original contract between the debt management company and the debtor, including all amendments.
2. A trust account general ledger, kept current daily, that reflects each deposit to and disbursement from the trust account.
3. Each reconciliation of the debt management company's trust account, prepared at least once a month.
4. A general ledger, kept current monthly, that reflects each financial transaction by the debt management company except those recorded in its trust account general ledger.
5. A financial statement produced in accordance with generally accepted accounting principles at least once every three months, or more frequently if directed by the Superintendent, that reflects the financial condition of the debt management company. The financial statement shall include:
 - a. A balance sheet,
 - b. A statement of income and retained earnings,
 - c. A statement of changes in financial condition, and
 - d. Appropriate footnotes that either:
 - i. Explain entries in the documents listed in subsections (A)(5)(a), (b), and (c);
 - ii. Contain material information not required or not reportable in documents listed in subsections (A)(5)(a), (b), or (c); or
 - iii. Contain other disclosures required by generally accepted accounting principles.
6. A record of all pending litigation naming the debt management company as a party. The debt management com-

pany shall keep, during the pendency of each case, a copy of the complaint, and a copy of any answer or motion filed by the debt management company in response to the complaint.

- B. All records required under this Section may be maintained at the debt management company's office in Arizona. A debt management company may keep its records outside this state if it:

1. Makes the records available to the Superintendent, for examination or other purposes, in this state not more than three business days after demand; and
2. Allows its debtor customers to call toll free to obtain information from the records that is not available from the debt management company's office in Arizona.

- C. Each debt management company shall preserve its books, accounts, and records for the period required by A.R.S. §§ 6-709(J) and 6-710(1).

Historical Note

Adopted effective January 1, 1979 (Supp. 78-5). R20-4-604 recodified from R4-4-604 (Supp. 95-1). Amended by final rulemaking at 8 A.A.R. 2708, effective June 6, 2002 (Supp. 02-2).

R20-4-605. Reserved

R20-4-606. Reserved

R20-4-607. Budget Analysis

- A. A debt management company shall not accept an account unless it first concludes that the debtor can reasonably meet the payments agreed upon by the debt management company and the debtor. The debt management company's conclusion shall be supported by a written budget analysis kept in the company's records.
- B. The written budget analysis shall either be part of an application form or a separate document. The debtor shall date and sign the written budget analysis before the debt management company draws any conclusions from the budget analysis.
- C. The budget analysis shall disclose the disposable income available for payment to the debt management company after the debtor pays its reasonable and necessary living expenses including taxes, insurance, child support, alimony, and residential rent or mortgage payments.

Historical Note

Adopted effective January 1, 1979 (Supp. 78-5). R20-4-607 recodified from R4-4-607 (Supp. 95-1). Amended by final rulemaking at 8 A.A.R. 2708, effective June 6, 2002 (Supp. 02-2).

R20-4-608. Reserved

R20-4-609. Repealed

Historical Note

Adopted effective October 26, 1978 (Supp. 78-5). R20-4-609 recodified from R4-4-609 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-610. Repealed

Historical Note

Adopted effective October 26, 1978 (Supp. 78-5). R20-4-610 recodified from R4-4-610 (Supp. 95-1). Repealed effective September 19, 1996 (Supp. 96-3).

R20-4-611. Advertising

- A. A debt management company shall send the Department copies of all advertising, communication, or sales material at least five days before the company uses the advertising, communi-

cation, or sales material to promote the sale of the company's services. This requirement applies to every type of promotional material used, whether the company will publish, exhibit, broadcast, or personally distribute the material by any other method or medium.

- B.** A debt management company shall not use advertising, communication, or sales material that contains:
1. A false, misleading, or deceptive statement about the debt management company's services or charges. A statement is a violation of this Section if the person making the statement does not state a material fact necessary to make the statement true, in light of the circumstances under which it is made;
 2. A claim, direct or implied, that the debt management company consolidates debts or makes loans; or
 3. A schedule of payments in any form.
- C.** A debt management company's advertising, communication, and sales material shall contain:
1. The name of the debt management company exactly as it appears on the current license; and
 2. The following legend, conspicuously displayed in at least 12 point type and in bold print:
"NOT A LOAN COMPANY."
- D.** The Department's failure to object to the advertising, communication, or sales material filed with it is not and shall not be represented as an approval of the material or the statements it contains.

Historical Note

Adopted effective October 26, 1978 (Supp. 78-5). R20-4-611 recodified from R4-4-611 (Supp. 95-1). Amended by final rulemaking at 8 A.A.R. 2708, effective June 6, 2002 (Supp. 02-2).

R20-4-612. Solvency and Minimum Liquid Assets

- A.** A debt management company shall not operate if it is insolvent. For purposes of this Section "insolvent" has the same meaning as in A.R.S. § 47-1201(23).
- B.** To determine compliance with A.R.S. § 6-709(A), a debt management company's liquid assets include funds held in its trust account. Liquid assets do not include goodwill and other intangible assets. A debt management company's total liquid assets shall exceed by \$2,500.00 the total of all its current business liabilities together with all balances held for debtors as reflected in the company's subsidiary ledgers.
- C.** Except as otherwise provided by this Section, or in a specific ruling by the Superintendent, a debt management company shall use generally accepted accounting principles to compute assets and liabilities.

Historical Note

Adopted effective October 26, 1978 (Supp. 78-5). R20-4-612 recodified from R4-4-612 (Supp. 95-1). Amended by final rulemaking at 8 A.A.R. 2708, effective June 6, 2002 (Supp. 02-2).

R20-4-613. Reserved

R20-4-614. Reserved

R20-4-615. Reserved

R20-4-616. Reserved

R20-4-617. Reserved

R20-4-618. Reserved

R20-4-619. Reserved

R20-4-620. Repealed

Historical Note

Adopted effective October 26, 1978 (Supp. 78-5). R20-4-620 recodified from R4-4-620 (Supp. 95-1). Section repealed by final rulemaking at 8 A.A.R. 2708, effective June 6, 2002 (Supp. 02-2).

ARTICLE 7. ESCROW AGENTS

R20-4-701. Change in Location of Business

An escrow agent shall mail the Superintendent written notice of any change in the location of the escrow agent's business. The escrow agent shall ensure that the Superintendent receives the notice at least five days before the escrow agent conducts business at the new location. The escrow agent shall mail the fee required by A.R.S. § 6-126(A), together with the current escrow license, to the Superintendent with the notice of the location change. The Superintendent shall change the submitted license to reflect the new business location and return it to the escrow agent.

Historical Note

Former Rule 1. R20-4-701 recodified from R4-4-701 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 5385, effective November 9, 2001 (Supp. 01-4).

R20-4-702. Account Practices and Records

An escrow agent shall maintain records to enable the Superintendent to reconstruct the details of each escrow transaction. The records shall include the following:

1. The seller's name and address;
2. The buyer's name and address;
3. The lender's name and address, if any;
4. The borrower's name and address, if any;
5. The real estate agent's name and address, if any;
6. Complete escrow instructions;
7. Records and supporting documentation for each receipt and disbursement made through the escrow; and
8. A copy of the escrow settlement.

Historical Note

Former Rule 2. R20-4-702 recodified from R4-4-702 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 5385, effective November 9, 2001 (Supp. 01-4).

R20-4-703. Preservation of Records

An escrow agent shall preserve the records, books, and accounts pertaining to each escrow transaction for at least three years following the final settlement date of the transaction. An escrow agent may use an electronic recordkeeping system. The Department shall not require an escrow agent to keep a written copy of the records, books, and accounts if the escrow agent can generate all information and copies of documents required by A.R.S. § 6-831 in a timely manner for examination or other purposes.

Historical Note

Former Rule 3. R20-4-703 recodified from R4-4-703 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 5385, effective November 9, 2001 (Supp. 01-4).

R20-4-704. Subsidiary Account Records

An escrow agent shall maintain subsidiary account records that identify the funds deposited in each escrow. The total of all credit balances in the subsidiary accounts shall always equal the balance of the general ledger control account.

Historical Note

Former Rule 4. R20-4-704 recodified from R4-4-704 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 5385, effective November 9, 2001 (Supp. 01-4).

R20-4-705. Reserved

R20-4-706. Repealed

Historical Note

Former Rule 6. R20-4-706 recodified from R4-4-706 (Supp. 95-1). Section repealed by final rulemaking at 7 A.A.R. 5385, effective November 9, 2001 (Supp. 01-4).

R20-4-707. Payment to the All Other Escrow Agents Account of the Arizona Escrow Guaranty Fund

A. As used in this rule, an "Other Escrow Agent" means any licensed Escrow Agent that is not required to contribute to the Real Property Escrow Agents Account as prescribed in A.R.S. § 6-847.02(C).

B. Every Other Escrow Agent shall pay a contribution to the Fund in the following amount:

1. Every person that is an Other Escrow Agent on January 1, 1993, shall pay a one-time contribution into the Fund within 60 days after the effective date of this rule. The contribution shall be in the following amounts:

Gross Income for 1992	Contribution
Less than \$300,000	\$500
\$300,000 to 750,000	750
over 750,000	1,000

2. From and after January 1, 1993, every person upon becoming an Other Escrow Agent that has not already paid a one-time contribution shall pay a one-time contribution in the amount of \$500 into the Fund.
3. In addition to the payments required by subsections (B)(1) and (2), each Other Escrow Agent shall pay into the Fund monies in accordance with the following schedule based upon its gross income generated by escrow fees, account servicing fees, and trustee and foreclosure fees, or \$1,000, whichever is greater, on or after January 1, 1993.

Source of Gross Income	Percentage of Gross Income to be Paid
Amount Servicing Fees	1.25%
Other Escrow Fees	1.25%
Trustee & Foreclosure Fees	1.00%

C. Payments made pursuant to subsection (B)(3) of this Section shall be made quarterly in an amount no less than \$250 and shall be due on the 15th day of the month following the end of the quarter for which the payment is made. With respect to payments for 1993, for the first two quarters, the payments shall be due within 60 days after the effective date of this rule. Payments shall be accompanied by reports in the form required by the Superintendent.

D. Payments to the Fund pursuant to subsection (B)(3) of this Section shall be required until the balance including interest of the all Other Escrow Agents Account equals \$750,000, at which time the Superintendent shall advise all contributors that have paid to the Fund for at least two years, in writing, that payments pursuant to subsection (B)(3) of this Section be discontinued. Other Escrow Agents that have not paid to the Fund for at least two years at the time the payments are discontinued shall continue to pay to the Fund until they have contributed for two years.

E. On or before January 31 of each year, if the account balance on December 31 of the previous year exceeds \$750,000 and the Superintendent determines that potentially covered claims

will not be greater than the amount by which the account exceeds \$1 million, the Superintendent shall disburse monies in excess of \$1 million in the following manner:

1. The account balance shall first be reduced pursuant to A.R.S. § 6-847.04(D).
 2. All Other Escrow Agents that have paid into the Fund shall receive a percentage of the remaining excess. The percentage shall be calculated by dividing that Escrow Agent's total contributions by the total account balance on December 31 of the applicable year.
 3. Any funds remaining after disbursement under subsections (E)(1) and (2) shall remain in the account.
- F.** If payments have been discontinued under subsection (C) of this Section and the account balance is less than \$750,000, the Superintendent may, at his discretion, direct Other Escrow Agents, in writing, to resume payments in accordance with subsection (B)(3) of this Section. All Other Escrow Agents shall resume making payments beginning with the next full month following the date of notice from the Superintendent.
- G.** For purposes of this rule, if the Other Escrow Agent has income from business activity that is taxable both within and without the state of Arizona, then "Gross Income" shall mean that portion of the Other Escrow Agent's gross income for federal income tax purposes that is apportionable to the state of Arizona pursuant to A.R.S. § 43-1139. For all remaining Other Escrow Agents, "Gross Income" shall mean the Other Escrow Agent's gross income for federal income tax purposes.

Historical Note

Adopted effective June 25, 1993 (Supp. 93-2). R20-4-707 recodified from R4-4-707 (Supp. 95-1).

R20-4-708. Financial Condition and Resources

The Superintendent shall consider the following criteria in evaluating an escrow agent's, other escrow agent's, or applicant's financial condition and resources under A.R.S. § 6-817:

1. Amount of positive net worth,
2. Amount of tangible net worth,
3. Amount of liquid assets,
4. Amount of cash provided by operations,
5. Ratio of debt to net worth,
6. Owner's personal financial resources,
7. Outside resources available,
8. Profitability,
9. Projected operating results,
10. Status as agent for a title insurance company, and
11. Sources of new business.

Historical Note

New Section made by final rulemaking at 7 A.A.R. 5385, effective November 9, 2001 (Supp. 01-4).

ARTICLE 8. TRUST COMPANIES

R20-4-801. Definitions

In this Article, unless the context otherwise requires:

"Account" means the trust, estate, or other fiduciary relationship established with a trust department or trust company.

"Affiliate" has the meaning stated at A.R.S. § 6-801.

"Certificate" has the meaning stated at A.R.S. § 6-851.

"Fiduciary" has the meaning stated at A.R.S. § 6-851.

"Governing instrument" means a document, and all its operative amendments, that:

Creates a trust and regulates the trustee's conduct,

Creates an agency relationship between a trust department or trust company and a client, or

Otherwise evidences a fiduciary relationship between a trust department or trust company and a client.

“Investment responsibility” means full and unrestricted discretion to invest trust funds without direction from anyone as to any matter, including the terms of the trade or the identity of the broker.

“Person” has the meaning stated at A.R.S. § 1-215.

“Superintendent” has the meaning stated at A.R.S. § 6-851.

“Trust asset” means any property or property right held by a trust department or trust company for the benefit of another.

“Trust business” has the meaning stated at A.R.S. § 6-851.

“Trust company” has the meaning stated at A.R.S. § 6-851.

“Trust department” means a permittee under both A.R.S. § 6-201 et seq. and Article 2 of this Chapter that possesses a banking permit authorizing it to engage in trust business.

“Trust funds” means any money held by a trust department or trust company for the benefit of another.

“Trustor” means a person who creates or funds a trust, or both.

Historical Note

Adopted effective June 30, 1977 (Supp. 77-3). R20-4-801 recodified from R4-4-801 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 2471, effective June 8, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 2718, effective June 6, 2002 (Supp. 02-2).

R20-4-802. Reserved

R20-4-803. Reserved

R20-4-804. Repealed

Historical Note

Adopted effective June 30, 1977 (Supp. 77-3). R20-4-804 recodified from R4-4-804 (Supp. 95-1). Repealed by final rulemaking at 6 A.A.R. 2471, effective June 8, 2000 (Supp. 00-2).

R20-4-805. Reports

- A. Within 90 days following each December 31, each trust department and trust company shall file an annual report of trust assets with the Superintendent on the form prescribed by the Superintendent. The annual report shall include the current market value of all trust assets held by the trust department or trust company as of December 31. The report shall also identify and briefly describe all transactions conducted in the report period that are regulated by R20-4-812(E) through R20-4-812(G).
- B. Each trust company shall deliver a copy of its annual report and certificate of disclosure to the Superintendent within 10 days of filing the report and certificate at the Arizona Corporation Commission. A report or certificate covered by this subsection is one filed under the authority of A.R.S. §§ 10-202 or 10-1622. A copy delivered to the Superintendent, as required in this subsection, shall be date-stamped by the Arizona Corporation Commission to confirm the actual filing date.
- C. Each trust company shall notify the Superintendent of any change in the directors or officers of the company within 10 days of the change. Any trust company with more than 25 officers may, after obtaining the Superintendent's written approval, limit the officers covered by this subsection to those with substantial involvement in the trust company's corporate operations or in the trust company's trust business in this state.

Historical Note

Adopted effective September 1, 1977 (Supp. 77-3). R20-4-805 recodified from R4-4-805 (Supp. 95-1). Amended

by final rulemaking at 6 A.A.R. 2471, effective June 8, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 2718, effective June 6, 2002 (Supp. 02-2).

R20-4-806. Records

- A. A trust company may use a computer recordkeeping system if the trust company gives the Superintendent advanced written notice that it intends to do so. Except for records required by subsections (B)(1)(a) and (B)(1)(b), the Department shall not require a trust company to keep a written copy of its records if the trust company can generate all information required by this Section in a timely manner for examination or other purposes. A trust company may add, delete, modify, or customize a computer recordkeeping system's hardware or software components. When requested, or in response to a written notice of an examination, a trust company shall report to the Superintendent any alteration in the computer recordkeeping system's fundamental character, medium, or function if the alteration changes the computer system to a paper-based system.
- B. A trust department or trust company shall keep books, accounts, and records adequate to provide clear and readily understandable evidence of all business conducted by the trust department or trust company, including the following:
 1. A file for each account that includes:
 - a. The original of the governing instrument,
 - b. The originals of all contracts and other legal documents,
 - c. Copies of all correspondence,
 - d. Accounting records disclosing all the financial transactions, and
 - e. A listing of all the account's assets and liabilities.
 2. An investment file for each account that includes:
 - a. All original documentary evidence of the account's assets; or
 - b. Copies of the original documentary evidence of the account's assets, together with written evidence of custody or receipt of the originals by an authorized holder; and
 - c. A record of the initial and annual investment reviews for the account.
 3. The corporate general ledger kept current on a daily basis. This record shall identify and segregate all financial transactions conducted by the trust department or trust company for itself, distinguishing them from those relating to the trust department's or trust company's trust business;
 4. Unaudited financial statements. A trust department or trust company shall produce these statements quarterly or more frequently when directed by the Superintendent. The financial statements shall include at least:
 - a. A balance sheet; and
 - b. A statement of income, expenses, and retained earnings.
 5. Adequate records of all pending litigation that names the trust department or trust company as a party.
- C. A trust department shall keep its fiduciary records separate and distinct from the trust department's corporate records.
- D. A trust department or trust company shall keep records described in subsections (B)(1) and (B)(2) for at least three years after closing an account. If litigation occurs concerning a particular account, the trust department or trust company shall keep that account's records, described in subsections (B)(1) and (B)(2), for three years after the litigation is resolved.

Historical Note

Adopted effective September 1, 1977 (Supp. 77-3). R20-4-806 recodified from R4-4-806 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 2471, effective June 8, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 2718, effective June 6, 2002 (Supp. 02-2).

R20-4-807. Unsafe or Unsound Condition

For purposes of A.R.S. §§ 6-863 and 6-865, a trust company conducts business in an unsafe manner or its affairs are in an unsound condition if it:

1. Violates any fiduciary duty or obligation, including those listed in R20-4-809 through R20-4-815;
2. Violates any state or federal requirement for operating or maintaining trusts, common trust funds, or other accounts;
3. Violates any applicable federal or state law or regulation regarding corporations or securities;
4. Employs an officer or director who violates a corporate fiduciary duty;
5. Is insolvent; or
6. Engages in any conduct that the Superintendent determines constitutes an unsafe or unsound business practice jeopardizing the trust company's financial condition or the interests of a stockholder, creditor, trustor, beneficiary, or trust company's principal.

Historical Note

Adopted effective June 30, 1977 (Supp. 77-3). R20-4-807 recodified from R4-4-807 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 2471, effective June 8, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 2718, effective June 6, 2002 (Supp. 02-2).

R20-4-808. Administration of Fiduciary Powers

- A. The board of directors and the officers share responsibility for the exercise of fiduciary powers by a trust department or trust company. The board of directors is responsible for determining policy; investing and disposing of trust assets; and directing and reviewing the actions of all directors, officers, and committees of the board that exercise fiduciary powers. The board of directors may delegate the necessary power and authority to perform the trust department's or trust company's duties as a fiduciary to selected directors, officers, employees, or committees of the board if the delegation is consistent with the corporate charter. The minutes of the board's meetings shall duly reflect all those delegations.
- B. A trust department or trust company shall not accept a new account without first obtaining the board's approval, or that of the directors, officers, or committees that the board may have authorized to approve new accounts. The trust department or trust company shall keep a written record of each new account approval and of the closing of each account. The trust department or trust company shall conduct an asset review within 60 days after it accepts each new account if it has investment responsibility for that account. The trust department's or trust company's board shall ensure that an annual review of account assets is conducted for any account in which the trust department or trust company has investment responsibility, to determine whether to retain or dispose of the assets.
- C. A trust department or trust company exercising fiduciary powers shall use independent legal counsel admitted to practice in Arizona to advise and inform the trust department or trust company on fiduciary matters and all other legal issues presented to the trust department or trust company by the conduct of its trust business.

Historical Note

Adopted effective June 30, 1977 (Supp. 77-3). R20-4-808 recodified from R4-4-808 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 2471, effective June 8, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 2718, effective June 6, 2002 (Supp. 02-2).

R20-4-809. Fiduciary Duties

A trust department or trust company shall perform all fiduciary duties imposed upon it by law, including the following:

1. Administer accounts strictly according to the governing instrument and solely in the account beneficiary's interests;
2. Use reasonable care and skill to make the account productive;
3. Provide complete and accurate information of the nature and amount of assets held to each account's beneficiary or principal and permit the beneficiary, principal, or any person duly authorized by the beneficiary or principal to inspect the account's records at any time during normal business hours. The information provided in compliance with this subsection shall be delivered at least quarterly, unless:
 - a. The trust department or trust company and its account's beneficiary, principal, or authorized person agree otherwise in writing;
 - b. The governing instrument provides otherwise; or
 - c. A different frequency is established by a lawful course of dealing before the effective date of this rule; and
4. Comply with all lawful provisions of the governing instrument.

Historical Note

Adopted effective June 30, 1977 (Supp. 77-3). R20-4-809 recodified from R4-4-809 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 2471, effective June 8, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 2718, effective June 6, 2002 (Supp. 02-2).

R20-4-810. Funds Awaiting Investment or Distribution

- A. Trust funds held by a trust department or trust company awaiting investment or distribution shall not remain uninvested or undistributed any longer than is reasonable for the account's proper management.
- B. A trust department or trust company may keep trust funds in deposit accounts maintained by the trust department or trust company, unless prohibited by law or by the governing instrument. The trust department or trust company shall set aside collateral security for all deposited trust funds under a third party's control. The collateral shall be the following types of securities, in any combination:
 1. Direct obligations of the United States or any agency, department, division, or administration of the federal government;
 2. Any other obligations fully guaranteed by the United States government as to principal and interest;
 3. Obligations of a Federal Reserve Bank;
 4. Obligations of any state, political subdivision of a state, or public authority organized under the laws of a state; or
 5. Readily marketable securities that either:
 - a. Qualify as investment securities under the Investment Securities regulations of the Comptroller of the Currency, 12 CFR, Chapter 1, Part 1; or
 - b. Satisfy state pledging requirements under A.R.S. § 6-245(C).
- C. The securities set aside under subsection (B) shall, at all times, have a market value no less than the amount of trust funds

deposited. No collateral security is required to the extent the Federal Deposit Insurance Corporation, or its successor, insures the deposited trust funds.

Historical Note

Adopted effective June 30, 1977 (Supp. 77-3). R20-4-810 recodified from R4-4-810 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 2471, effective June 8, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 2718, effective June 6, 2002 (Supp. 02-2).

R20-4-811. Investment of Trust Funds

- A.** A trust department or trust company shall invest trust funds according to:
1. The governing instrument; and
 2. All applicable laws, including A.R.S. §§ 6-862, 14-7402, and 14-7601 through 14-7611.
- B.** A trust department or trust company shall make any collective investment of trust funds exclusively under the terms of R20-4-815.

Historical Note

Adopted effective June 30, 1977 (Supp. 77-3). R20-4-811 recodified from R4-4-811 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 2471, effective June 8, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 2718, effective June 6, 2002 (Supp. 02-2).

R20-4-812. Self-dealing

- A.** A trust department or trust company shall not invest trust funds in the following types of property unless expressly authorized by the governing instrument, applicable state or federal law, or court order:
1. Its own securities;
 2. Other types of property acquired from the trust department or trust company;
 3. Property acquired from the trust department's or trust company's directors, officers, or employees;
 4. Property acquired from the trust department's or trust company's affiliates;
 5. Property acquired from its affiliates' directors, officers, or employees; or
 6. Property acquired from other individuals or organizations with an interest in the trust department or trust company if that interest might affect the trust department's or trust company's exercise of discretion to the detriment of its trust clients.
- B.** A trust department or trust company may use trust funds to purchase its own securities, or its affiliates' securities:
1. If the trust department or trust company has authority under subsection (A), and
 2. If those securities are offered pro rata to all stockholders of the trust department or trust company.
- C.** A trust department or trust company shall not sell or loan trust property to itself, or to the following types of persons, unless expressly authorized by the governing instrument, applicable state or federal law, or court order:
1. Its directors, officers, or employees;
 2. Its affiliates;
 3. Its affiliates' directors, officers, or employees; or
 4. Other individuals or organizations with an interest in the trust department or trust company if that interest might affect the trust department's or trust company's exercise of discretion to the detriment of its trust clients.
- D.** However, a trust department or trust company may sell or loan trust property to persons prohibited by subsection (C) if either:
1. Its counsel has advised in writing that, by holding certain property, the trust department or trust company has

incurred a contingent or potential liability for breach of fiduciary duty; and

- a. The proposed sale or loan avoids the contingent or potential liability;
 - b. Its board of directors authorizes the sale or loan by an action duly noted in the trust department's or trust company's minutes;
 - c. Its board of directors' action expressly authorizes reimbursement to the affected account; and
 - d. The affected account is reimbursed, in cash, at no loss to that account; or
- 2.** The Superintendent requires or approves, in writing, the sale or loan to otherwise prohibited parties.
- E.** A trust department or trust company may sell trust property held in one account to another of its accounts if:
1. The transaction is fair to both accounts; and
 2. The transaction is not prohibited by the governing instruments, applicable state or federal law, or court order.
- F.** A trust department or trust company may loan trust property held in one account to another of its accounts if:
1. The transaction is fair to both accounts; and
 2. The transaction is not prohibited by the governing instruments, applicable state or federal law, or court order.
- G.** A trust department or trust company may make a loan to a trust account, taking trust assets of the borrowing account as security for repayment, if:
1. The transaction is fair to the borrowing account; and
 2. The transaction is not prohibited by the governing instrument, applicable state or federal law, or court order.

Historical Note

Adopted effective June 30, 1977 (Supp. 77-3). R20-4-812 recodified from R4-4-812 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 2471, effective June 8, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 2718, effective June 6, 2002 (Supp. 02-2).

R20-4-813. Custody of Investments

- A.** A trust department or trust company shall keep each account's investments separate from its own assets. It shall place each account's assets in the joint control of at least two officers or employees of the trust department or trust company designated in writing for that purpose by:
1. The trust department's or trust company's board of directors, or
 2. One or more officers authorized by the trust department's or trust company's board of directors to make the designation.
- B.** A trust department or trust company shall either:
1. Keep each account's investments separate from all other accounts' investments, except as provided in R20-4-815; or
 2. Adequately identify each account's property in the trust department's or trust company's records.

Historical Note

Adopted effective June 30, 1977 (Supp. 77-3). R20-4-813 recodified from R4-4-813 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 2471, effective June 8, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 2718, effective June 6, 2002 (Supp. 02-2).

R20-4-814. Compensation

- A.** A trust department or trust company acting as a fiduciary may charge a reasonable fee for its services. It shall receive the fee allowed by the court when it is acting under a court appointment. Any agreement as to fees in the governing instrument

shall control the fee unless contrary to law, regulation, or court order.

- B. A trust department or trust company shall not permit any of its officers or employees to take any compensation for acting as a co-fiduciary with the trust department or trust company in the administration of an account.

Historical Note

Adopted effective June 30, 1977 (Supp. 77-3). R20-4-814 recodified from R4-4-814 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 2471, effective June 8, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 2718, effective June 6, 2002 (Supp. 02-2).

R20-4-815. Collective Investments

- A. All collective investments made by a trust department or trust company shall be in a common trust fund established under A.R.S. § 6-871, and maintained by the trust department or trust company exclusively for the collective investment and reinvestment of funds contributed by the trust department or trust company acting as a fiduciary. A trust department or trust company shall not establish a common trust fund unless it first:
 - 1. Prepares a written plan regarding the common trust fund; and
 - 2. Obtains its board of directors' approval of the plan, evidenced by a duly adopted resolution or the board's unanimous written consent.
- B. The plan shall describe the common trust fund's operational details, including a description of:
 - 1. The trust department's or trust company's investment powers and investment policy over all funds deposited in the common trust fund,
 - 2. The manner for allocating the common trust fund's income and losses,
 - 3. The criteria for admission to or withdrawal from participating in the common trust fund, and
 - 4. The method for valuing assets in the common trust fund and the frequency of valuation.
- C. A trust department or trust company shall advise all persons having an interest in its common trust fund of the existence of the plan described in subsection (B), and shall provide a copy of the plan upon request.
- D. The annual report required under R20-4-805(A) shall include all common trust funds operated by the trust department or trust company.

Historical Note

Adopted effective June 30, 1977 (Supp. 77-3). R20-4-815 recodified from R4-4-815 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 2471, effective June 8, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 2718, effective June 6, 2002 (Supp. 02-2).

R20-4-816. Termination of Trust or Fiduciary Powers and Duties

- A. Any trust department that wants to surrender its trust powers shall file with the Superintendent a certified copy of the appropriate resolution of its board of directors or of the board's unanimous written consent. If, after investigation, the Superintendent concludes that the trust department has no remaining fiduciary duties, the Superintendent shall notify the trust department that it no longer has authority to exercise trust powers.
- B. Any trust company that wants to surrender its certificate of authority to conduct trust business and wind up its affairs shall file with the Superintendent a certified copy of the appropriate resolution of its board of directors or of the board's unanimous

written consent. Upon receipt of the resolution or consent, the Superintendent shall cancel the trust company's certificate of authority, and the trust company shall not accept new trust accounts.

- C. After winding up its affairs, any trust company that wants to surrender its rights and obligations as a fiduciary and remove itself from the Superintendent's supervision shall file with the Superintendent a certified copy of the appropriate resolution of its board of directors or of the board's unanimous written consent. If, after investigation, the Superintendent concludes that the trust company has no further fiduciary duties, the Superintendent shall notify the trust company that it no longer has authority to exercise fiduciary powers.
- D. Any trust department or trust company that surrenders its powers, rights, obligations, or certificate under this Section or that has them cancelled, suspended, or revoked shall continue to be regulated under A.R.S. § 6-864 and this Article until it winds up its affairs. No action under this Section impairs any liability or cause of action, existing or incurred, against any trust department or trust company or its stockholders, directors, or officers.

Historical Note

Adopted effective June 30, 1977 (Supp. 77-3). R20-4-816 recodified from R4-4-816 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 2471, effective June 8, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 2718, effective June 6, 2002 (Supp. 02-2).

Appendix A. Repealed

Historical Note

Appendix A repealed by final rulemaking at 6 A.A.R. 2471, effective June 8, 2000 (Supp. 00-2).

Appendix B. Repealed

Historical Note

Appendix B repealed by final rulemaking at 6 A.A.R. 2471, effective June 8, 2000 (Supp. 00-2).

ARTICLE 9. MORTGAGE BROKERS

R20-4-901. Reserved

Historical Note

Adopted effective August 14, 1991 (Supp. 91-3). R20-4-901 recodified from R4-4-901 (Supp. 95-1). Section repealed by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-902. Reserved

Historical Note

Adopted effective August 14, 1991 (Supp. 91-3). R20-4-902 recodified from R4-4-902 (Supp. 95-1). Section repealed by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-903. Exemption for an Entity Regulated by an Agency of this State, Other States, or by the United States

- A. The exemption under A.R.S. § 6-902 (A)(1) only applies to a person whose offers to make or negotiate a mortgage loan, as defined in A.R.S. § 6-901, and all mortgage loans made or negotiated by the person are regulated directly by an agency of this state, any other state, or the United States.
- B. The required regulation of the transactions listed in subsection (A) includes:
 - 1. Rules governing a claimant's accounting and recordkeeping practices;
 - 2. The authority to examine a claimant's books and records relating to its mortgage lending activities; and

3. The ability to place a claimant in a receivership or conservatorship with regard to the claimant's mortgage lending activities.

Historical Note

Adopted effective August 14, 1991 (Supp. 91-3). R20-4-903 recodified from R4-4-903 (Supp. 95-1). Amended by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-904. Reserved**Historical Note**

Adopted effective August 14, 1991 (Supp. 91-3). R20-4-904 recodified from R4-4-904 (Supp. 95-1). Section repealed by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-905. Repealed**Historical Note**

Adopted effective August 14, 1991 (Supp. 91-3). R20-4-905 recodified from R4-4-905 (Supp. 95-1). Section repealed by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-906. Equivalent and Related Experience

- A. An applicant may satisfy the three years' experience requirement of A.R.S. § 6-903 by the types of lending-related experience listed in this subsection. The Department counts each month in the following types of work experience toward the three years required for a mortgage broker license, under A.R.S. § 6-903(B), or as a responsible individual, under A.R.S. § 6-903(E). The Department counts a fractional month of experience, at least 15 days long, as a full month.
 1. Mortgage broker with an Arizona license, responsible individual, or branch manager for a licensee;
 2. Mortgage banker with an Arizona license, responsible individual, or branch manager for a licensee;
 3. Loan officer with responsibility primarily for loans secured by lien interests on real property;
 4. Lender's branch manager with responsibility primarily for loans secured by lien interests on real property;
 5. Mortgage broker with license from another state, or responsible individual for a mortgage broker licensed in another state;
 6. Mortgage banker with license from another state, or responsible individual for a mortgage banker licensed in another state;
 7. Attorney certified by any state as a real estate specialist.
- B. An applicant with insufficient actual experience of the types listed in subsection (A) may satisfy the remainder of the three years' experience requirement of A.R.S. § 6-903 by the types of related experience listed in this subsection. The Department counts each month in the following types of work experience according to the ratio listed below, of actual experience to equivalent experience, credited towards qualifying for a license, under A.R.S. § 6-903(B), or as a responsible individual, under A.R.S. § 6-903(E). The Department counts a fractional month of experience, at least 15 days long, as a full month. An applicant receives credit in only one area listed and for not more than three years' actual experience. The remaining years of experience required to qualify for a license shall be obtained from types of work experiences listed in subsection (A).
 1. Attorney without state bar certified real estate specialty...3:2
 2. Paralegal with experience in real estate matters...3:2
 3. Loan underwriter...3:2

4. Mortgage broker or mortgage banker from another state without license...3:2
5. Real estate broker with an Arizona license or license from a state with substantially equivalent licensing requirements...3:2
6. Escrow officer...3:2
7. Trust officer with a title company...3:2
8. Executive, supervisor, or policy maker involved in administering or operating a mortgage-related business...3:1.5
9. Title officer with a title company...3:1.5
10. Real estate broker, not qualified under subsection (B)(5)...3:1.5
11. Loan processor with responsibility primarily for loans secured by lien interests on real property...3:1.5
12. Lender's branch manager with responsibility primarily for loans not secured by lien interests on real property...3:1.5
13. Real property salesperson with an Arizona license or a license from a state with substantially equivalent licensing requirements...3:1
14. Loan officer, with responsibility primarily for loans not secured by lien interests on real property...3:1

Historical Note

Adopted effective August 14, 1991 (Supp. 91-3). R20-4-906 recodified from R4-4-906 (Supp. 95-1). Amended by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-907. Course of Study

- A. A course of study shall be satisfactorily completed if the applicant has:
 1. Attended at least 24 hours of class, and
 2. Received a passing grade on the final exam.
- B. A course of study shall meet all the following requirements:
 1. The following items shall be submitted by the school to the Superintendent on an annual basis:
 - a. Course materials;
 - b. Class content outlines on a session-by-session basis; and
 - c. Sample final exam.
 2. The following subjects shall be taught:
 - a. Mortgage, deed of trust, and security agreement law;
 - b. Negotiable instrument law;
 - c. Mortgage broker law;
 - d. Escrow agent law;
 - e. Recordkeeping requirements of R20-4-917;
 - f. Federal Housing Administration, Veterans Administration, Federal National Mortgage Association, Federal Home Loan Mortgage Corporation requirements;
 - g. Ethics;
 - h. Principal and agent law;
 - i. Arithmetical computations common to mortgage brokerage;
 - j. Real estate lending principles;
 - k. Real estate law;
 - l. Real Estate Settlement Procedures Act, 12 U.S.C. 2601 through 2617, and Consumer Credit Protection Act, 15 U.S.C. 1601 through 1666j; and
 - m. Securities law.

3. A final exam shall be given that substantially tests the student's knowledge of the subjects described above.

- C. The Superintendent shall review the items submitted to the Department and determine within 60 days of submission whether the proposed course of study is satisfactory. The Superintendent may audit a course of study at any time. If the Superintendent finds that a course of study is unsatisfactory, or if the Superintendent has not received the course materials, course content outlines, and sample final exam within the prior 13 months, the Superintendent may withhold or suspend approval.

Historical Note

Adopted effective August 14, 1991 (Supp. 91-3). R20-4-907 recodified from R4-4-907 (Supp. 95-1).

R20-4-908. Reserved

Historical Note

Adopted effective August 14, 1991 (Supp. 91-3). R20-4-908 recodified from R4-4-908 (Supp. 95-1). Section repealed by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-909. Reserved

Historical Note

Adopted effective August 14, 1991 (Supp. 91-3). R20-4-909 recodified from R4-4-909 (Supp. 95-1). Section repealed by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-910. Reserved

Historical Note

Adopted effective August 14, 1991 (Supp. 91-3). R20-4-910 recodified from R4-4-910 (Supp. 95-1). Section repealed by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-911. Qualified Replacement Responsible Individual

If a licensee chooses an individual to serve as a replacement responsible individual and that individual has not satisfactorily completed the course of study required by A.R.S. § 6-903(B)(2) or passed the mortgage broker examination required by A.R.S. § 6-903(B)(3), and is not given the opportunity to do so prior to the expiration of the 90-day time period provided in A.R.S. § 6-903(F), but otherwise meets the requirements of A.R.S. § 6-903(B), the individual shall be qualified as a replacement responsible individual until the next course of study has been held and, if the person successfully completes the course of study, until the mortgage broker examination next following the completion of the course of study has been held and the results of the examination are available. If the individual fails to satisfactorily complete the course of study or fails the mortgage broker examination, the licensee shall then have a new 90-day time period within which to place itself under the active management of a qualified responsible individual. Notwithstanding the foregoing, a licensee shall have no longer than 180 days within which to place the license under the active management of a qualified responsible individual unless the Superintendent grants additional time to the licensee for good cause shown.

Historical Note

Adopted effective August 14, 1991 (Supp. 91-3). R20-4-911 recodified from R4-4-911 (Supp. 95-1).

R20-4-912. Restrictions on the Term of a Cash Alternative

If an applicant or a licensee elects to place with the Superintendent a deposit in the form of a certificate of deposit or investment certificate, in addition to the requirements of A.R.S. § 6-903(J), the

certificate of deposit or investment certificate shall not be renewable, nor expire, earlier than 12 months from the date of issuance.

Historical Note

Adopted effective August 14, 1991 (Supp. 91-3). R20-4-912 recodified from R4-4-912 (Supp. 95-1).

R20-4-913. Reserved

Historical Note

Adopted effective August 14, 1991 (Supp. 91-3). R20-4-913 recodified from R4-4-913 (Supp. 95-1). Section repealed by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-914. Reserved

Historical Note

Adopted effective August 14, 1991 (Supp. 91-3). R20-4-914 recodified from R4-4-914 (Supp. 95-1). Section repealed by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-915. Requirements for a Person Intended to Oversee a Branch Office

A person designated to oversee the operations of a branch office shall be knowledgeable about the branch activities of the licensee, shall supervise compliance by the branch with applicable law and rules, and shall have sufficient authority to ensure such compliance. One person may oversee more than one branch.

Historical Note

Adopted effective August 14, 1991 (Supp. 91-3). R20-4-915 recodified from R4-4-915 (Supp. 95-1).

R20-4-916. Notification of Change of Address

If the address of the principal place of business or of any branch office is changed, the licensee shall notify the Superintendent of the change within five business days after the occurrence of the change of location. Together with such notice, the licensee shall provide to the Department the license for the office changing addresses together with the fee required by A.R.S. § 6-126 for changing the address of an office. A copy of such license shall continue to be displayed at the place of business until a new license is issued.

Historical Note

Adopted effective August 14, 1991 (Supp. 91-3). R20-4-916 recodified from R4-4-916 (Supp. 95-1).

R20-4-917. Recordkeeping Requirements

- A. The Superintendent shall approve a licensee's use of a computer or mechanical recordkeeping system if the licensee gives the Superintendent advanced written notice that it intends to do so. The Department shall not require a licensee to keep a written copy of the records if the licensee can generate all information required by this Section in a timely manner for examination or other purposes. A licensee may add, delete, modify, or customize an approved computer or mechanical recordkeeping system's hardware or software components. When requested, or in response to a written notice of an examination, a licensee shall report to the Superintendent any alteration in the approved system's fundamental character, medium, or function if the alteration changes:
1. Any approved computer or mechanical system back to a paper-based system;
 2. An approved mechanical system to a computer system;
 3. An approved computer system to a mechanical system.
- B. In addition to any statutory requirement regarding records, a record maintained by a mortgage broker shall include the following:

1. A list of all executed loan applications or executed fee agreements that includes the following information:
 - a. Applicant's name;
 - b. Application date;
 - c. Amount of initial loan request;
 - d. Final disposition date;
 - e. Disposition (funded, denied, etc.); and
 - f. Name of loan officer;
 2. A record, such as a cash receipts journal, of all money received in connection with a mortgage loan including:
 - a. Payor's name;
 - b. Date received;
 - c. Amount; and
 - d. Receipt's purpose, including identification of a related loan, if any;
 3. A sequential listing of checks written for each bank account relating to the mortgage broker business, such as a cash disbursement journal, including:
 - a. Payee's name;
 - b. Amount;
 - c. Date; and
 - d. Payment's purpose, including identification of a related loan, if any;
 4. Bank account activity source documents for the mortgage broker business including receipted deposit tickets, numbered receipts for cash, bank account statements, paid checks, and bank advices.
 5. A trust subsidiary ledger for each borrower that deposits trust funds showing:
 - a. Borrower's name or co-borrowers' names;
 - b. Loan number, if any;
 - c. Amount received;
 - d. Purpose for the amount received;
 - e. Date received;
 - f. Date deposited into trust account;
 - g. Amount disbursed;
 - h. Date disbursed;
 - i. Disbursement's payee and purpose; and
 - j. Balance;
 6. A file for each application for a mortgage loan containing:
 - a. The agreement with the customer concerning the broker's services, whether as a loan application, fee agreement, or both;
 - b. Document showing the application's final disposition, such as a settlement statement, or a denial or withdrawal letter;
 - c. Correspondence sent, received, or both by the licensee;
 - d. Contract, agreement, and escrow instructions to or with any depository;
 - e. Documents showing compliance with the Consumer Credit Protection Act's (15 U.S.C. §§ 1601 through 1666j) and the Real Estate Settlement Procedures Act's (12 U.S.C. §§ 2601 through 2617) disclosure requirements, to the extent applicable;
 - f. If the loan is funded by an investor that is not a financial institution, an enterprise, a licensed real estate broker or salesman, a profit sharing or pension trust or, an insurance company, the documents provided to the investor under A.R.S. § 6-907, a copy of the executed note and executed deed of trust or mortgage, and any assignment by the broker to the investor;
 - g. If the loan is closed in the mortgage broker's name, a copy of all closing documents including: closing instructions, any applicable rescission notice, HUD-1 settlement statement, final truth-in-lending disclosure, executed note, executed deed of trust or mortgage, and each assignment of beneficial interest by the licensee; and
 - h. Itemized list of all fees taken in advance including appraisal fee, credit report fee, and application fee;
 7. Samples of every piece of advertising relating to the mortgage broker's business in Arizona;
 8. Copies of governmental or regulatory compliance reviews;
 9. If the licensee is not a natural person, a file containing:
 - a. Organizational documents for the entity;
 - b. Minutes;
 - c. A record, such as a stock or ownership transfer ledger, showing ownership of all proportional equity interests in the licensee, ascertainable as of any given record date; and
 - d. Annual report, if required by law;
 10. If the licensee or anyone directly or indirectly owning more than 20% of the licensee has a felony conviction, a copy of the judgment or other record of conviction;
 11. If the licensee or anyone directly or indirectly owning more than 20% of the licensee has, in the previous seven years, been named a defendant in any civil suit, a copy of the complaint, any answer filed by the licensee, and any judgment, dismissal, or other final order disposing of the action; and
 12. If the Superintendent has granted approval to maintain records outside this state, the specific address where the records are kept, and a person's name to contact for them.
- C.** If 10 or fewer transactions have occurred during the prior calendar quarter, a licensee shall reconcile and update all records specified in subsection (B) at least once each calendar quarter. A licensee shall reconcile and update all records specified in subsection (B) monthly if more than 10 transactions occurred during the prior calendar quarter. In addition to reconciling each trust bank account, a licensee shall verify each trust balance to each trust subsidiary ledger at each reconciliation.
- D.** A licensee shall retain the documents described in subsections (B)(1) and (B)(6) for the length of time provided in A.R.S. § 6-906. For the purposes of A.R.S. § 6-906, a mortgage loan's closing date, on a loan application that did not result in the making of a loan, is either:
1. The date a licensee receives a written cancellation notice from an applicant; or
 2. The date a licensee mails written notice to an applicant that the application has been denied, as required by federal law.
- E.** A licensee shall maintain all records described in this Section, and not included in subsection (D), for at least two years.

Historical Note

Adopted effective August 14, 1991 (Supp. 91-3). R20-4-917 recodified from R4-4-917 (Supp. 95-1). Amended by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-918. Repealed

Historical Note

Adopted effective August 14, 1991 (Supp. 91-3). R20-4-918 recodified from R4-4-918 (Supp. 95-1). Section repealed by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-919. Deposit of Monies Received by a Mortgage Broker

All monies received by a mortgage broker which are required to be deposited into an escrow account with an escrow agent licensed pursuant to A.R.S. § 6-801 et seq. shall be so deposited by 5:00 p.m. on the next business day after receipt of the funds.

Historical Note

Adopted effective August 14, 1991 (Supp. 91-3). R20-4-919 recodified from R4-4-919 (Supp. 95-1).

R20-4-920. Requirements for the Testing Committee

- A. No licensee shall submit more than five names as nominees to serve on the testing committee. The resumes of the nominees shall be included. The names and resumes shall be submitted to the Superintendent no later than August 1 of each even-numbered year. On or before September 30 of each even-numbered year, the Superintendent shall appoint four persons from the nominees submitted and one employee of the Department as members of the testing committee. A person may serve more than one two-year term. If the Superintendent does not find at least four persons from the list to be acceptable, the Superintendent shall solicit additional nominees from licensees.
- B. In the event of a vacancy on the testing committee, the remaining members of the committee shall submit a list of nominees within 45 days of the vacancy to the Superintendent containing not less than two nominees for each vacancy. The Superintendent shall then appoint a nominee from the list to fill each vacancy for the remainder of the term. If the Superintendent does not find at least one person from the list to be acceptable to fill each vacancy, the remaining members of the committee shall, upon request, submit an additional list of nominees to the Superintendent.
- C. The Superintendent may remove any member of the committee at any time without cause.
- D. The committee shall review and revise questions on the test not less than once every two years. All questions used on the test shall first be submitted to and approved by the Superintendent.
- E. The committee shall inform the applicant of the applicant's score on the test in writing within 30 days of administration of the test.
- F. The handbook for mortgage brokers shall be updated by the committee as necessary to reflect changes in the law.

Historical Note

Adopted effective August 14, 1991 (Supp. 91-3). R20-4-920 recodified from R4-4-920 (Supp. 95-1).

R20-4-921. Authorizations to Complete Blank Spaces

An authorization, under A.R.S. § 6-909, allowing a licensee or escrow agent to complete certain blank spaces in a document after it is signed by a party to the transaction shall:

1. Specifically identify the document and the blank spaces to be completed;
2. Be in writing, dated, and signed by the authorizing parties; and
3. Contain the following notice, conspicuously printed on its face: YOUR SIGNATURE BELOW AUTHORIZES YOUR MORTGAGE BROKER OR ESCROW AGENT TO FILL IN SPACES YOU LEFT BLANK IN SPECIFIED LOAN DOCUMENTS YOU ARE ABOUT TO SIGN OR MAY HAVE ALREADY SIGNED. UNDER STATE LAW YOU CAN GIVE THIS AUTHORITY, BUT YOU ARE NOT REQUIRED TO DO SO. YOU CAN REFUSE TO SIGN ANY DOCUMENTS UNTIL ALL BLANKS ARE COMPLETELY FILLED IN.

Historical Note

Adopted effective August 14, 1991 (Supp. 91-3). R20-4-921 recodified from R4-4-921 (Supp. 95-1). Amended by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-922. Determining Loan Amounts

In determining the amount of a mortgage loan pursuant to A.R.S. § 6-909(D) or (G), only the principal amount of the loan shall be considered and not any points, interest, finance charges, insurance premiums of any kind, compensation paid to third parties or compensation retained by the mortgage broker or its agents.

Historical Note

Adopted effective August 14, 1991 (Supp. 91-3). R20-4-922 recodified from R4-4-922 (Supp. 95-1).

R20-4-923. Delay or Cause Delay

A mortgage broker shall not be deemed to have delayed or caused delay if such delay occurs due to events outside the control of the mortgage broker.

Historical Note

Adopted effective August 14, 1991 (Supp. 91-3). R20-4-923 recodified from R4-4-923 (Supp. 95-1).

R20-4-924. Receipt and Disbursement of Monies

A licensee is not receiving or disbursing monies in servicing or arranging a mortgage loan if the licensee, at the request of the lender or servicing agent, on an infrequent basis, assists in the collection or servicing of a mortgage loan by receiving from the borrower a check or draft payable to the lender or servicing agent and forwarding such instrument to the lender or servicing agent not later than 5:00 p.m. on the next business day after receipt by the licensee. For the purposes of this rule, an infrequent basis means, with regard to a particular loan, for not more than 25% of the regularly scheduled payments of the mortgage loan during any calendar year.

Historical Note

Adopted effective August 14, 1991 (Supp. 91-3). R20-4-924 recodified from R4-4-924 (Supp. 95-1).

R20-4-925. Waiver of Examination and Course of Study

The Superintendent's waiver of the examination and course of study requirement under A.R.S. § 6-903 extends to a person designated as a responsible individual by either an applicant or a licensee under A.R.S. § 6-903.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-926. Acquisition of Additional Interest in Licensee by Majority Owner

A person that owns 51% or more of a licensee's outstanding voting equity interests, and that acquires the power to vote additional fractional equity interests, shall deliver written notice of the acquisition to the Superintendent. The person shall deliver the notice before completing the acquisition. Within 10 days after completing the acquisition, the person shall deliver documentation evidencing the acquisition to the Superintendent.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-927. Conversion to Commercial Mortgage Broker License

- A. Under A.R.S. § 6-913, a mortgage broker licensee shall only be permitted to convert his or her license to a commercial

mortgage broker license during the renewal period established by A.R.S. § 6-904.

- B. The licensee seeking conversion shall not be subject to the 12 continuing education units as prescribed by A.R.S. § 6-903(V).
- C. The licensee seeking conversion shall submit:
 1. The renewal fees required by A.R.S. § 6-126 for commercial mortgage brokers, and
 2. The information and documents required by A.R.S. § 6-903.

Historical Note

New Section adopted by final rulemaking at 18 A.A.R. 2622, effective December 2, 2012 (Supp. 12-4).

R20-4-928. Certificate of Exemption Application and Renewal

- A. Under A.R.S. § 6-912(C), upon application for a certificate of exemption, an applicant shall pay a nonrefundable fee of \$300.
- B. A person holding a certificate of exemption shall pay a renewal fee of \$150.00 on or before December 31 of each year. Certificates of exemption not renewed by December 31 are automatically suspended, and the certificate holder shall not act as a registered exempt person until the certificate is renewed or a new certificate is issued pursuant to A.R.S. § 6-912. While the certificate is suspended, the licensed loan originators sponsored by the registered exempt person may not transact business as a loan originator. A registered exempt person may renew an automatically suspended certificate by paying the renewal fee plus \$25.00 for each day after December 31 that a renewal fee is not received by the Superintendent and applying for renewal as prescribed by the Superintendent. A certificate of exemption that is not renewed by January 31 expires. A certificate of exemption shall not be granted to the holder of an expired certificate of exemption except as provided in A.R.S. § 6-912 for the issuance of an original certificate of exemption. Each licensed loan originator that is sponsored by a registered exempt person whose certificate has expired shall have his or her license placed on inactive status and shall not transact business in Arizona as a loan originator pursuant to A.R.S. § 6-991.02(M).
- C. In addition to the application fee, on issuance of the certificate of exemption, the Superintendent shall collect the first year's renewal fee prorated according to the number of quarters remaining until the date of the next annual renewal, as required by A.R.S. § 6-126(B).
- D. The following fees are payable to the Department:
 1. To change the name of the federally chartered savings bank on a certificate of exemption: \$250.00.
 2. To change the responsible individual for the exempt entity: \$250.00.
 3. To issue a duplicate or replace a lost certificate of exemption: \$100.00.
 4. To change the address of the federally chartered savings bank on a certificate of exemption: \$50.00.

Historical Note

New Section adopted by final rulemaking at 18 A.A.R. 2622, effective December 2, 2012 (Supp. 12-4).

ARTICLE 10. SAFE DEPOSIT AND SAFEKEEPING CODE

R20-4-1001. Notice of Change of Location of Safe Deposit Repository

- A. A corporation or association that moves a repository shall give written notice of the location change to the Superintendent and to its customers.
 1. A corporation or association shall provide notice of the location change to the Superintendent by mailing the

notice required under this subsection by first class mail no less than 30 days before the scheduled moving date. The corporation or association shall include a copy of the notice to customers required under subsection (B).

2. A corporation or association shall provide notice of the location change to its customers by:
 - a. Publishing notice of the change of location in:
 - i. An English language newspaper of general circulation in the county where the repository will be closed,
 - ii. In a weekly newspaper for two consecutive publications, or
 - iii. In a daily newspaper for three consecutive days; and
 - b. Publishing the notice no more than 90 days, and no less than 30 days, before the scheduled moving date.
- B. The corporation or association shall include all the following information in the notice:
 1. The date the corporation or association intends to move the repository,
 2. The earliest date a customer can remove contents and transact other business related to the move,
 3. The latest date a customer can remove contents and transact other business related to the move,
 4. The street address of the repository to be closed, and
 5. The street address of the new repository.

Historical Note

Former Rule 1. R20-4-1001 recodified from R4-4-1001 (Supp. 95-1). Amended by final rulemaking at 8 A.A.R. 5227, effective February 4, 2003 (Supp. 02-4). Preceding Historical Note entry corrected to read 2003 instead of 2002 (Supp. 03-1).

ARTICLE 11. PUBLIC DEPOSITORIES FOR PUBLIC MONIES

R20-4-1101. Capital structure of banks; defined

"Capital structure" as the term is applied to banks under Article 2, Chapter 2, Title 35, Arizona Revised Statutes, means the sum of the following reserves and capital accounts of the institution as stated in the institution's report of condition required by the supervisory banking authority for the year end next preceding the institution's bid for deposit:

1. Reserve for bad debt losses on loans.
2. Other reserves on loans.
3. Reserves on securities.
4. Capital notes and debentures.
5. Preferred stock -- total par value.
6. Common stock -- total par value.
7. Surplus.
8. Undivided profits.
9. Reserve for contingencies and other capital reserves.

Historical Note

Adopted as an emergency effective July 29, 1975 (Supp. 75-1). Amended effective December 26, 1975 (Supp. 75-2). R20-4-1101 recodified from R4-4-1101 (Supp. 95-1).

R20-4-1102. Capital structure of savings and loan associations; defined

"Capital structure" as the term is applied to savings and loan associations under Article 2, Chapter 2, Title 35, Arizona Revised Statutes, means the sum of the following net worth accounts of the institution as stated in the institution's report of condition required by the supervisory banking authority for the year end next preceding the institution's bid for deposit:

1. Capital notes and debentures.
2. Guaranty capital stock.

3. General reserves. (Including bad debt reserves)
4. Other reserves.
5. Paid in surplus.
6. Earned surplus and undivided profits.

Historical Note

Adopted as an emergency effective July 29, 1975 (Supp. 75-1). Amended effective December 26, 1975 (Supp. 75-2). R20-4-1102 recodified from R4-4-1102 (Supp. 95-1).

ARTICLE 12. RULES OF PRACTICE AND PROCEDURE BEFORE THE SUPERINTENDENT

R20-4-1201. Scope of Article

This Article governs procedures in all contested cases and appealable agency actions, including administrative appeals, filed with the Department. The Department shall use the authority of A.R.S. §§ 41-1092 through 41-1092.12, and the Office of Administrative Hearings' procedural rules to govern the initiation and conduct of proceedings. In a case or action, special procedural requirements in state statute or another Section in this Chapter shall also govern the proceedings unless the requirements are inconsistent with either A.R.S. §§ 41-1092 through 41-1092.12 or the Office of Administrative Hearings' rules. This Article does not apply to rulemaking or to investigative proceedings before the Superintendent.

Historical Note

Adopted effective February 7, 1978 (Supp. 78-1). R20-4-1201 recodified from R4-4-1201 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 4262, effective September 12, 2001 (Supp. 01-3).

R20-4-1202. Definitions

In this Article, unless the context otherwise requires:

- "Administrative law judge" has the meaning stated at A.R.S. § 41-1092(1).
- "Appealable agency action" has the meaning stated at A.R.S. § 41-1092 3).
- "Contested case" has the meaning stated at A.R.S. § 41-1001(4).
- "Department" means the Arizona State Department of Financial Institutions.
- "License" has the meaning stated at A.R.S. § 41-1001(10).
- "Party" means:
 - The Department;
 - The Superintendent;
 - Each person either named or admitted as a party, and
 - Each person properly seeking, and entitled, to be a party.
- "Superintendent" has the meaning stated in A.R.S. § 6-101(16).

Historical Note

Adopted effective February 7, 1978 (Supp. 78-1). R20-4-1202 recodified from R4-4-1202 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 4262, effective September 12, 2001 (Supp. 01-3).

R20-4-1203. Repealed

Historical Note

Adopted effective February 7, 1978 (Supp. 78-1). R20-4-1203 recodified from R4-4-1203 (Supp. 95-1). Section repealed by final rulemaking at 7 A.A.R. 4262, effective September 12, 2001 (Supp. 01-3).

R20-4-1204. Filing; Service

- A. A person shall either personally deliver all papers permitted or required to be filed with the Superintendent or shall mail them by first class, certified, or express mail, or send them by facsimile transmission (602-381-1225), to the Superintendent at 2910 N. 44th Street, Suite 310, Phoenix, AZ 85018-7270, or

shall serve them by any method permitted under R2-19-108. The Department considers papers filed when actually received at the Superintendent's address stated in this subsection.

- B. A party in a contested case or appeal from an agency action shall make any required or permitted service in the manner permitted under R2-19-108. A party shall make service upon each represented party's attorney unless the administrative law judge orders separate service on the actual party. A party shall make service upon each unrepresented party by service on the actual party.

Historical Note

Adopted effective February 7, 1978 (Supp. 78-1). R20-4-1204 recodified from R4-4-1204 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 4262, effective September 12, 2001 (Supp. 01-3). Amended to correct a typographical error in subsection (B) (Supp. 01-4).

R20-4-1205. Repealed

Historical Note

Adopted effective February 7, 1978 (Supp. 78-1). R20-4-1205 recodified from R4-4-1205 (Supp. 95-1). Section repealed by final rulemaking at 7 A.A.R. 4262, effective September 12, 2001 (Supp. 01-3).

R20-4-1206. Repealed

Historical Note

Adopted effective February 7, 1978 (Supp. 78-1). R20-4-1206 recodified from R4-4-1206 (Supp. 95-1). Section repealed by final rulemaking at 7 A.A.R. 4262, effective September 12, 2001 (Supp. 01-3).

R20-4-1207. Repealed

Historical Note

Adopted effective February 7, 1978 (Supp. 78-1). R20-4-1207 recodified from R4-4-1207 (Supp. 95-1). Section repealed by final rulemaking at 7 A.A.R. 4262, effective September 12, 2001 (Supp. 01-3).

R20-4-1208. Commencement of Proceedings; Notice of Hearing

A person may obtain a hearing under A.R.S. § 41-1092.03 (B) on any appealable agency action or contested case, including the following, unless otherwise provided by law.

1. A letter or order granting or denying a license;
2. A license issued with restrictions or conditions;
3. A cease and desist order;
4. An order to remedy unsafe or unsound conditions;
5. An order to remedy an impairment of capital;
6. An order taking possession and control of a financial institution or enterprise;
7. An order assessing a fine;
8. Any other order or matter reviewable in a hearing either under the authority of these rules, a statute or an administrative rule enforced by the Superintendent, or by the order's express terms.

Historical Note

Adopted effective February 7, 1978 (Supp. 78-1). R20-4-1208 recodified from R4-4-1208 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 4262, effective September 12, 2001 (Supp. 01-3).

R20-4-1209. Answer to Notice of Hearing

- A. The Superintendent may, in a notice of hearing, direct one or more parties to file an answer to the assertions in the notice of hearing. Any party to the proceeding may file an answer without being directed to do so.

- B. A party directed to file an answer shall do so within 20 days after issuance of a notice of hearing, unless the notice of hearing states a different period for the answer. The Superintendent may require any party to answer, in a reasonable time, amendments to the assertions in the notice made after service of the original notice.
- C. An answer filed under this Section shall briefly state the party's position or defense to the proceeding and shall specifically admit or deny each of the assertions in the notice of hearing. An answering party that does not have, or cannot easily obtain, knowledge or information sufficient to admit or deny an assertion shall state that inability in its answer. That statement shall have the effect of a denial. A party admits each assertion that it does not deny. An answering party that intends to deny only a part or a qualification of an assertion, or to qualify an assertion, shall expressly admit as much of that assertion as is true and shall deny the remainder.
- D. A party that fails to file an answer required by this Section within the time allowed is in default. The Superintendent may resolve the proceeding against a defaulting party. In doing so, the Superintendent may regard any assertions in the notice of hearing as admitted by the defaulting party.
- E. An answering party waives all defenses not raised in its answer.

Historical Note

Adopted effective February 7, 1978 (Supp. 78-1). R20-4-1209 recodified from R4-4-1209 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 4262, effective September 12, 2001 (Supp. 01-3).

R20-4-1210. Stays

A person aggrieved by the Department's action or order who files a timely written request for a hearing may ask, in the request for a hearing, that the Superintendent stay an action or any part of an order that will become effective before the Department can hold a hearing. The Superintendent may, in the Superintendent's discretion, stay the legal effectiveness of any action or order until the matter can be heard and finally decided if the aggrieved person's request demonstrates that:

1. The person has a reasonable defense that might prevail on the merits at the hearing,
2. The person will suffer irreparable injury unless the Superintendent grants the stay,
3. The stay would not substantially or irreparably harm other interested persons, and
4. The stay would not jeopardize the public interest or contravene public policy.

Historical Note

Adopted effective February 7, 1978 (Supp. 78-1). R20-4-1210 recodified from R4-4-1210 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 4262, effective September 12, 2001 (Supp. 01-3).

R20-4-1211. Intervention

A person may only intervene in a proceeding if the person timely applies and:

1. A statute confers a right to intervene, or
2. The person's claim or defense shares a question of law or fact in common with the main proceeding.

Historical Note

Adopted effective February 7, 1978 (Supp. 78-1). R20-4-1211 recodified from R4-4-1211 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 4262, effective September 12, 2001 (Supp. 01-3).

R20-4-1212. Repealed**Historical Note**

Adopted effective February 7, 1978 (Supp. 78-1). R20-4-1212 recodified from R4-4-1212 (Supp. 95-1). Section repealed by final rulemaking at 7 A.A.R. 4262, effective September 12, 2001 (Supp. 01-3).

R20-4-1213. Repealed**Historical Note**

Adopted effective February 7, 1978 (Supp. 78-1). R20-4-1213 recodified from R4-4-1213 (Supp. 95-1). Section repealed by final rulemaking at 7 A.A.R. 4262, effective September 12, 2001 (Supp. 01-3).

R20-4-1214. Repealed**Historical Note**

Adopted effective February 7, 1978 (Supp. 78-1). R20-4-1214 recodified from R4-4-1214 (Supp. 95-1). Section repealed by final rulemaking at 7 A.A.R. 4262, effective September 12, 2001 (Supp. 01-3).

R20-4-1215. Repealed**Historical Note**

Adopted effective February 7, 1978 (Supp. 78-1). R20-4-1215 recodified from R4-4-1215 (Supp. 95-1). Section repealed by final rulemaking at 7 A.A.R. 4262, effective September 12, 2001 (Supp. 01-3).

R20-4-1216. Repealed**Historical Note**

Adopted effective February 7, 1978 (Supp. 78-1). R20-4-1216 recodified from R4-4-1216 (Supp. 95-1). Section repealed by final rulemaking at 7 A.A.R. 4262, effective September 12, 2001 (Supp. 01-3).

R20-4-1217. Repealed**Historical Note**

Adopted effective February 7, 1978 (Supp. 78-1). R20-4-1217 recodified from R4-4-1217 (Supp. 95-1). Section repealed by final rulemaking at 7 A.A.R. 4262, effective September 12, 2001 (Supp. 01-3).

R20-4-1218. Repealed**Historical Note**

Adopted effective February 7, 1978 (Supp. 78-1). R20-4-1218 recodified from R4-4-1218 (Supp. 95-1). Section repealed by final rulemaking at 7 A.A.R. 4262, effective September 12, 2001 (Supp. 01-3).

R20-4-1219. Rehearing

- A. Except as provided in subsection (H), any party in a contested case who is aggrieved by a decision rendered in that case may file with the Superintendent, within time limits and other procedural guidelines contained in A.R.S. § 41-1092.09, a written motion for rehearing or review of the decision specifying the particular reason for rehearing.
- B. A party requesting rehearing under this Section may amend a motion for rehearing at any time before the Superintendent rules on the motion. Any other party, or the Attorney General, may file a response to the motion for rehearing within 15 days after service of the motion for rehearing, or the amended motion for rehearing. The Superintendent may require a written brief of the issues raised in the motion and may allow oral argument.
- C. The Superintendent may grant a motion for rehearing for any of the following causes:

1. Irregularity in the proceedings before the Superintendent, in any order, or any abuse of discretion that deprives the moving party of a fair hearing;
 2. Misconduct of the Superintendent, the Superintendent employees, the administrative law judge, or the prevailing party;
 3. Accident or surprise that could not have been prevented by ordinary care;
 4. Newly discovered material evidence that could not reasonably have been discovered and produced at the original hearing;
 5. Excessive or insufficient penalties;
 6. Error in admitting or rejecting evidence or other legal errors occurring at the hearing;
 7. The decision is not justified by the evidence or is contrary to law.
- D.** The Superintendent may affirm or modify the decision or grant a rehearing as to all or any of the parties and on all or part of the issues for any reason listed in subsection (C). An order granting a rehearing shall specify the reason for granting the rehearing, and the rehearing shall cover only those matters specified.
- E.** The Superintendent, within the time for filing a motion for rehearing, may without a motion order a rehearing or review of a decision for any reason that would allow the granting of a motion for rehearing by a party. The order for rehearing, granted without a motion, shall specify the reason for granting the rehearing.
- F.** After giving the parties notice and an opportunity to be heard on the matter, the Superintendent may grant a motion for rehearing, timely served, for a reason not stated in the motion. The order for rehearing, granted for a reason not stated in the motion, shall specify the reason for granting the rehearing.
- G.** When a motion for rehearing is based on an affidavit, the moving party shall serve the affidavit with the motion. An opposing party or the Attorney General may serve opposing affidavits within 10 days after service of the motion for rehearing.
- H.** The Superintendent may issue a final decision, subject only to judicial review, and without an opportunity for rehearing or administrative review if the Superintendent includes in the decision:
1. An express finding that the decision needs to be made immediately effective to preserve the public peace, health, and safety; and
 2. An express finding that a rehearing or review is:
 - a. Impossible,
 - b. Unnecessary, or
 - c. Contrary to the public interest.

Historical Note

Adopted effective February 7, 1978 (Supp. 78-1). R20-4-1219 recodified from R4-4-1219 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 4262, effective September 12, 2001 (Supp. 01-3).

R20-4-1220. Consent Agreements

- A.** The Department will enter into a consent agreement, either in litigation or in an administrative proceeding, only if the defendant or respondent admits to the allegations in the complaint, notice, or order relating to the jurisdiction of the Superintendent or the jurisdiction of the tribunal that will enter the judgment or order.
- B.** A refusal to admit allegations is a denial. However, a defendant or respondent may consent to a judgment or order reciting that it does not admit or deny the allegations except those required by subsection (A). A consent agreement shall contain

those additional provisions required by the Superintendent in a given matter, and may include:

1. Waiving any right to seek judicial review challenging the judgment's or order's validity,
2. Waiving findings of fact and conclusions of law,
3. Stating that the agreement is signed only to settle the matter and not as an admission that the defendant or respondent has violated the law.

- C.** The Superintendent has sole discretion to decide whether to resolve a matter by consent agreement. Nothing in this Section gives the Superintendent a duty to approve a consent agreement in any matter.

Historical Note

Adopted effective February 7, 1978 (Supp. 78-1). R20-4-1220 recodified from R4-4-1220 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 4262, effective September 12, 2001 (Supp. 01-3).

**EMERGENCY RULEMAKING
ARTICLE 13. LOAN ORIGINATORS**

EMERGENCY RULEMAKING

R20-4-1301. Scope of Article

This Article applies to:

1. All loan originating activities of any person licensed under Arizona law as a loan originator, and
2. The conduct of any applicant for a loan originator license.

Historical Note

New Section made by emergency rulemaking at 16 A.A.R. 839, effective April 27, 2010 for 180 days (Supp. 10-2). Section renewed by emergency rulemaking and amended at 16 A.A.R. 2165, effective October 24, 2010 for 180 days expiring April 21, 2011 (Supp. 10-4).

EMERGENCY RULEMAKING

R20-4-1302. Course of Study to Qualify for Licensure

- A.** The Superintendent shall, under the authority of A.R.S. § 6-991.03(B)(1), approve a course of study that includes only those courses reviewed and approved by the Nationwide Mortgage Licensing System pursuant to A.R.S. § 6-991.03(E) and (F) and the Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (P.L. 110-289, 122 Stat. 2810, 12 U.S.C. 5101 through 5116).
- B.** An applicant for a loan originator license shall satisfactorily complete a course of study by:
1. Attending at least 20 hours of instruction; and
 2. Receiving a passing grade of not less than 75 percent correct answers on both the national and Arizona state exam required by A.R.S. § 6-991.07 and the Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (P.L. 110-289, 122 Stat. 2810, 12 U.S.C. 5101 through 5116).
- C.** A pre-licensure course of study shall include 20 hours of instruction in the following areas:
1. Federal law and regulation, including the Real Estate Settlement Procedures Act ("RESPA"), the Truth in Lending Act ("TILA"), good faith estimates, federal privacy laws, fair lending laws including the Equal Credit Opportunity Act ("ECOA") and the Fair Credit Reporting Act ("FCRA"): Three hours;
 2. Business ethics, including fraud, consumer protection laws, and fair lending practices: Three hours;
 3. Non-traditional mortgage product lending standards: Two hours;
 4. Arizona real estate and mortgage lending law, including loan origination and processing, Arizona law relating to agency, and the obligations between principal and agent, and state privacy laws: Four hours;

5. The remaining eight hours should be comprised of instruction in the obligations between principal and agent, the statutory and regulatory laws governing loan originators, arithmetical computations common to mortgage lending, principles of real estate lending, the purpose and effect of mortgages, deeds of trust, and security agreements, the terms and conditions of conforming and non-conforming residential mortgages, real estate appraisal and the principles of appraisal independence.
- D.** A continuing education course of study shall include eight hours of instruction each year in the following areas:
1. Federal law and regulation, including the Real Estate Settlement Procedures Act ("RESPA"), the Truth in Lending Act ("TILA"), good faith estimates, federal privacy laws, fair lending laws including the Equal Credit Opportunity Act ("ECOA") and the Fair Credit Reporting Act ("FCRA"): Three hours;
 2. Business ethics, including fraud, consumer protection laws, and fair lending practices: Two hours;
 3. Non-traditional mortgage product lending standards: Two hours;
 4. Arizona real estate and mortgage lending law, including loan origination and processing, Arizona law relating to agency, and the obligations between principal and agent, and state privacy laws: One hour.

Historical Note

New Section made by emergency rulemaking at 16 A.A.R. 839, effective April 27, 2010 for 180 days (Supp. 10-2). Section renewed by emergency rulemaking and amended at 16 A.A.R. 2165, effective October 24, 2010 for 180 days expiring April 21, 2011 (Supp. 10-4).

EMERGENCY RULEMAKING

R20-4-1303. Financial Responsibility

An applicant for a loan originator license shall demonstrate financial responsibility, as required by A.R.S. § 6-991.03, by either:

1. Depositing with the Superintendent a bond as specified by A.R.S. § 6-991.03(B)(4) and paying to the Superintendent, for deposit into the Mortgage Recovery Fund, the sum of \$100 at the time of filing an original or a renewal application pursuant to A.R.S. § 6-991.03(B)(6); or
2. Depositing with the Superintendent a bond as specified by A.R.S. § 6-991.03(B)(4) and depositing with the Superintendent a bond as specified by A.R.S. § 6-991.03(B)(6).

Historical Note

New Section made by emergency rulemaking at 16 A.A.R. 839, effective April 27, 2010 for 180 days (Supp. 10-2). Section renewed by emergency rulemaking at 16 A.A.R. 2165, effective October 24, 2010 for 180 days expiring April 21, 2011 (Supp. 10-4).

EMERGENCY RULEMAKING

R20-4-1304. Fees

Loan Originator program fees:

1. Initial application fee (non-refundable) pursuant to A.R.S. § 6-126(A)(33): \$350,
2. Initial license fee (prorated according to the number of quarters remaining until the next annual renewal) pursuant to A.R.S. § 6-126(B): \$150,
3. Annual renewal fee pursuant to A.R.S. § 6-126(C)(12) or fee for change to inactive status pursuant to A.R.S. § 6-126(C)(13): \$150,
4. Transfer license to new employer fee pursuant to A.R.S. § 6-126(A)(34): \$50,

5. Change of residence address fee pursuant to A.R.S. § 6-991.04(J): \$50,
6. Examination fee pursuant to A.R.S. § 6-991.07(E): The amount charged by the vendor,
7. Late renewal fee pursuant to A.R.S. § 6-991.04(E): \$25 per day after the filing deadline.

Historical Note

New Section made by emergency rulemaking at 16 A.A.R. 839, effective April 27, 2010 for 180 days (Supp. 10-2). Section renewed by emergency rulemaking and amended at 16 A.A.R. 2165, effective October 24, 2010 for 180 days expiring April 21, 2011 (Supp. 10-4).

EMERGENCY RULEMAKING

R20-4-1305. Practice and Procedure

Loan originators shall follow the practice outlined in 20 A.A.C. 4, Article 12 (Rules of Practice and Procedure Before the Superintendent) for challenging information the Superintendent enters into the Nationwide Mortgage Licensing System and Registry pursuant to A.R.S. §§ 6-991.03(K) and 6-991.04(M).

Historical Note

New Section made by emergency rulemaking at 16 A.A.R. 839, effective April 27, 2010 for 180 days (Supp. 10-2). Section repealed; new Section made by renewed emergency rulemaking and amended at 16 A.A.R. 2165, effective October 24, 2010 for 180 days expiring April 21, 2011 (Supp. 10-4).

ARTICLE 13. LOAN ORIGINATORS

R20-4-1301. Scope of Article

This Article applies to:

1. All loan originating activities of any person licensed under Arizona law as a loan originator, and
2. The conduct of any applicant for a loan originator license.

Historical Note

New Section made by emergency rulemaking at 16 A.A.R. 839, effective April 27, 2010 for 180 days (Supp. 10-2). Section renewed by emergency rulemaking and amended at 16 A.A.R. 2165, effective October 24, 2010 for 180 days (Supp. 10-4). Emergency expired April 21, 2011; new Section made by final rulemaking at 16 A.A.R. 2401, effective April 22, 2011 (Supp. 10-4).

R20-4-1302. Course of Study to Qualify for Licensure

- A.** The Superintendent shall, under the authority of A.R.S. § 6-991.03(B)(1), approve a course of study that includes only those courses reviewed and approved by the Nationwide Mortgage Licensing System pursuant to A.R.S. § 6-991.03(E) and (F) and the Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (P.L. 110-289; 122 Stat. 2810; 12 U.S.C. 5101 through 5116).
- B.** An applicant for a loan originator license shall satisfactorily complete a course of study by:
 1. Attending at least 20 hours of instruction, and
 2. Receiving a passing grade of not less than 75 percent correct answers on both the national and Arizona state exam required by A.R.S. § 6-991.07 and the Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (P.L. 110-289; 122 Stat. 2810; 12 U.S.C. 5101 through 5116).
- C.** A pre-licensure course of study shall include 20 hours of instruction in the following areas:
 1. Federal law and regulation, including the Real Estate Settlement Procedures Act ("RESPA"), the Truth in Lending Act ("TILA"), good faith estimates, federal privacy laws, fair lending laws including the Equal Credit Opportunity

- Act ("ECOA") and the Fair Credit Reporting Act ("FCRA"): Three hours;
2. Business ethics, including fraud, consumer protection laws, and fair lending practices: Three hours;
 3. Non-traditional mortgage product lending standards: Two hours;
 4. Arizona real estate and mortgage lending law, including loan origination and processing, Arizona law relating to agency and the obligations between principal and agent, and state privacy laws: Four hours;
 5. The remaining eight hours should be comprised of instruction in:
 - a. The obligations between principal and agent;
 - b. The statutory and regulatory laws governing loan originators;
 - c. Arithmetical computations common to mortgage lending;
 - d. Principles of real estate lending;
 - e. The purpose and effect of mortgages, deeds of trust, and security agreements;
 - f. The terms and conditions of conforming and non-conforming residential mortgages;
 - g. Real estate appraisal; and
 - h. The principles of appraisal independence.
- D.** A continuing education course of study shall include eight hours of instruction each year in the following areas:
1. Federal law and regulation, including the Real Estate Settlement Procedures Act ("RESPA"), the Truth in Lending Act ("TILA"), good faith estimates, federal privacy laws, fair lending laws including the Equal Credit Opportunity Act ("ECOA") and the Fair Credit Reporting Act ("FCRA"): Three hours;
 2. Business ethics, including fraud, consumer protection laws, and fair lending practices: Two hours;
 3. Non-traditional mortgage product lending standards: Two hours;
 4. Arizona real estate and mortgage lending law, including loan origination and processing, Arizona law relating to agency and the obligations between principal and agent, and state privacy laws: One hour.

Historical Note

New Section made by emergency rulemaking at 16 A.A.R. 839, effective April 27, 2010 for 180 days (Supp. 10-2). Section renewed by emergency rulemaking and amended at 16 A.A.R. 2165, effective October 24, 2010 for 180 days (Supp. 10-4). Emergency expired April 21, 2011; new Section made by final rulemaking at 16 A.A.R. 2401, effective April 22, 2011 (Supp. 10-4).

R20-4-1303. Financial Responsibility

An applicant for a loan originator license shall demonstrate financial responsibility, as required by A.R.S. § 6-991.03, by either:

1. Depositing with the Superintendent a bond as specified by A.R.S. § 6-991.03(B)(4) and paying to the Superintendent, for deposit into the Mortgage Recovery Fund, the sum of \$100 at the time of filing an original or a renewal application pursuant to A.R.S. § 6-991.03(B)(6); or
2. Depositing with the Superintendent a bond as specified by A.R.S. § 6-991.03(B)(4) and depositing with the Superintendent a bond as specified by A.R.S. § 6-991.03(B)(6).

Historical Note

New Section made by emergency rulemaking at 16 A.A.R. 839, effective April 27, 2010 for 180 days (Supp. 10-2). Section renewed by emergency rulemaking at 16 A.A.R. 2165, effective October 24, 2010 for 180 days

(Supp. 10-4). Emergency expired April 21, 2011; new Section made by final rulemaking at 16 A.A.R. 2401, effective April 22, 2011 (Supp. 10-4).

R20-4-1304. Fees

Loan Originator program fees:

1. Initial application fee (non-refundable) pursuant to A.R.S. § 6-126(A)(33): \$350,
2. Initial license fee (prorated according to the number of quarters remaining until the next annual renewal) pursuant to A.R.S. § 6-126(B): \$150,
3. Annual renewal fee pursuant to A.R.S. § 6-126(C)(12) or fee for change to inactive status pursuant to A.R.S. §§ 6-126(C)(13) and 6-991.04(G): \$150,
4. Transfer license to new employer fee pursuant to A.R.S. § 6-126(A)(34): \$50,
5. Change of residence address fee pursuant to A.R.S. § 6-991.04(J): \$50,
6. Examination fee pursuant to A.R.S. § 6-991.07(E): the amount charged by the vendor,
7. Late renewal fee pursuant to A.R.S. § 6-991.04(E): \$25 per day after the filing deadline.

Historical Note

New Section made by emergency rulemaking at 16 A.A.R. 839, effective April 27, 2010 for 180 days (Supp. 10-2). Section renewed by emergency rulemaking and amended at 16 A.A.R. 2165, effective October 24, 2010 for 180 days (Supp. 10-4). Emergency expired April 21, 2011; new Section made by final rulemaking at 16 A.A.R. 2401, effective April 22, 2011 (Supp. 10-4).

R20-4-1305. Practice and Procedure

Loan originators shall follow the practice outlined in 20 A.A.C. 4, Article 12 (Rules of Practice and Procedure Before the Superintendent) for challenging information the Superintendent enters into the Nationwide Mortgage Licensing System and Registry pursuant to A.R.S. §§ 6-991.03(K) and 6-991.04(M).

Historical Note

New Section made by emergency rulemaking at 16 A.A.R. 839, effective April 27, 2010 for 180 days (Supp. 10-2). Section repealed; new Section made by renewed emergency rulemaking at 16 A.A.R. 2165, effective October 24, 2010 for 180 days (Supp. 10-4). Emergency expired April 21, 2011; new Section made by final rulemaking at 16 A.A.R. 2401, effective April 22, 2011 (Supp. 10-4).

ARTICLE 14. INVESTIGATIONS

R20-4-1401. Definitions

In this Article, unless the context otherwise requires:

1. "Examination" means reviewing an applicant's or licensee's operations, books, and records for any lawful purpose, including those listed in A.R.S. § 6-124(A).
2. "Investigation" means an inquiry, other than an examination, into the affairs of a licensed or unlicensed entity including a review of the entity's operations, books, and records, conducted by the Superintendent for any lawful purpose, including those listed in A.R.S. § 6-124(A).
3. "Licensee" means a financial institution or enterprise.

Historical Note

Adopted effective February 7, 1978 (Supp. 78-1). Former Section R4-4-1401 repealed, new Section R4-4-1401 renumbered from R4-4-1402 and amended effective August 14, 1991 (Supp. 91-3). Amended effective August 14, 1991 (Supp. 91-3). R20-4-1401 recodified from R4-

4-1401 (Supp. 95-1). Amended by final rulemaking at 9 A.A.R. 4653, effective December 6, 2003 (Supp. 03-4).

R20-4-1402. Repealed

Historical Note

Former Section R4-4-1402 renumbered to R4-4-1401, new Section R4-4-1402 adopted effective August 14, 1991 (Supp. 91-3). R20-4-1402 recodified from R4-4-1402 (Supp. 95-1). Section repealed by final rulemaking at 9 A.A.R. 4653, effective December 6, 2003 (Supp. 03-4).

R20-4-1403. Subpoenas: Service; Amendment; Investigation or Examination not a Condition of the Superintendent's Subpoena Power

The Superintendent may serve a subpoena either by personal delivery or by first class, certified, or express mail, or by facsimile transmission. A Department employee, or an attorney or agent of the Attorney General's office, may accomplish service for the Superintendent. The Superintendent may amend a subpoena at any time, and may serve the amended subpoena as provided in this Section. Under A.R.S. §§ 6-123(3), 6-124(B), and 12-2212, the Superintendent may compel testimony or document production, by subpoena or other means, regardless of whether an examination or investigation is in progress.

Historical Note

Adopted effective February 7, 1978 (Supp. 78-1). Former Section R4-4-1403 repealed, new Section R4-4-1403 renumbered from R4-4-1407 and amended effective August 14, 1991 (Supp. 91-3). R20-4-1403 recodified from R4-4-1403 (Supp. 95-1). Amended by final rulemaking at 9 A.A.R. 4653, effective December 6, 2003 (Supp. 03-4).

R20-4-1404. Repealed

Historical Note

Adopted effective February 7, 1978 (Supp. 78-1). Repealed effective August 14, 1991 (Supp. 91-3). R20-4-1404 recodified from R4-4-1404 (Supp. 95-1).

R20-4-1405. Fingerprints; Background Information

- A.** In connection with an examination or investigation, the Superintendent may investigate the following persons' background:
1. An applicant or a licensee, or a person whom the Superintendent reasonably believes may be violating any statute or rule administered by the Superintendent; and
 2. An officer, director, agent, employee, partner, joint venturer, affiliate, or other person associated with a person described in subsection (A)(1), if the other person has or had any involvement in or control over the activities of the person described in subsection (A)(1).
- B.** In connection with an examination or investigation, the Superintendent may require a person described in A.R.S. § 6-123.01(A) or (E) to submit a statement of personal history and fingerprints to the Department.

Historical Note

Adopted effective February 7, 1978 (Supp. 78-1). Former Section R4-4-1405 repealed, new Section R4-4-1405 renumbered from R4-4-1409 and amended effective August 14, 1991 (Supp. 91-3). R20-4-1405 recodified from R4-4-1405 (Supp. 95-1). Amended by final rulemaking at 9 A.A.R. 4653, effective December 6, 2003 (Supp. 03-4).

R20-4-1406. Repealed

Historical Note

Adopted effective February 7, 1978 (Supp. 78-1). Repealed effective August 14, 1991 (Supp. 91-3). R20-4-1406 recodified from R4-4-1406 (Supp. 95-1).

R20-4-1407. Renumbered

Historical Note

Adopted effective February 7, 1978 (Supp. 78-1). Renumbered to R4-4-1403 effective August 14, 1991 (Supp. 91-3). R20-4-1407 recodified from R4-4-1407 (Supp. 95-1).

R20-4-1408. Repealed

Historical Note

Adopted effective February 7, 1978 (Supp. 78-1). Repealed effective August 14, 1991 (Supp. 91-3). R20-4-1408 recodified from R4-4-1408 (Supp. 95-1).

R20-4-1409. Renumbered

Historical Note

Adopted effective February 7, 1978 (Supp. 78-1). Renumbered to R4-4-1405 effective August 14, 1991 (Supp. 91-3). R20-4-1409 recodified from R4-4-1409 (Supp. 95-1).

R20-4-1410. Repealed

Historical Note

Adopted effective February 7, 1978 (Supp. 78-1). Repealed effective August 14, 1991 (Supp. 91-3). R20-4-1410 recodified from R4-4-1410 (Supp. 95-1).

ARTICLE 15. COLLECTION AGENCIES

R20-4-1501. Definitions

In this Article, unless the context otherwise requires:

1. "Account" means a contractual arrangement between a client and a collection agency that obligates the collection agency to attempt to collect one or more debts on the client's behalf.
2. "Active Manager" means the person who is in active management of the conduct of the collection agency's business, and who meets the qualifications listed in A.R.S. § 32-1023(A).
3. "Client" means a person who has hired a collection agency to collect a debt.
4. "Collection agency" has the meaning in A.R.S. § 32-1001(A)(2).
5. "Contact" means to communicate with, and includes attempted communications.
6. "Credit bureau" or "credit reporting agency" means any person engaged exclusively in the business of gathering, recording, and disseminating information about the credit-worthiness, financial responsibility, paying habits, and character of persons being considered for credit extension.
7. "Creditor" means a person who offers or extends credit creating a debt, or to whom a debt is owed. The term does not include a person that receives an assignment or transfer of a defaulted debt solely for use in collecting the debt for someone else.
8. "Debt" means a debtor's actual or claimed obligation to pay money, whether or not the obligation has been reduced to judgment.
9. "Debtor" means a person obligated to pay a debt. The term also means a person claimed to be obligated to pay a debt.

10. "Superintendent" has the meaning in A.R.S. § 6-101.

Historical Note

Adopted as an emergency effective September 6, 1978, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 78-5). Adopted effective December 6, 1978 (Supp. 78-6). R20-4-1501 recodified from R4-4-1501 (Supp. 95-1). Amended by final rulemaking at 12 A.A.R. 1331, effective June 4, 2006 (Supp. 06-2).

R20-4-1502. Applications

- A.** An applicant for a license shall complete and file an application, as required by the Department, by delivering the application to the Superintendent, together with the following documents and payment:
1. The bond required by A.R.S. § 32-1021;
 2. The nonrefundable investigation fee and original license fee required by A.R.S. § 32-1028 and stated in A.R.S. § 6-126;
 3. A current financial statement in the form required by the Department;
 4. A certified copy of the current articles of incorporation, by-laws, partnership agreement, or other organizational documents under which the applicant proposes to conduct business; and
 5. A statement of personal history for each principal officer, partner, and manager of the applicant, in the form required by the Department.
- B.** An out-of-state collection agency applying for a license under A.R.S. § 32-1024 shall complete and file the application required by subsection (A), together with a signed statement declaring that:
1. The requirements for securing the out-of-state license were, when issued, substantially the same or equivalent to the requirements imposed under A.R.S. Title 32, Chapter 9, Article 2. The statement shall also contain a complete description of those requirements.
 2. The state issuing the out-of-state license extends reciprocity to Arizona licensees under similar circumstances. The statement shall also contain a complete description of the conditions for reciprocity in the other state.
- C.** A licensee applying for license renewal shall complete and file an application, as required by the Department, by delivering the renewal application to the Superintendent before January 1, together with the renewal fee required by A.R.S. § 32-1028 and stated in A.R.S. § 6-126. An application for renewal shall also include a current financial statement in the form required by the Department.
- D.** An applicant for a provisional license under A.R.S. § 32-1027 shall complete and file an application as required by the Department, by delivering the application to the Superintendent within 30 days of the event justifying a provisional license. The applicant shall deliver the application together with each of the following:
1. A bond that satisfies the requirements of A.R.S. § 32-1022;
 2. A current financial statement as required by the Department;
 3. A detailed description of the facts justifying the issuance of a provisional license; and
 4. Evidence that the licensee notified the Superintendent as required by A.R.S. § 32-1023, in the event the licensee has terminated its active manager.
- E.** An applicant for a provisional license shall, in each instance, be appropriate to the circumstances justifying the provisional license, as follows:

1. A licensee's personal representative, or the personal representative's appointee, shall complete and file an application if the licensee, a natural person, has died;
 2. The surviving partners shall complete and file an application if the licensee, a partnership, has dissolved;
 3. A licensee shall complete and file an application if an active manager's employment was terminated.
- F.** An applicant for a provisional license shall clearly label the top of the first page with the heading "APPLICATION FOR PROVISIONAL LICENSE UNDER A.R.S. § 32-1027."
- G.** The Superintendent may require additional information the Superintendent considers necessary in connection with any application under this rule.

Historical Note

Adopted as an emergency effective September 6, 1978, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 78-5). Adopted effective December 6, 1978 (Supp. 78-6). R20-4-1502 recodified from R4-4-1502 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 4742, effective November 13, 2000 (Supp. 00-4).

R20-4-1503. Reports

- A.** A collection agency shall notify the Superintendent in writing of any change in the officers, directors, partners, or active manager of the collection agency not more than ten days after the change. With the notice, the collection agency shall provide the Superintendent with a Statement of Personal History for each new officer, director, partner, or active manager on a form obtained from the Department.
- B.** A collection agency shall notify the Superintendent in writing of any change in its place of business not more than 10 days after the change.

Historical Note

Adopted effective December 18, 1979 (Supp. 79-6). R20-4-1503 recodified from R4-4-1503 (Supp. 95-1). Amended by final rulemaking at 12 A.A.R. 1331, effective June 4, 2006 (Supp. 06-2).

R20-4-1504. Records

- A.** A licensee may use a computer recordkeeping system if the licensee gives the Superintendent advanced written notice that it intends to do so. The Department shall not require a licensee to keep a written copy of its books, accounts, and records if the licensee can generate all information required by this Section in a timely manner for examination or other purposes. A licensee may modify a computer recordkeeping system's hardware or software components. When requested, or in response to a written notice of an examination, a licensee shall report to the Superintendent any modification that changes a computer system back to a paper-based recordkeeping system;
- B.** All licensees shall keep and maintain books, accounts, and records adequate to provide a clear and readily understandable record of all business conducted by the collection agency, including:
1. Records or books of account listing all clients' accounts in numerical order, or in alphabetical order according to the clients' names. If a collection agency keeps books of accounting in numerical order, the collection agency shall alphabetically cross-index each client name with the corresponding account's number. Each account shall reflect its true condition at each calendar month's end, and shall include:
 - a. The client's name and address;
 - b. Each debtor's name worked for collection in that month;

- c. The amount, description, and date of each debit and each credit to the account; and
 - d. The balance due to, or owing from, the client.
- 2. A record and history of each debt for collection that clearly shows:
 - a. The debtor's name;
 - b. The debt's principal amount;
 - c. The interest charged or collected;
 - d. The amount, and a description of any other charges;
 - e. The amount, and date, of each payment received or collected; and
 - f. The current balance due on the debt.
- 3. An original of each written contract, between the licensee and a client, including any contract amendments.
- 4. A trust general ledger reflecting all deposits to and payments from a trust account. A licensee shall post transactions to its trust general ledger at least every five business days. A licensee shall bring its trust general ledger current within 24 hours when requested by the Superintendent.
- 5. The licensee's trust account reconciliation, prepared at least once a month.
- 6. Books, records, and files maintained so that the Superintendent can easily conduct an unannounced spot check, as well as the examinations and investigations required by A.R.S. §§ 6-122 and 6-124.
- 7. A copy of all pleadings in pending litigation that names the collection agency as a defendant.
- 8. A record of fictitious names used by the agency's debt collectors as required by R20-4-1520.
- C. A person issuing a receipt for a collection agency shall sign the receipt using that person's true name. Each receipt shall also show the collection agency's name.
- D. A licensee shall maintain all records required under this Section and shall make them available for examination, investigation, or audit in Arizona within three working days after the Superintendent demands the records.
- E. A licensee shall retain the records required by this Section for the following periods:
 - 1. A licensee shall retain all records described in subsections (B)(1), (B)(3), (B)(4), (B)(5), (B)(6), (B)(7), and (B)(8) for at least six years following their creation.
 - 2. A licensee shall retain all records described in subsection (B)(2) for at least three years from an account's assignment to the licensee. If a licensee collects any money on an account, the licensee shall retain the records described in subsection (B)(2) for at least three years from the last collection date.

Historical Note

Adopted as an emergency effective September 6, 1978, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 78-5). Adopted effective December 6, 1978 (Supp. 78-6). Amended effective December 18, 1979 (Supp. 79-6). R20-4-1504 recodified from R4-4-1504 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 4742, effective November 13, 2000 (Supp. 00-4).

R20-4-1505. Trust Account

- A. A licensee that maintains an office in Arizona shall deposit all funds collected for a client in a trust account with an Arizona bank or savings and loan association. A licensee that does not maintain an office in Arizona shall deposit all funds collected for a client in a trust account at a depository in the state where the licensee maintains its principal office. A licensee shall deposit all client funds before the close of its business on the

third business day after the licensee receives the funds. Client funds shall remain on deposit as required by this Section until:

- 1. Paid over to a client, or
 - 2. Otherwise paid as provided in this Section.
- B. A licensee shall pay funds from the trust account either:
 - 1. By prenumbered printed checks, or
 - 2. By electronic payment.
- C. A licensee shall deposit in its trust account only the funds it has collected for its client. A licensee, its officers, directors, partners, managers, members, or employees shall not commingle, or permit the commingling of, their own funds with client funds. This prohibition includes any funds that a licensee, or any officer, director, partner, manager, member, or employee claims an interest in if that interest arises outside the licensee's contract with a client.
- D. A licensee shall keep unpaid client funds in its trust account. A licensee may maintain a separate trust account for dormant accounts into which the licensee deposits unpaid funds such as those of a client that cannot be located, or any trust account check issued to a client that is returned without being negotiated. As to all those unpaid funds, under A.R.S. § 44-317, a licensee shall file an abandoned property report at the Arizona Department of Revenue as and when required by law.
- E. A licensee shall withdraw from its trust account all fees and commissions due the licensee under its contract with a client and deposit them directly into its own operating account.
- F. A licensee shall not pay funds from its trust account except as:
 - 1. Provided in this Section,
 - 2. Expressly authorized in its contract with a client, or
 - 3. Authorized in writing by the Superintendent.

Historical Note

Adopted effective December 18, 1979 (Supp. 79-6). R20-4-1505 recodified from R4-4-1505 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 4742, effective November 13, 2000 (Supp. 00-4).

R20-4-1506. Articles of Incorporation; Bylaws; Organizing Documents

- A. A collection agency organized as a corporation shall file with the Superintendent a copy of each amendment to its articles of incorporation within 30 days after the amendment is adopted. Before filing with the Superintendent, an officer of the collection agency shall:
 - 1. Certify the copy filed in compliance with this Section, in writing, signed by the certifying officer, attesting to the completeness, accuracy, and authenticity of the certified copy; and
 - 2. Ensure the copy bears a stamp affixed by the Arizona Corporation Commission to evidence filing with the Commission.
- B. A collection agency organized as a corporation shall file with the Superintendent a copy of each amendment to its bylaws within 10 days after the amendment is adopted. An officer of the collection agency shall certify the copy filed in compliance with this Section, in writing, attesting to the completeness, accuracy, and authenticity of the certified copy.
- C. A collection agency not organized as a corporation shall file with the Superintendent a copy of each amendment to its organizing documents within 10 days after the amendment is adopted. A partner, active manager, or agent of the collection agency shall certify the copy filed in compliance with this Section, in writing, attesting to the completeness, accuracy, and authenticity of the certified copy.

Historical Note

Adopted effective December 18, 1979 (Supp. 79-6). R20-4-1506 recodified from R4-4-1506 (Supp. 95-1).

Amended by final rulemaking at 12 A.A.R. 1331, effective June 4, 2006 (Supp. 06-2).

R20-4-1507. Representations of Collection Agency's Identity

In all communications with debtors, either orally or in writing, all the following rules apply:

1. A collection agency shall represent itself as a collection agency.
2. A collection agency shall not directly or indirectly claim to be a credit reporting agency or credit bureau if it is not.
3. A collection agency shall not directly or indirectly claim to be a law enforcement agency.
4. A collection agency shall not directly or indirectly claim to be a law firm.

Historical Note

Adopted as an emergency effective September 6, 1978, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 78-5). Adopted effective December 6, 1978 (Supp. 78-6). R20-4-1507 recodified from R4-4-1507 (Supp. 95-1). Amended by final rulemaking at 12 A.A.R. 1331, effective June 4, 2006 (Supp. 06-2).

R20-4-1508. Representations of the Law

A collection agency shall not:

1. Misrepresent the state of the law to a debtor,
2. Send a debtor written material that simulates legal process, or
3. Represent or imply that a debtor is, or may be, subject to criminal prosecution or arrest because of a failure to pay the debt.

Historical Note

Adopted as an emergency effective September 6, 1978, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 78-5). Adopted effective December 6, 1978 (Supp. 78-6). R20-4-1508 recodified from R4-4-1508 (Supp. 95-1). Amended by final rulemaking at 12 A.A.R. 1331, effective June 4, 2006 (Supp. 06-2).

R20-4-1509. Representations as to Fees, Costs, and Legal Proceedings; Disinterested Counsel Required

- A. A collection agency shall neither threaten to collect, nor attempt to collect, an attorney's fee, collection cost, or other fee that the debtor is not obliged to pay under the debtor's contract with the collection agency's creditor client.
- B. A collection agency shall not inform a debtor that legal proceedings have been started unless, in fact, a lawsuit has been filed against the debtor.
- C. A collection agency shall not threaten to start legal proceedings against a debtor unless the collection agency actually intends, at the time of the threat, to sue.
- D. A collection agency shall not threaten to turn an account over to a lawyer unless the collection agency actually intends to do so at the time of the threat.
- E. A collection agency shall not file a lawsuit against a debtor unless the lawsuit is filed by an attorney who has no personal or financial interest in that collection agency.

Historical Note

Adopted as an emergency effective September 6, 1978, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 78-5). Adopted effective December 6, 1978 (Supp. 78-6). R20-4-1509 recodified from R4-4-1509 (Supp. 95-1). Amended by final rulemaking at 12 A.A.R. 1331, effective June 4, 2006 (Supp. 06-2).

R20-4-1510. Representations as to Rights Waived or Remedies Available

- A. A collection agency shall not inform a debtor that the debtor waives any legal right or legal defense by a failure to contact the collection agency.
- B. A collection agency shall not inform a debtor that the collection agency has the power or right to bypass the legal process.
- C. A collection agency shall not misrepresent the remedies available to the collection agency.

Historical Note

Adopted as an emergency effective September 6, 1978, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 78-5). Adopted effective December 6, 1978 (Supp. 78-6). R20-4-1510 recodified from R4-4-1510 (Supp. 95-1). Amended by final rulemaking at 12 A.A.R. 1331, effective June 4, 2006 (Supp. 06-2).

R20-4-1511. Prohibition of Harassment

- A. A collection agency shall not use unauthorized or oppressive tactics designed to harass any person to pay a debt.
- B. A collection agency shall not use written or oral communications that either ridicule, disgrace, or humiliate any person or tend to ridicule, disgrace, or humiliate any person.
- C. A collection agency shall not state, imply, or tend to imply, in written or oral communications that any person is guilty of fraud or any other crime.
- D. A collection agency shall not permit its agents, employees, representatives, debt collectors, or officers to use obscene or abusive language in efforts to collect a debt.
- E. A collection agency or its agents, employees, representatives or officers are subject to penalties listed in A.R.S. § 32-1056(B) for any violation of this Article, as well as other liabilities imposed under any other provision of law.

Historical Note

Adopted as an emergency effective September 6, 1978, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 78-5). Adopted effective December 6, 1978 (Supp. 78-6). R20-4-1511 recodified from R4-4-1511 (Supp. 95-1). Amended by final rulemaking at 12 A.A.R. 1331, effective June 4, 2006 (Supp. 06-2).

R20-4-1512. Contacts with Debtors and Others

- A. A collection agency shall contact a debtor by telephone only during reasonable hours. A collection agency shall make a reasonable attempt to contact a debtor at the debtor's residence. A collection agency may contact a debtor at the debtor's place of employment if a reasonable attempt to contact the debtor at the debtor's residence has failed.
- B. A collection agency shall not contact a third party, including a debtor's friend, relative, neighbor, or employer and:
 1. Inform the third party of the debt;
 2. Ask the third party to pressure the debtor into paying the debt, or;
 3. Ask the third party to pay the debt, unless the third party is legally obligated to pay the debt.
- C. A collection agency shall not threaten to contact a third party listed in subsection (B) for any purpose listed in subsection (B).
- D. Despite the other provisions of this Section, a collection agency may make lawful service on third parties, including employers, of a writ of garnishment or other writ in aid of execution after judgment has been entered against a debtor.

Historical Note

Adopted as an emergency effective September 6, 1978, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 78-5). Adopted effective December 6, 1978

(Supp. 78-6). R20-4-1512 recodified from R4-4-1512 (Supp. 95-1). Amended by final rulemaking at 12 A.A.R. 1331, effective June 4, 2006 (Supp. 06-2).

R20-4-1513. Cessation of Communication with the Debtor

- A. A collection agency shall stop contacting a debtor, directly or indirectly, if the debtor tells the collection agency that the debtor is represented by a lawyer and wants the collection agency to communicate with the debtor through that lawyer. The collection agency may later contact the debtor if the collection agency contacts the lawyer named by the debtor and learns that the lawyer does not represent the debtor.
- B. A collection agency shall stop contacting a debtor, directly or indirectly, if the debtor gives the collection agency written notice that the debtor:
 - 1. Refuses to pay the debt, or;
 - 2. Wants the collection agency to stop all further communication with the debtor.
- C. Despite the provisions of subsection (B), a collection agency may contact a debtor to inform the debtor that:
 - 1. The collection agency has stopped trying to collect the debt, or
 - 2. The collection agency or the creditor may invoke specific remedies that are customarily used by the collection agency or the creditor.
- D. The debtor's written notice under subsection (B) is effective upon receipt by the collection agency if delivered by mail.

Historical Note

Adopted as an emergency effective September 6, 1978, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 78-5). Adopted effective December 6, 1978 (Supp. 78-6). Amended effective December 18, 1979 (Supp. 79-6). R20-4-1513 recodified from R4-4-1513 (Supp. 95-1). Amended by final rulemaking at 12 A.A.R. 1331, effective June 4, 2006 (Supp. 06-2).

R20-4-1514. Disclosure of Information to Debtor

- A. Within five days after the initial communication with the debtor, a collection agency shall obtain, and be able to inform the debtor of:
 - 1. The name of the creditor;
 - 2. The time and place of the creation of the debt;
 - 3. The merchandise, services, or other value provided in exchange for the debt; and
 - 4. The date when the account was turned over to the collection agency by the creditor.
- B. A collection agency shall give the debtor access to any of the collection agency's records that contain the information listed in subsection (A).
- C. At the debtor's request, the collection agency shall give the debtor, free of charge, a copy of any document from its records that contains the information listed in subsection (A).

Historical Note

Adopted as an emergency effective September 6, 1978, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 78-5). Adopted effective December 6, 1978 (Supp. 78-6). R20-4-1514 recodified from R4-4-1514 (Supp. 95-1). Amended by final rulemaking at 12 A.A.R. 1331, effective June 4, 2006 (Supp. 06-2).

R20-4-1515. Aiding and Abetting

- A collection agency shall not help or encourage, directly or indirectly, any other person to evade or violate any provision of:
- 1. This Article, or
 - 2. A.R.S. Title 32, Chapter 9.

Historical Note

Adopted as an emergency effective September 6, 1978, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 78-5). Adopted effective December 6, 1978 (Supp. 78-6). R20-4-1515 recodified from R4-4-1515 (Supp. 95-1). Amended by final rulemaking at 12 A.A.R. 1331, effective June 4, 2006 (Supp. 06-2).

R20-4-1516. Advertising

A collection agency shall not use any form of communication to state or imply that it is:

- 1. Approved, bonded by, or affiliated with the state of Arizona;
- 2. A state agency;
- 3. The director of any state agency; or
- 4. Authorized to practice law.

Historical Note

Adopted as an emergency effective September 6, 1978, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 78-5). Adopted effective December 6, 1978 (Supp. 78-6). R20-4-1516 recodified from R4-4-1516 (Supp. 95-1). Amended by final rulemaking at 12 A.A.R. 1331, effective June 4, 2006 (Supp. 06-2).

R20-4-1517. Repealed

Historical Note

Adopted as an emergency effective September 6, 1978, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 78-5). Adopted effective December 6, 1978 (Supp. 78-6). R20-4-1517 recodified from R4-4-1517 (Supp. 95-1). Section repealed by final rulemaking at 12 A.A.R. 1331, effective June 4, 2006 (Supp. 06-2).

R20-4-1518. Agreements with Clients

A collection agency's records shall document each client's account in writing. The records for an account shall include either a written agreement between the client creditor and the collection agency, or a written direction from the creditor to the collection agency concerning a specific debt placed for collection. The collection agency shall keep records that are specific, easily understood, and unambiguous. A provision of a written agreement or written direction that suggests the collection agency has authority to represent the client in court or to practice law in any other way is void and prohibited by this Section. The records for an account shall separately state:

- 1. The names of the parties to the agreement or written direction,
- 2. The terms or rate of compensation paid to the collection agency,
- 3. The length of time the agreement or written direction is intended to be in effect, and
- 4. Any conditions regarding collection of a particular debt.

Historical Note

Adopted effective December 18, 1979 (Supp. 79-6). R20-4-1518 recodified from R4-4-1518 (Supp. 95-1). Amended by final rulemaking at 12 A.A.R. 1331, effective June 4, 2006 (Supp. 06-2).

R20-4-1519. Licensee Names and Control

- A. The Department shall not issue a license with a name that is:
 - 1. Similar to, or that may be confused with, any federal, state, county, or municipal government function or agency;
 - 2. Descriptive of any business activity that the applicant does not actually conduct;
 - 3. The same as, or similar to, the name of any existing collection agency, or;

4. Otherwise deceptive or misleading.
- B. The Department may permit the use of a name otherwise prohibited under subsection (A)(3) based on its analysis of whether the name includes geographic or other information that distinguishes it from the other collection agency.
- C. A collection agency shall not use a collection agency license to do business under more than one name. Each collection agency shall apply for and obtain a separate license for each business name it intends to use in Arizona.

Historical Note

Adopted effective December 18, 1979 (Supp. 79-6). R20-4-1519 recodified from R4-4-1519 (Supp. 95-1).
Amended by final rulemaking at 12 A.A.R. 1331, effective June 4, 2006 (Supp. 06-2).

R20-4-1520. Representations of Collection Agency Employees' Identity or Position

- A. A collection agency shall not allow its debt collector, agent, representative, employee, or officer to:
 1. Misrepresent the person's true position with the collection agency,
 2. Claim to be, or imply that the person is, an attorney unless the person is licensed to practice law, or
 3. Claim to be, or imply that the person is, a public official, peace officer, or any other type of public employee, or
 4. Claim to be, or imply that the person is, any other third party.
- B. In any communication with a debtor, a person working for a collection agency shall indicate that the person is a debt collector.
- C. A collection agency shall keep a record of all fictitious names used by its debt collectors during their employment. The collection agency shall record the information required by this subsection before permitting the use of a fictitious name. The collection agency shall file a copy of the record of fictitious names with the Department on July 1 and December 31 of each year. After filing the initial report, a collection agency shall identify all changes to the record on July 1 and December 31 of each year. The collection agency's record of fictitious names shall include:
 1. The true name of each debt collector that uses a fictitious name,
 2. Each fictitious name used by the debt collector, together with the dates when the name is used, and
 3. The residential street address and residential mailing address of each debt collector that uses a fictitious name.

Historical Note

Adopted effective December 18, 1979 (Supp. 79-6). R20-4-1520 recodified from R4-4-1520 (Supp. 95-1).
Amended by final rulemaking at 12 A.A.R. 1331, effective June 4, 2006 (Supp. 06-2).

R20-4-1521. Duty of Investigation

A collection agency shall give copies of its evidence of the debt to the debtor or the debtor's attorney on request. After providing the evidence, but before continuing its collection efforts against the debtor, the collection agency shall investigate any claim by the debtor or the debtor's attorney that:

1. The debtor has been misidentified,
2. The debt has been paid,
3. The debt has been discharged in bankruptcy, or
4. Based on any other reasonable claim, the debt is not owed.

Historical Note

Adopted effective December 18, 1979 (Supp. 79-6). R20-4-1521 recodified from R4-4-1521 (Supp. 95-1).

Amended by final rulemaking at 12 A.A.R. 1331, effective June 4, 2006 (Supp. 06-2).

R20-4-1522. Reserved**R20-4-1523. Reserved****R20-4-1524. Reserved****R20-4-1525. Reserved****R20-4-1526. Reserved****R20-4-1527. Reserved****R20-4-1528. Reserved****R20-4-1529. Reserved****R20-4-1530. Repealed****Historical Note**

Adopted as an emergency effective September 6, 1978, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 78-5). Adopted effective December 6, 1978 (Supp. 78-6). R20-4-1530 recodified from R4-4-1530 (Supp. 95-1). Section repealed by final rulemaking at 6 A.A.R. 4742, effective November 13, 2000 (Supp. 00-4).

ARTICLE 16. ACQUIRING CONTROL OF FINANCIAL INSTITUTIONS**R20-4-1601. Definitions**

In this Article, unless the context otherwise requires:

"Acquiring party" means a person who intends to acquire control of a bank, trust company, savings and loan association, or controlling person under A.R.S. Title 6, Chapter 1, Article 4.

"Acquisition of control" has the meaning stated in A.R.S. § 6-141.

"Bank" has the meaning stated in A.R.S. § 6-101.

"Control" has the meaning stated in A.R.S. § 6-141.

"Controlling person" has the meaning stated in A.R.S. § 6-141.

"Person" has the meaning stated in A.R.S. § 6-141.

"Savings and loan association" means a person required to possess a permit issued by the Superintendent under A.R.S. Title 6, Chapter 3.

"Superintendent" has the meaning stated in A.R.S. § 6-101.

"Target company" means a bank, savings and loan association, trust company, or controlling person to be acquired by an acquiring party.

"Trust company" has the meaning stated in A.R.S. § 6-851.

"Voting security" has the meaning stated in A.R.S. § 6-141.

Historical Note

Adopted as an emergency effective September 6, 1978, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 78-5). Adopted effective January 12, 1979 (Supp. 79-1). R20-4-1601 recodified from R4-4-1601 (Supp. 95-1). Amended by final rulemaking at 9 A.A.R. 5055, effective January 3, 2004 (Supp. 03-4).

R20-4-1602. Application for Approval to Acquire Control of Financial Institution

- A. An applicant seeking approval to acquire control of a bank, savings and loan association, or controlling person of a bank or savings and loan association, under A.R.S. Title 6, Chapter 1, Article 4, shall file with the Superintendent copies of all application documents filed with federal regulatory agencies in connection with the planned acquisition of control.

- B.** As used in this subsection, “executive officer” includes the chairman of the board, president, each vice president, cashier, secretary, treasurer, and every other person who participates in major policymaking functions of the applicant. Under A.R.S. § 6-145(A), an applicant seeking approval to acquire control of a trust company or controlling person of a trust company, under A.R.S. Title 6, Chapter 1, Article 4 shall supply all information the Superintendent requires under this subsection. The Superintendent may require an applicant to supplement or amend its application based on issues raised by the initial submission. The initial application shall consist of the following items:
1. A copy of the signed purchase agreement,
 2. The applicant’s audited financial statement,
 3. A personal history statement, on a form supplied by the Department, for each executive officer and each director of the acquiring party,
 4. Each executive officer’s and each director’s audited financial statement,
 5. A fingerprint card for each executive officer and each director, and
 6. A copy of each executive officer’s and each director’s driver’s license.

Historical Note

Adopted as an emergency effective September 6, 1978, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 78-5). Adopted effective January 12, 1979 (Supp. 79-1). R20-4-1602 recodified from R4-4-1602 (Supp. 95-1). Amended by final rulemaking at 9 A.A.R. 5055, effective January 3, 2004 (Supp. 03-4).

R20-4-1603. Repealed

Historical Note

Adopted as an emergency effective September 6, 1978, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 78-5). Adopted effective January 12, 1979 (Supp. 79-1). R20-4-1603 recodified from R4-4-1603 (Supp. 95-1). Section repealed by final rulemaking at 9 A.A.R. 5055, effective January 3, 2004 (Supp. 03-4).

R20-4-1604. Repealed

Historical Note

Adopted as an emergency effective September 6, 1978, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 78-5). Adopted effective January 12, 1979 (Supp. 79-1). R20-4-1604 recodified from R4-4-1604 (Supp. 95-1). Section repealed by final rulemaking at 9 A.A.R. 5055, effective January 3, 2004 (Supp. 03-4).

ARTICLE 17. ARIZONA INTERSTATE BANK AND SAVINGS AND LOAN ASSOCIATION ACT

R20-4-1701. Definitions

In this Article, unless the context otherwise requires:

- “Acquire” has the meaning stated at A.R.S. § 6-321(1).
 “Applicant” means an out-of-state financial institution that intends to acquire control of an in-state financial institution.
 “Control” has the meaning stated at A.R.S. § 6-321(2).
 “In-state financial institution” has the meaning stated at A.R.S. § 6-321(5).
 “Out-of-state financial institution” has the meaning stated at A.R.S. § 6-321(6).

Historical Note

Adopted effective October 1, 1986 (Supp. 86-5). R20-4-1701 recodified from R4-4-1701 (Supp. 95-1). Amended

by final rulemaking at 11 A.A.R. 2031, effective July 2, 2005 (Supp. 05-2).

R20-4-1702. Notice to the Superintendent of Intent to Acquire Control of an In-state Financial Institution; Surrender of an Acquired Financial Institution’s Charter

- A.** An applicant shall give written notice of an acquisition to the Superintendent in the form of a courtesy copy of its federal application. The acquiring entity shall ensure that the notice is delivered to the Superintendent not less than ten days before the effective date of the acquisition. No other application is required under the provisions of A.R.S. Title 6, Chapter 2, Article 7, the Arizona Interstate Bank and Savings and Loan Association Act. The Superintendent may impose conditions on an acquisition under the authority of A.R.S. §§ 6-324 and 6-328.
- B.** An acquired in-state financial institution shall surrender, by delivery to the Superintendent, all permits and certificates issued by the Superintendent within ten days after the effective date of the acquisition unless the acquired institution intends to continue operating, after the acquisition, as a stand alone subsidiary under the authority of its existing Arizona banking permit.

Historical Note

Adopted effective October 1, 1986 (Supp. 86-5). R20-4-1702 recodified from R4-4-1702 (Supp. 95-1). Amended by final rulemaking at 11 A.A.R. 2031, effective July 2, 2005 (Supp. 05-2).

R20-4-1703. Repealed

Historical Note

Adopted effective October 1, 1986 (Supp. 86-5). R20-4-1703 recodified from R4-4-1703 (Supp. 95-1). Section repealed by final rulemaking at 11 A.A.R. 2031, effective July 2, 2005 (Supp. 05-2).

R20-4-1704. Public Notice

- A.** An applicant shall transmit to the Superintendent of Banks two copies of each notice and the publisher’s affidavit of publication required by the Federal Reserve Board, Federal Home Loan Bank Board, the Federal Deposit Insurance Corporation, or other regulatory authority that has concurrent jurisdiction.
- B.** An applicant shall provide the Superintendent of Banks copies of any protests known to have been received by the Federal Reserve Board, Federal Home Loan Bank Board, the Federal Deposit Insurance Corporation, or other regulatory authority that has concurrent jurisdiction.

Historical Note

Adopted effective October 1, 1986 (Supp. 86-5). R20-4-1704 recodified from R4-4-1704 (Supp. 95-1). Amended by final rulemaking at 11 A.A.R. 2031, effective July 2, 2005 (Supp. 05-2).

R20-4-1705. Repealed

Historical Note

Adopted effective October 1, 1986 (Supp. 86-5). R20-4-1705 recodified from R4-4-1705 (Supp. 95-1). Section repealed by final rulemaking at 11 A.A.R. 2031, effective July 2, 2005 (Supp. 05-2).

R20-4-1706. Repealed

Historical Note

Adopted effective October 1, 1986 (Supp. 86-5). R20-4-1706 recodified from R4-4-1706 (Supp. 95-1). Section repealed by final rulemaking at 11 A.A.R. 2031, effective July 2, 2005 (Supp. 05-2).

ARTICLE 18. MORTGAGE BANKERS**R20-4-1801. Exemption for an Entity Regulated by an Agency of this State, Other States, or by the United States**

- A.** The exemption under A.R.S. § 6-942(A)(1) only applies to a person whose offers to make or negotiate a “mortgage banking loan” or a “mortgage loan,” as those terms are defined in A.R.S. § 6-941, and all mortgage banking loans and mortgage loans made or negotiated by the person are regulated directly by an agency of this state, any other state, or the United States.
- B.** The required regulation of the transactions listed in subsection (A) includes:
1. Rules governing a claimant’s accounting and recordkeeping practices;
 2. The authority to examine a claimant’s books and records relating to its mortgage banking activities or mortgage lending activities, or both; and
 3. The ability to place a claimant in a receivership or conservatorship with regard to the claimant’s mortgage banking activities, mortgage lending activities, or both.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-1802. Equivalent and Related Experience

- A.** An applicant may satisfy the three years’ experience requirement of A.R.S. § 6-943 by the types of lending-related experience listed in this subsection. The Department counts each month in the following types of work experience toward the three years required either for a mortgage banker license, or as a responsible individual, both under A.R.S. § 6-943(C). The Department counts a fractional month of experience, at least 15 days long, as a full month.
1. Mortgage banker with an Arizona license, responsible individual, or branch manager for a licensee;
 2. Mortgage broker with an Arizona license, responsible individual, or branch manager for a licensee;
 3. Loan officer with responsibility primarily for loans secured by lien interests on real property;
 4. Lender’s branch manager with responsibility primarily for loans secured by lien interests on real property;
 5. Mortgage banker with license from another state, or responsible individual for the mortgage banker;
 6. Mortgage broker with license from another state, or responsible individual for the mortgage broker;
 7. Attorney certified by any state as a real estate specialist.
- B.** An applicant with insufficient actual experience of the types listed in subsection (A) may satisfy the remainder of the three years’ experience requirement of A.R.S. § 6-943 by the types of related experience listed in this subsection. The Department counts each month in the following types of work experience according to the ratio listed below, of actual experience to equivalent experience, credited toward qualifying for a license, or as a responsible individual, both under A.R.S. § 6-943(C). The Department counts a fractional month of experience, at least 15 days long, as a full month. An applicant receives credit in only one area listed and for not more than three years’ actual experience. The remaining years of experience required to qualify for a license shall be obtained from types of work experiences listed in subsection (A).
1. Attorney without state bar certified real estate specialty...3:2
 2. Paralegal with experience in real estate matters...3:2
 3. Loan underwriter...3:2
 4. Mortgage banker or mortgage broker from another state without license...3:2
 5. Real estate broker with an Arizona

- license or license from a state with substantially equivalent licensing requirements...3:2
- Escrow officer...3:2
- Trust officer with a title company...3:2
- Executive, supervisor, or policy maker involved in administering or operating a mortgage-related business...3:1.5
- Title officer with a title company...3:1.5
- Real estate broker, not qualified under subsection (B)(5)...3:1.5
- Loan processor with responsibility primarily for loans secured by lien interests on real property...3:1.5
- Lender’s branch manager with responsibility primarily for loans not secured by lien interests on real property...3:1.5
- Real property salesperson, with an Arizona license or a license from a state with substantially equivalent licensing requirements...3:1
- Loan officer, with responsibility primarily for loans not secured by lien interests on real property...3:1

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-1803. Restrictions on the Term of a Cash Alternative to a Surety Bond

A licensee or applicant shall not place a certificate of deposit or investment certificate as a cash alternative to a surety bond with the Superintendent that is renewable or expires earlier than 12 months from the date of issuance.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-1804. Requirements for a Person Intended to Oversee a Branch Office

A person designated to oversee the operations of a branch office shall be knowledgeable about the branch activities of the licensee, supervise compliance by the branch with applicable law and rules, and have sufficient authority to ensure such compliance. One person may oversee more than one branch.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-1805. Notification of Change of Address

If a licensee changes the licensee’s principal place of business, or the location of a branch office, the licensee shall notify the Superintendent at least five business days before the address change. With the notice, a licensee shall provide the Superintendent with the license for the office changing its address and the fee required by A.R.S. § 6-126 for changing an office address. A copy of the license shall continue to be displayed at the place of business until a new license is issued.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2). Amended by final rulemaking at 8 A.A.R. 145, effective December 10, 2001 (Supp. 01-4).

R20-4-1806. Recordkeeping Requirements

- A.** The Superintendent shall approve a licensee’s use of a computer or mechanical recordkeeping system if the licensee gives

the Superintendent advanced written notice that it intends to do so. The Department shall not require a licensee to keep a written copy of the records if the licensee can generate all information required by this Section in a timely manner for examination or other purposes. A licensee may add, delete, modify, or customize an approved computer or mechanical recordkeeping system's hardware or software components. When requested, or in response to a written notice of an examination, a licensee shall report to the Superintendent any alteration in the approved system's fundamental character, medium, or function if the alteration changes:

1. Any approved computer or mechanical system back to a paper-based system; or
2. An approved mechanical system to a computer system; or
3. An approved computer system to a mechanical system.

B. In addition to any statutory requirement regarding records, a record maintained by a mortgage banker shall include the following:

1. A list of all executed loan applications or executed fee agreements that includes the following information:
 - a. Applicant's name;
 - b. Application date;
 - c. Amount of initial loan request;
 - d. Final disposition date;
 - e. Disposition (funded, denied); and
 - f. Name of loan officer;
2. A record, such as a cash receipts journal, of all money received in connection with mortgage banking loans or mortgage loans including:
 - a. Payor's name;
 - b. Date received;
 - c. Amount; and
 - d. Receipt's purpose including identification of a related loan, if any;
3. A sequential listing of checks written for each bank account relating to the mortgage banker business, such as a cash disbursement journal, including:
 - a. Payee's name;
 - b. Amount;
 - c. Date; and
 - d. Payment's purpose including identification of a related loan, if any;
4. Bank account activity source documents for the mortgage banker business including receipted deposit tickets, numbered receipts for cash, bank account statements, paid checks, and bank advices;
5. A trust subsidiary ledger for each borrower that deposits trust funds showing:
 - a. Borrower's name or co-borrowers' names;
 - b. Loan number, if any;
 - c. Amount received;
 - d. Purpose for the amount received;
 - e. Date received;
 - f. Date deposited into trust account;
 - g. Amount disbursed;
 - h. Date disbursed;
 - i. Disbursement's payee and purpose; and
 - j. Balance;
6. A file for each application for a mortgage banking loan or a mortgage loan containing:
 - a. The agreement with the customer concerning the mortgage banker's services, whether as a loan application, fee agreement, or both;
 - b. Document showing the application's final disposition, such as a settlement statement, or a denial or withdrawal letter;

- c. Correspondence sent, received, or both by the licensee;
 - d. Contract, agreement and escrow instructions to or with any depository;
 - e. Documents showing compliance with the Consumer Credit Protection Act's (15 U.S.C. §§ 1601 through 1666j) and the Real Estate Settlement Procedures Act's (12 U.S.C. §§ 2601 through 2617) disclosure requirements, to the extent applicable;
 - f. If the loan is closed in the licensee's name, and funded by a lender that is not an institutional investor as defined at A.R.S. § 6-943, a copy of the executed note, executed deed of trust or mortgage, and each assignment of beneficial interest by the licensee, if any. If any of the documents listed in this subsection have been recorded, the file shall also contain legible copies of the recorded documents, and;
 - g. Itemized list of all fees taken in advance including appraisal fee, credit report fee, and application fee;
 7. Samples of every piece of advertising relating to the mortgage banker's business in Arizona;
 8. Copies of governmental or regulatory compliance reviews;
 9. If the licensee is not a natural person, a file containing:
 - a. Organizational documents for the entity;
 - b. Minutes;
 - c. A record, such as a stock or ownership transfer ledger, showing ownership of all proportional equity interests in the licensee, ascertainable as of any given record date; and
 - d. Annual report, if required by law;
 10. If the licensee or anyone directly or indirectly owning more than 20% of the licensee has a felony conviction, a copy of the judgment or other record of conviction;
 11. If the licensee or anyone directly or indirectly owning more than 20% of the licensee has, in the previous seven years, been named a defendant in any civil suit, a copy of the complaint, any answer filed by the licensee, and any judgment, dismissal or other final order disposing of the action;
 12. If the Superintendent has granted approval to maintain records outside this state, the specific address where the records are kept, and a person's name to contact for them;
 13. If a licensee does business in other states, it must be able to separate Arizona loan information from information relating to other states to enable the Superintendent to conduct an examination.
 14. A licensee shall produce a trial balance of the general ledger monthly to evidence the mortgage banker's net worth.
- C.** If 10 or fewer transactions have occurred during the prior calendar quarter, a licensee shall reconcile and update all records specified in subsection (B) at least once each calendar quarter. A licensee shall reconcile and update all records specified in subsection (B) monthly if more than 10 transactions occurred during the prior calendar quarter. In addition to reconciling each trust bank account, a licensee shall verify each trust balance to each trust subsidiary ledger at each reconciliation.
- D.** A licensee shall retain the documents described in subsections (B)(1) and (6) for the length of time provided in A.R.S. § 6-946. For the purposes of A.R.S. § 6-946, the mortgage banking loan's closing date, on a loan application that did not result in the making of a loan, is either:
1. The date a licensee receives a written cancellation notice from an applicant; or

2. The date a licensee mails written notice to an applicant that an application has been denied, as required by federal law.
- E. A licensee shall maintain all other records described in this Section, and not included in subsection (D), for at least two years.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R.
2094, effective June 10, 1999 (Supp. 99-2).

R20-4-1807. Providing Copies of Records

For each loan closed in an Arizona mortgage broker's name with a concurrent assignment of beneficial interest to a mortgage banker, the mortgage banker licensee shall provide to the mortgage broker in whose name the loan closed a copy of:

1. The closing instructions;
2. Any applicable rescission notice;
3. The HUD-1 settlement statement;
4. The final truth-in-lending disclosure;
5. The note;
6. The executed deed of trust or mortgage; and
7. Each assignment of beneficial interest by the mortgage banker licensee.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R.
2094, effective June 10, 1999 (Supp. 99-2).

R20-4-1808. Authorization to Complete Blank Spaces

An authorization, under A.R.S. § 6-947, allowing a licensee or escrow agent to complete certain blank spaces in a document after it is signed by a party to the transaction shall:

1. Specifically identify the document and the blank spaces to be completed;
2. Be in writing, dated, and signed by the authorizing parties, and
3. Contain the following notice, conspicuously printed on its face: YOUR SIGNATURE BELOW AUTHORIZES YOUR MORTGAGE BANKER OR ESCROW AGENT TO FILL IN SPACES YOU LEFT BLANK IN SPECIFIED LOAN DOCUMENTS YOU ARE ABOUT TO SIGN OR MAY HAVE ALREADY SIGNED. UNDER STATE LAW YOU CAN GIVE THIS AUTHORITY, BUT YOU ARE NOT REQUIRED TO DO SO. YOU CAN REFUSE TO SIGN ANY DOCUMENTS UNTIL ALL BLANKS ARE COMPLETELY FILLED IN.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R.
2094, effective June 10, 1999 (Supp. 99-2).

R20-4-1809. Determining Loan Amounts

The amount of a mortgage banking loan or a mortgage loan under A.R.S. § 6-947(E) or 6-947(K), is the principal amount of the loan and does not include any points, interest, finance charges, insurance premiums of any kind, compensation paid to third parties, or compensation retained by a mortgage banker or its agents.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R.
2094, effective June 10, 1999 (Supp. 99-2).

R20-4-1810. Delay or Cause Delay

A mortgage banker does not delay or cause delay if the delay occurs due to events outside the control of the mortgage banker.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R.
2094, effective June 10, 1999 (Supp. 99-2).

R20-4-1811. Impound Account

The total of all funds retained by a mortgage banker from all periodic payments made by a borrower to maintain a cushion, as defined in R20-4-102, shall not exceed 1/6th of the estimated total annual payments from the impound account.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R.
2094, effective June 10, 1999 (Supp. 99-2).

R20-4-1812. Acquisition of Additional Interest in Licensee by Majority Owner

A person that owns 51% or more of a licensee's outstanding voting equity interests, and that acquires the power to vote additional fractional equity interests, shall deliver written notice of the acquisition to the Superintendent. The person shall deliver the notice before completing the acquisition. Within 10 days after completing the acquisition, the person shall deliver documentation evidencing the acquisition to the Superintendent.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R.
2094, effective June 10, 1999 (Supp. 99-2).

R20-4-1813. Conversion to Mortgage Broker License

Under A.R.S. § 6-949 to apply for a conversion from a mortgage banker license to a mortgage broker license, the applicant shall submit during the renewal period all applicable renewal documents and renewal fees required by A.R.S. §§ 6-126 and 6-903 for mortgage brokers.

Historical Note

New Section adopted by final rulemaking at 18 A.A.R.
2622, effective December 2, 2012 (Supp. 12-4).

ARTICLE 19. COMMERCIAL MORTGAGE BANKERS**R20-4-1901. Exemption for an Institutional Investor**

- A. The exemption from the licensure requirement for an institutional investor, solely as that term is used in A.R.S. §§ 6-971, 6-972, and this Article, applies only if a person claiming the exemption meets all the following criteria:
 1. The claimant originates or directly or indirectly makes, negotiates, or offers to make or negotiate commercial mortgage loans that are all exclusively funded by the claimant's own resources, as defined in A.R.S. § 6-971;
 2. The claimant does so in the regular course of business;
 3. The claimant makes only commercial mortgage loans, as defined in A.R.S. § 6-971;
 4. The claimant makes each loan on the security of commercial property, as defined in A.R.S. § 6-971; and
 5. The claimant makes only loans of more than \$250,000.
- B. If a claimant makes even one commercial mortgage loan that does not satisfy all the above criteria, any claim of exemption is invalid, and that person shall not engage in any lending activity before obtaining a license.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R.
2094, effective June 10, 1999 (Supp. 99-2).

R20-4-1902. Exemption for an Entity Regulated by an Agency of this State, Other States, or by the United States

- A. The exemption under A.R.S. § 6-972(9) only applies to a person whose offers to make or negotiate a "commercial mortgage loan," as that term is defined in A.R.S. § 6-971, and all commercial mortgage loans made or negotiated by the person are regulated directly by an agency of this state, any other state, or the United States.
- B. The required regulation of the transactions listed in subsection (A) includes:

1. Rules governing a claimant's accounting and recordkeeping practices;
2. The authority to examine a claimant's books and records relating to its commercial mortgage lending activities;
3. The ability to place a claimant in a receivership or conservatorship with regard to the claimant's commercial mortgage lending activities.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-1903. Equivalent and Related Experience

- A. An applicant may satisfy the three years' experience requirement of A.R.S. § 6-973 by the types of lending-related experience listed in this subsection. The Department counts each month in the following types of work experience towards the three years required either for a commercial mortgage banker license, or as a responsible individual, both under A.R.S. § 6-973(D). The Department counts a fractional month of experience, at least 15 days long, as a full month.
1. Commercial mortgage banker with an Arizona license, or Responsible Individual or branch manager for a licensee;
 2. Mortgage broker with Arizona license, or Responsible Individual or branch manager for a licensee;
 3. Mortgage banker with an Arizona license, or Responsible Individual or branch manager for a licensee;
 4. Loan officer, with responsibility primarily for loans secured by lien interests on commercial real property;
 5. Lender's branch manager, with responsibility primarily for loans secured by lien interests on commercial real property;
 6. Commercial mortgage banker with license from another state, or Responsible Individual for the commercial mortgage banker;
 7. Mortgage broker with license from another state, or Responsible Individual for the mortgage broker;
 8. Mortgage banker with license from another state, or responsible individual for the mortgage banker;
 9. Attorney certified by any state as a real estate specialist.
- B. The experience of an applicant with insufficient actual experience of the types listed in subsection (A) is reviewed and evaluated on a case by case basis.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-1904. Restrictions on the Term of a Cash Alternative to a Surety Bond

A licensee or applicant shall not place a certificate of deposit or investment certificate as a cash alternative to a surety bond with the Superintendent that is renewable or expires earlier than 12 months from the date of issuance.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-1905. Requirements for a Person Intended to Oversee a Branch Office

A Person designated to oversee the operations of a branch office shall be knowledgeable about the branch activities of the licensee, supervise compliance by the branch with applicable law and rules, and have sufficient authority to ensure such compliance. One Person may oversee more than one branch.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-1906. Notification of Change of Address

If a licensee changes the licensee's principal place of business, or the location of a branch office, the licensee shall notify the Superintendent within five business days after the address change. With the notice, a licensee shall provide the Superintendent with the license for the office changing its address and the fee required by A.R.S. § 6-126 for changing an office address. A copy of the license shall continue to be displayed at the place of business until a new license is issued.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-1907. Recordkeeping Requirements

- A. The Superintendent shall approve a licensee's use of a computer or mechanical recordkeeping system if the licensee gives the Superintendent advanced written notice that it intends to do so. The Department shall not require a licensee to keep a written copy of the records if the licensee can generate all information required by this Section in a timely manner for examination or other purposes. A licensee may add, delete, modify, or customize an approved computer or mechanical recordkeeping system's hardware or software components. When requested, or in response to a written notice of an examination, a licensee shall report to the Superintendent any material alteration in the approved system's fundamental character, medium, or function if the alteration changes:
1. Any approved computer or mechanical system back to a paper-based system; or
 2. An approved mechanical system to a computer system; or
 3. An approved computer system to a mechanical system.
- B. In addition to any statutory requirement regarding records, a record maintained by a commercial mortgage banker shall include the following:
1. A list of all executed loan applications or executed fee agreements that includes the following information:
 - a. Applicant's name;
 - b. Application date;
 - c. Amount of initial loan request;
 - d. Final disposition date;
 - e. Disposition (funded, denied); and
 - f. Name of loan officer;
 2. A record, such as a cash receipts journal, of all money received in connection with commercial mortgage loans including:
 - a. Payor's name;
 - b. Date received;
 - c. Amount; and
 - d. Receipt's purpose including identification of a related loan, if any;
 3. A sequential listing of checks written for each bank account relating to the commercial mortgage banker business, such as a cash disbursement journal, including:
 - a. Payee's name;
 - b. Amount;
 - c. Date; and
 - d. Payment's purpose including identification of a related loan, if any;
 4. Bank account activity source documents for the commercial mortgage banker business including receipted deposit tickets, numbered receipts for cash, bank account statements, paid checks, and bank advices.
 5. A trust subsidiary ledger for each borrower that deposits trust funds showing:
 - a. Borrower's name or co-borrowers' names;
 - b. Loan number, if any;

- c. Amount received;
 - d. Purpose for the amount received;
 - e. Date received;
 - f. Date deposited into trust account;
 - g. Amount disbursed;
 - h. Date disbursed;
 - i. Disbursement's payee and purpose, and
 - j. Balance.
6. A file for each application for a commercial mortgage loan containing:
- a. The agreement with the customer concerning the commercial mortgage banker's services, whether as a loan application, fee agreement, or both;
 - b. The documents showing the application's final disposition, such as a settlement statements, a denial or withdrawal letter, or internal memorandum;
 - c. Correspondence sent, received, or both by the licensee;
 - d. Contract, agreement, and escrow instructions to or with any depository;
 - e. If the loan is closed in the licensee's name, a copy of all closing documents including: closing instructions, copy of the executed note, executed deed of trust or mortgage, and each assignment of beneficial interest by the licensee, if any. If any of the documents listed in this subsection have been recorded, the file shall also contain legible copies of the recorded documents, and
 - f. Itemized list of all fees taken in advance including appraisal fee, credit report fee, and application fee.
7. Samples of every piece of advertising relating to the commercial mortgage banker's business in Arizona;
8. Copies of governmental or regulatory reviews;
9. If the licensee is a not a natural person, a file containing:
- a. Organizational documents for the entity;
 - b. Minutes;
 - c. A record, such as a stock or ownership transfer ledger, showing ownership of all proportional equity interests in the licensee, ascertainable as of any given record date; and
 - d. Annual report, if required by law;
10. If the licensee or anyone directly or indirectly owning more than 20% of the licensee has a felony conviction, a copy of the judgment or other record of conviction.
11. If the licensee or anyone directly or indirectly owning more than 20% of the licensee has, in the previous seven years, been named a defendant in any civil suit, a copy of the complaint, any answer filed by the licensee, and any judgment, dismissal or other final order disposing of the action.
12. If the Superintendent has granted approval to maintain records outside this state, the specific address where the records are kept, and a person's name to contact for them.
13. If a licensee does business in other states, it must be able to separate Arizona loan information from information relating to other states to enable the Superintendent to conduct an examination.
14. A licensee shall produce a trial balance of the general ledger monthly to evidence the commercial mortgage banker's net worth.
- C. If 10 or fewer transactions have occurred during the prior calendar quarter, a licensee shall reconcile and update all records specified in subsection (B) at least once each calendar quarter. A licensee shall reconcile and update all records specified in subsection (B) monthly if more than 10 transactions occurred during the prior calendar quarter. In addition to reconciling

each trust bank account, a licensee shall verify each trust balance to each trust subsidiary ledger at each reconciliation.

- D. A licensee shall retain the documents described in subsections (B)(1) and (6) for the length of time provided in A.R.S. § 6-983. For the purposes of A.R.S. § 6-983, the commercial mortgage loan's closing date, on a loan application that did not result in the making of a loan, is either:
- 1. The date a licensee receives a written cancellation notice from the applicant; or
 - 2. The date a licensee mails written notice to an applicant that an application has been denied; or
 - 3. The date of a licensee's internal memorandum closing a loan file.
- E. A licensee shall maintain all other records described in this Section, and not included in subsection (D), for at least two years.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-1908. Impound Accounts

The total of all funds, if any, retained by the commercial mortgage banker from all periodic payments made by the borrower to maintain a Cushion, as defined in R20-4-102, is limited only by the written agreement of the parties, if at all.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-1909. Authorization to Complete Blank Spaces

An authorization, under A.R.S. § 6-984, allowing a licensee or escrow agent to complete certain blank spaces in a document after it is signed by a party to the transaction shall:

- 1. Specifically identify the document and the blank spaces to be completed;
- 2. Be in writing, dated, and signed by the authorizing party, and
- 3. Contain the following notice, conspicuously printed on its face: YOUR SIGNATURE BELOW AUTHORIZES YOUR COMMERCIAL MORTGAGE BANKER OR ESCROW AGENT TO FILL IN SPACES YOU LEFT BLANK IN SPECIFIED LOAN DOCUMENTS YOU ARE ABOUT TO SIGN OR MAY HAVE ALREADY SIGNED. UNDER STATE LAW YOU CAN GIVE THIS AUTHORITY, BUT YOU ARE NOT REQUIRED TO DO SO. YOU CAN REFUSE TO SIGN ANY DOCUMENTS UNTIL ALL BLANKS ARE COMPLETELY FILLED IN.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-1910. Delay or Cause Delay

A commercial mortgage banker does not delay or cause delay if the delay occurs due to events outside the control of the commercial mortgage banker.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

R20-4-1911. Acquisition of Additional Interest in Licensee by Majority Owner

A person that owns 51% or more of a licensee's outstanding voting equity interests, and that acquires the power to vote additional fractional equity interests, shall deliver written notice of the acquisition to the Superintendent. The person shall deliver the notice before

completing the acquisition. Within 10 days after completing the acquisition, the person shall deliver documentation evidencing the acquisition to the Superintendent.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 2094, effective June 10, 1999 (Supp. 99-2).

TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE**CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA**

(Authority: A.R.S. § 23-101 et seq.)

20 A.A.C. 5, consisting of R20-5-101 through R20-5-164, R20-5-201 through R20-5-224, R20-5-301 through R20-5-318, R20-5-401 through R20-5-428, R20-5-501 through R20-5-512, R20-5-601 through R20-5-682, R20-5-801 through R20-5-829, R20-5-901 through R20-5-914, and R20-5-1001 through R20-5-1007 recodified from 4 A.A.C. 13, consisting of R4-13-101 through R4-13-164, R4-13-201 through R4-13-224, R4-13-301 through R4-13-318, R4-13-401 through R4-13-428, R4-13-501 through R4-13-512, R4-13-601 through R4-13-682, R4-13-801 through R4-13-829, R4-13-901 through R4-13-914, and R4-13-1001 through R4-13-1007, pursuant to R1-1-102 (Supp. 95-1).

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Article 2, consisting of Sections R4-13-201 through R4-13-222, adopted effective July 6, 1993 (Supp. 93-3).

Article 2, consisting of Sections R4-13-201 through R4-13-224, repealed effective July 6, 1993 (Supp. 93-3).

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- R20-5-201. Definition of Self-insurer
- R20-5-202. Self-insurance Application; Requirements
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- R20-5-316. Reissuance of Employment Agent License After Suspension under A.R.S. § 23-529(D)
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- R20-5-318. Form of Books, Registers and Records
- R20-5-319. Form and Requirements of Contracts
- R20-5-320. Bona Fide Job Order
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Industrial Commission of Arizona

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Appendix C. Sample Warning Tag (Nonmandatory)

R20-5-628. Safe Transportation of Compressed Air or Other Gases

R20-5-629. The Occupational Injury and Illness Recording and Reporting Requirements, 29 CFR 1904

R20-5-630. Repealed

R20-5-631. Repealed

R20-5-632. Repealed

R20-5-633. Repealed

R20-5-634. Repealed

R20-5-635. Repealed

R20-5-636. Repealed

R20-5-637. Repealed

R20-5-638. Repealed

R20-5-639. Repealed

R20-5-640. Repealed

R20-5-641. Repealed

R20-5-642. Repealed

R20-5-643. Repealed

R20-5-644. Repealed

R20-5-645. Repealed

R20-5-646. Emergency Expired

R20-5-647. Reserved

R20-5-648. Reserved

R20-5-649. Reserved

R20-5-650. Definitions

R20-5-651. Petitions for Amendments

R20-5-652. Effects of Variances

R20-5-653. Public Notice of a Granted Variance

R20-5-654. Form of Documents; Subscription; Copies

R20-5-655. Variances

R20-5-656. Variances under A.R.S. § 23-412

R20-5-657. Renewal of Rules or orders: Federal Multi-state Variances

R20-5-658. Action on Applications

R20-5-659. Request for Hearings on Petition

R20-5-660. Consolidation of Proceedings

R20-5-661. Notice of Hearing

R20-5-662. Manner of Service

R20-5-663. Industrial Commission; Powers and Duties

R20-5-664. Prehearing Conferences

R20-5-665. Consent Findings and Rules or Orders

R20-5-666. Discovery

R20-5-667. Hearings

R20-5-668. Decisions of the Commission

R20-5-669. Judicial Review

R20-5-670. Field Sanitation

R20-5-671. Reserved

R20-5-672. Reserved

R20-5-673. Reserved

R20-5-674. Emergency expired

R20-5-675. Reserved

R20-5-676. Reserved

R20-5-677. Reserved

R20-5-678. Reserved

R20-5-679. Reserved

R20-5-680. Protected Activity

R20-5-681. Elements of a Violation of A.R.S. § 23-425

R20-5-682. Procedure

ARTICLE 7. SELF-INSURANCE REQUIREMENTS FOR WORKERS' COMPENSATION POOLS ORGANIZED UNDER A.R.S. § 23-961.01

Article 7, consisting of new Sections R20-5-701 through R20-

5-739, adopted effective September 9, 1998 (Supp. 98-3).

Laws 1981, Ch. 149, effective January 1, 1982, provided for the transfer of the Office of Fire Marshal from the Industrial Commission to the Department of Emergency and Military Affairs, Division of Emergency Services (Supp. 82-2).

New Article 7 adopted effective July 13, 1989. (Supp. 89-3)

Article 7, consisting of Sections R4-13-701 through R4-13-708, transferred to the Department of Agriculture, Title 3, Chapter 8, Article 7, Sections R3-8-201 through R3-8-208, pursuant to Laws 1990, Ch. 374, Sec. 445 (Supp. 91-3). R20-5-701 through R20-5-708 recodified from R4-13-701 through R4-13-708 (Supp. 95-1).

Section

- R20-5-701. Definitions
- R20-5-702. Computation of Time
- R20-5-703. Forms Prescribed by the Commission
- R20-5-704. Requirement for Commission Approval to Act as Self-insurer
- R20-5-705. Duration of Certificate of Authority
- R20-5-706. Time-frames for Processing Initial and Renewal Application for Authority to Self-insure
- R20-5-707. Filing Requirements for Initial Application for Self-Insurance License
- R20-5-708. Filing Requirements for Renewal Application for Self-Insurance License
- R20-5-709. Combined Net Worth
- R20-5-710. Similar Industry Requirement
- R20-5-711. Joint and Several Liability of Members
- R20-5-712. Fidelity Policy
- R20-5-713. Guaranty Bond
- R20-5-714. Securities Deposited with the Arizona State Treasurer
- R20-5-715. Aggregate and Specific Excess Insurance Policies
- R20-5-716. Rates and Code Classifications; Penalty Rate
- R20-5-717. Gross Annual Premium of Pool; Calculation and Payment of Workers' Compensation Premiums; Discounts; Refunds
- R20-5-718. Financial Statements
- R20-5-719. Board of Trustees
- R20-5-720. Administrator; Prohibitions; Disclosure of Interest
- R20-5-721. Admission of Employers into an Existing Workers' Compensation Pool
- R20-5-722. Termination by a Member in a Pool; Cancellation of Membership by a Pool; Final Accounting
- R20-5-723. Trustee Fund; Loss Fund
- R20-5-724. Investment Activity of a Pool
- R20-5-725. Service Companies; Qualifications; Contracts; Transfer of Claims
- R20-5-726. Processing of Workers' Compensation Claims by a Pool
- R20-5-727. Loss Control and Underwriting Programs
- R20-5-728. Insufficient Assets or Funds of a Pool; Plans of Abatement; Notice of Bankruptcy
- R20-5-729. Arizona Office; Recordkeeping; Records Available for Review
- R20-5-730. Order for Additional Financial Information; Examination of Accounts and Records by Commission
- R20-5-731. Assignment of Claims Under A.R.S. § 23-966; Obligation of Member to Reimburse the Commission
- R20-5-732. Calculation and Payment of Taxes under A.R.S. § 23-961 and A.R.S. § 23-1065
- R20-5-733. Review of Initial and Renewal Applications for Authority to Self-insure by the Division
- R20-5-734. Decision by the Commission on Initial or Renewal Applications for Authority to Self-insure

- R20-5-735. Right to Request a Hearing
- R20-5-736. Hearing Rights and Procedures
- R20-5-737. Decision Upon Hearing by Commission
- R20-5-738. Request for Review
- R20-5-739. Revocation of Authority to Self-insure

ARTICLE 8. OCCUPATIONAL SAFETY AND HEALTH RULES OF PROCEDURE BEFORE THE INDUSTRIAL COMMISSION OF ARIZONA

Section

- R20-5-801. Notice of Rules
- R20-5-802. Location of Office and Office Hours
- R20-5-803. Definitions
- R20-5-804. Computation of Time
- R20-5-805. Record Address
- R20-5-806. Service and Notice
- R20-5-807. Consolidation
- R20-5-808. Severance
- R20-5-809. Election to Appear
- R20-5-810. Employee Representatives
- R20-5-811. Form of Pleadings
- R20-5-812. Caption; Titles of Cases
- R20-5-813. Requests for Hearing
- R20-5-814. Pre-hearing Conference
- R20-5-815. Payment of Witness Fees and Mileage
- R20-5-816. Notice of Hearing
- R20-5-817. Failure to Appear -- Withdrawal of Request for Hearing
- R20-5-818. Duties and Powers of Hearing Officers
- R20-5-819. Witnesses' Oral Deposition; In State
- R20-5-820. Witnesses' Oral Deposition; Out-of-State
- R20-5-821. Parties' Deposition upon Written Interrogatories
- R20-5-822. Refusal to Answer; Refusal to Attend
- R20-5-823. Burden of Proof
- R20-5-824. Intermediary Rulings or Orders by the Hearing Officer
- R20-5-825. Legal Memoranda
- R20-5-826. Decisions of Hearing Officers
- R20-5-827. Settlement
- R20-5-828. Special Circumstances; Waiver of Rules
- R20-5-829. Variances

ARTICLE 9. EXPIRED

Article 9, consisting of Sections R20-5-901 through R20-5-914, expired pursuant to A.R.S. § 41-1056(E), filed in the Office of the Secretary of State February 4, 2000 (Supp. 00-1).

Former Article 9 consisting of Sections R4-13-901 through R4-13-906 repealed effective May 27, 1977. R20-5-901 through R20-5-914 recodified from R4-13-901 through R4-13-914 (Supp. 95-1).

Article 9 consisting of Sections R4-13-901 through R4-13-914 adopted effective May 27, 1977.

Section

- R20-5-901. Expired
- R20-5-902. Expired
- R20-5-903. Expired
- R20-5-904. Expired
- R20-5-905. Expired
- R20-5-906. Expired
- R20-5-907. Expired
- R20-5-908. Expired
- R20-5-909. Expired
- R20-5-910. Expired
- R20-5-911. Expired
- R20-5-912. Expired
- R20-5-913. Expired

R20-5-914. Expired

ARTICLE 10. WAGE CLAIMS

Section

- R20-5-1001. Definitions
- R20-5-1002. Forms
- R20-5-1003. Filing Requirements; Time for Filing; Computation of Time
- R20-5-1004. Investigation of Claim
- R20-5-1005. Mediation of Disputes
- R20-5-1006. Dismissal of Claim
- R20-5-1007. Notice of Right of Review
- R20-5-1008. Payment of Claim
- R20-5-1009. Service of Determinations, Notices, and Other Documents

ARTICLE 11. SELF-INSURANCE FOR INDIVIDUAL EMPLOYERS

Article 11, consisting of Sections R20-5-1101 through R20-5-1136, made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1).

Section

- R20-5-1101. Definitions
- R20-5-1102. Computation of Time
- R20-5-1103. Forms
- R20-5-1104. Commission Approval to Act as Self-insurer
- R20-5-1105. Resolution of Authorization
- R20-5-1106. Time-frames
- R20-5-1107. Initial Application under A.R.S. § 23-961
- R20-5-1108. Self-insurance Renewal
- R20-5-1109. Security Deposit; Excess Insurance Policy
- R20-5-1110. Posting of Guaranty Bond; Bond Amount; Effective Date
- R20-5-1111. Posting of Other Bonds or Treasury Notes of the United States instead of Guaranty Bond; Registration; Deposit
- R20-5-1112. Letter of Credit or Local Government Investment Pool Funds (LGIP)
- R20-5-1113. Substitution of Securities
- R20-5-1114. Exemption from Requirement to Post Security
- R20-5-1115. Rating Plans Available for a Self-insurer
- R20-5-1116. Fixed-Premium Plan; Formula; Eligibility; Necessary Information for Plan
- R20-5-1117. Ex-medical Plan; Formula; Eligibility; Necessary Information for Plan
- R20-5-1118. Guaranteed-Cost Plan; Formula; Eligibility; Necessary Information for Plan
- R20-5-1119. Retrospective-Rating Plan; Formula; Eligibility; Necessary Information for Plan
- R20-5-1120. Completion of Reports in Support of Tax Rating Plan; Calculation and Payment of Taxes Owed by Self-insurer under A.R.S. §§ 23-961 and 23-1065
- R20-5-1121. Basis for Definitions, Classifications, Rating Procedures, and Plans
- R20-5-1122. Report, Book, Record, and Data Review by the Commission
- R20-5-1123. Audit and Cost of Audit
- R20-5-1124. Requirement to Provide Information to the Commission
- R20-5-1125. Notice to Commission of Location of Self-insurer's Claims Files
- R20-5-1126. Processing of Workers' Compensation Claims by a Self-insured Employer
- R20-5-1127. Review of Initial Application and Request for Renewal to Self-insure

R20-5-1128. Decision by the Commission on Initial Application or Request for Renewal of Authorization to Self-insure

- R20-5-1129. Right to Request a Hearing
- R20-5-1130. Hearing Rights and Procedures
- R20-5-1131. Decision Upon Hearing by the Commission
- R20-5-1132. Request for Review
- R20-5-1133. Revocation of Authorization to Self-insure
- R20-5-1134. Notice of Bankruptcy, Change in Ownership Status, or Change in Business Address
- R20-5-1135. Plan of Action for Retaining Self-insurance Authority in the Event of Insolvency or Bankruptcy
- R20-5-1136. Notice of Termination of Authorization to Self-insure by Self-insurer

ARTICLE 12. ARIZONA MINIMUM WAGE ACT PRACTICE AND PROCEDURE

Article 12, consisting of Sections R20-5-1201 through R20-5-1220, made by final rulemaking at 13 A.A.R. 4315, effective January 13, 2008 (Supp. 07-4).

Emergency renewed at 13 A.A.R. 2785, effective July 17, 2007 for 180 days (Supp. 07-3).

Article 12, consisting of Sections R20-5-1201 through R20-5-1220, made by emergency rulemaking at 13 A.A.R. 473, effective January 25, 2007 for 180 days (Supp. 07-1).

Section

- R20-5-1201. Notice of Rules
- R20-5-1202. Definitions
- R20-5-1203. Duty to Provide Current Address
- R20-5-1204. Forms Prescribed by the Department
- R20-5-1205. Determination of Employment Relationship
- R20-5-1206. Payment of Minimum Wage; Commissions; Tips
- R20-5-1207. Tip Credit Toward Minimum Wage
- R20-5-1208. Posting Requirements
- R20-5-1209. Records Availability
- R20-5-1210. General Recordkeeping Requirements
- R20-5-1211. Administrative Complaints
- R20-5-1212. Conduct that Hinders Investigation
- R20-5-1213. Findings and Order Issued by the Department
- R20-5-1214. Review of Department Findings and Order; Hearings; Issuance of Decision Upon Hearing
- R20-5-1215. Request for Rehearing or Review of Decision Upon Hearing
- R20-5-1216. Judicial Review of Decision Upon Hearing or Decision Upon Review
- R20-5-1217. Assessment of Civil Penalties Under A.R.S. § 23-364(F)
- R20-5-1218. Collection of Wages or Penalty Payments Owed
- R20-5-1219. Resolution of Disputes
- R20-5-1220. Small Employer Request for Exception to Record-keeping Requirements

ARTICLE 1. WORKERS' COMPENSATION PRACTICE AND PROCEDURE

R20-5-101. Application of the Article; Notice of Rules; Part of Record

- A. This Article applies to all actions and proceedings before the Commission resulting from:
 - 1. Injuries that occurred on or after January 1, 1969;
 - 2. Petitions to Reopen or Petitions for Readjustment or Rearrangement of Compensation filed on or after that date; and
 - 3. Requests for hearing under A.R.S. §§ 23-907(H), (I), and (J).

- B. This Article is part of the record in each action or proceeding without reference to the Article.
- C. The Commission deems all parties to have knowledge of this Article.
- D. The Commission shall provide a copy of this Article upon request to any person free of charge.

Historical Note

Former Rule 1. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-101 recodified from R4-13-101 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3). Amended by final rulemaking at 14 A.A.R. 4530, effective, December 2, 2008 (Supp. 08-4).

R20-5-102. Definitions

In this Article, unless the context otherwise requires:

“Act” means the Arizona Workers’ Compensation Act, A.R.S. Title 23, Ch. 6, Articles 1 through 11.

“Authorized representative” means an individual authorized by law to act on behalf of a party who files with the Commission a written instrument advising of the individual’s authority to act on behalf of the party.

“Carrier” or “insurance carrier” means the state compensation fund and every insurance carrier authorized by the Arizona Department of Insurance to underwrite workers’ compensation insurance in Arizona.

“Claimant” means an employee who files a claim for workers’ compensation.

“Filing” means actual receipt of a report, document, instrument, videotape, audiotape, or other written matter at a Commission office during office hours as set forth in R20-5-103.

“Physician” means a licensed physician or other licensed practitioner of the healing arts.

“Self-insured employer” means an employer or workers’ compensation pool granted authority by the Commission to self-insure for workers’ compensation.

“Uninsured employer” or “noncomplying employer” means an employer that is subject to and fails to comply with A.R.S. §§ 23-961 or 23-962.

“Working days” means all days except Saturdays, Sundays, and state legal holidays.

Historical Note

Former Rule 2. R20-5-102 recodified from R4-13-102 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-103. Location of Industrial Commission Offices and Office Hours

The main office of the Industrial Commission of Arizona is located in Phoenix, Arizona. An office is also located in Tucson, Arizona. The offices are open for business from 8:00 a.m. until 5:00 p.m. every day except Saturdays, Sundays, and state legal holidays.

Historical Note

Former Rule 3. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-103 recodified from R4-13-103 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-104. Address of Claimant and Uninsured Employer

- A. A claimant shall advise the Commission and carrier or self-insured employer of the claimant’s current mailing address and place of residence. If a claimant files a workers’ compensation claim against an uninsured employer, the claimant shall advise the special fund division of the claimant’s current mailing address and place of residence.
- B. An uninsured employer against whom a claimant files a workers’ compensation claim shall advise the special fund division of the uninsured employer’s current mailing address and place or places of residence.
- C. Providing the address of a claimant’s or uninsured employer’s attorney or authorized representative is not sufficient to meet the requirements of this Section.

Historical Note

Former Rule 4. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-104 recodified from R4-13-104 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-105. Filing Requirements; Time for Filing; Computation of Time; Response to Motion

- A. A report, document, instrument, videotape, audiotape, or other written matter required to be filed with the Commission under A.R.S. § 23-901 et seq. and this Article shall be filed at a Commission office within the time required by law and this Article.
- B. For purposes of computing time under this Article, the following applies:
 1. The Commission shall not include in the computation of time the day of the act or event from which the designated period begins to run.
 2. The Commission shall include in the computation of time the last day of the designated period, unless the last day is a Saturday, Sunday, or state legal holiday, in which event the period runs until the end of the next day that is not a Saturday, Sunday, or state legal holiday.
 3. If this Article or other law requires that a report, document, instrument, videotape, audiotape, or other written matter be filed within a designated period of time before hearing, the Commission shall not include the day of the act or event from which the designated period of time begins to run. The Commission shall include the last day of the designated period unless that day is a Saturday, Sunday, or state legal holiday, in which event the period runs to the end of the next day that is not a Saturday, Sunday, or state legal holiday.
 4. If the period of time prescribed is less than 11 days, the Commission shall not include intermediate Saturdays, Sundays, or state legal holidays in the computation of time.
- C. The Commission shall deem a report, document, instrument, videotape, audiotape, or other written matter filed at the Tucson office as filed at the main office for purposes of computing time.
- D. A person upon whom a motion to join is filed under this Article may file a response to the motion within 10 days after the motion is filed.
- E. The Commission shall not consider a discovery motion unless the moving party attaches a separate statement to the discovery motion certifying that after good faith efforts to do so, the moving party has been unable to satisfactorily resolve the matter giving rise to the discovery motion with the opposing party.

Historical Note

Former Rule 5. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-105 recodified

from R4-13-105 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-106. Commission Forms

A. The following forms shall be used when applicable:

1. Employer's report of industrial injury (form 101) shall contain:
 - a. Employee, employer, and carrier identification;
 - b. Description of employment;
 - c. Description of accident and injury;
 - d. Description of medical treatment received by employee;
 - e. Employee's wage data;
 - f. Date, signature, and title of employer or the employer's representative; and
 - g. Statement doubting the validity of the claim, if the employer doubts the validity of the claim.
2. The physician's portion of the worker's and physician's report of injury (form 102) shall contain:
 - a. Name and address of physician;
 - b. Information regarding preexisting conditions;
 - c. Information regarding the industrial injury, treatment, and prognosis;
 - d. Statement authorizing the attachment of a medical report that contains the information required in form 102; and
 - e. Physician's signature and date.
3. Notice of supportive medical benefits (form 103) shall contain:
 - a. Employee, employer, insurance carrier, and claim identification;
 - b. Description of authorized medical benefits;
 - c. Date the notice is mailed;
 - d. Name and telephone number of the individual issuing the notice; and
 - e. Statement regarding reopening and appeal rights including filing requirements.
4. Notice of claim status (form 104) shall contain:
 - a. Employee, employer, insurance carrier, and claim identification;
 - b. Status of the claim;
 - c. Date the notice is mailed;
 - d. Name and telephone number of the individual issuing the notice; and
 - e. Statement of a party's hearing and appeal rights including filing requirements.
5. Notice of suspension of benefits (form 105) shall contain:
 - a. Employee, employer, insurance carrier, and claim identification;
 - b. Effective date of the suspension;
 - c. Reasons for the suspension;
 - d. Date the notice is mailed;
 - e. Name and telephone number of the individual issuing the notice; and
 - f. Statement of a party's hearing and appeal rights including filing requirements.
6. Notice of permanent disability or death benefits (form 106) shall contain:
 - a. Employee, employer, insurance carrier, and claim identification;
 - b. Applicable statutory authority under which compensation is paid;
 - c. Disability and compensation information;
 - d. Date the notice is mailed;
 - e. Name and telephone number of the individual issuing the notice; and
 - f. Statement regarding hearing and appeal rights including filing requirements.
7. Notice of permanent disability and request for determination of benefits (form 107) shall contain:
 - a. Employee, employer, insurance carrier, and claim identification;
 - b. Type of disability;
 - c. Applicable statutory authority for designated disability;
 - d. Designation of dependents where death is involved;
 - e. Designation of advanced payments and amount of the advance;
 - f. Date the notice is mailed; and
 - g. Name and telephone number of the individual issuing the notice.
8. Carrier's recommended average monthly wage calculation (form 108) shall contain:
 - a. Employee, employer, insurance carrier, and claim identification;
 - b. Employment and wage history;
 - c. Designation of dependents; and
 - d. Carrier's calculations for the recommended average monthly wage and the basis for the calculation.
9. Notice of permanent compensation payment plan (form 111) shall contain:
 - a. Employee, employer, and carrier identification;
 - b. Amount of permanent compensation and description of payment plan;
 - c. Name of the responsible entity contracted by the carrier to administer the payment plan;
 - d. Statement that the carrier remains the responsible party for payment;
 - e. Statement regarding supportive care and reopening rights;
 - f. Date the notice is mailed; and
 - g. Name and telephone number of the individual issuing the notice.
10. Report of insurance coverage (form 0006) shall contain:
 - a. Name and address of the carrier;
 - b. Legal name of entity that the carrier insures;
 - c. All other insured names or subsidiary entities under which the carrier's insured does business in Arizona;
 - d. Address of all insured entities with insurance policy information for each address; and
 - e. Employer Identification Number (EIN), Taxpayer Identification Number (TIN), or Federal Identification Number (FIN) assigned to each insured person or entity.
11. Report of significant work exposure to bodily fluids or other infectious material shall contain:
 - a. The requirements set forth in A.R.S. §§ 23-1043.02(B), 23-1043.03(B), and 23-1043.04(B);
 - b. Employee identification,
 - c. Employer identification,
 - d. Source of exposure person identification (if known),
 - e. Details of the exposure including:
 - i. Date of exposure,
 - ii. Time of exposure,
 - iii. Place of exposure,
 - iv. How exposure occurred,
 - v. Type of bodily fluid or fluids,
 - vi. Source of bodily fluid or fluids,
 - vii. Part or parts of body exposed to bodily fluid or fluids,
 - viii. Presence of break or rupture in skin or mucous membrane, and

- ix. Witnesses (if known), and
 - f. Dated signature of employee or the employee's authorized representative.
- B.** The following forms may be used:
1. The workers' portion of the worker's and physician's report of injury (form 102) requests:
 - a. Employee, employer, insurance carrier, and physician identification;
 - b. Description of the accident, including date of injury; and
 - c. Date and signature of the employee or the employee's authorized representative.
 2. Worker's report of injury (form 407) requests:
 - a. Employee and employer identification,
 - b. Job title,
 - c. Employment description,
 - d. Employee's wage data,
 - e. Date of injury,
 - f. Accident and injury descriptions,
 - g. Medical treatment information,
 - h. Information concerning prior injuries of the employee,
 - i. Disability income, and
 - j. Date and signature of the employee or the employee's authorized representative.
 3. Worker's annual report of income (form 110-A) requests:
 - a. Employee, employer, insurance carrier, and claim identification;
 - b. Employment and wage history for the preceding 12 months;
 - c. Date and signature of the employee or the employee's authorized representative attesting to the truthfulness of the employment and wage information; and
 - d. Statement that failure to submit an annual report of income may result in a suspension of benefits by the carrier or self-insured employer.
 4. Notice of intent to suspend (form 110-B) requests:
 - a. Employee, employer, insurance carrier, and claim identification;
 - b. Employment and wage history for the preceding 12 months;
 - c. Date and signature of the employee or the employee's authorized representative attesting to the truthfulness of the employment and wage information;
 - d. Statement that failure to submit an annual report within 30 days of the date of the notice shall result in a suspension of benefits by the carrier or self-insured employer.
 5. Request for hearing requests:
 - a. Names of the employee, employer, and insurance carrier;
 - b. Claim identification;
 - c. Identification of the award, notice, order, or determination protested and reason(s) for the protest;
 - d. Estimated length of time for hearing and city or town in which hearing is requested;
 - e. Name and address of any witness for whom a subpoena is requested; and
 - f. Date and signature of party or the party's authorized representative.
 6. Petition to reopen requests:
 - a. Names of the employee, employer, and insurance carrier;
 - b. Claim identification;
 - c. Identification or description of the new, additional, or previously undiscovered temporary or permanent disability or medical condition justifying the reopening of the claim; and
 - d. Employee's medical and employment history.
 7. Petition for rearrangement or readjustment of compensation requests:
 - a. Names of the employee, employer, and insurance carrier;
 - b. Claim identification;
 - c. Income and employment history;
 - d. Medical history; and
 - e. Statement of the basis for the increase or decrease in earning capacity.
 8. Claim for dependent's benefits-fatality form requests:
 - a. Identification of dependent filing claim;
 - b. Identification of deceased;
 - c. Date of death;
 - d. Date of injury, if different than date of death;
 - e. Name and address of employer at time of deceased's death;
 - f. Statement of cause of death;
 - g. Names and addresses of health care providers rendering treatment to deceased in two years before death;
 - h. Conditions treated by health care providers in the two years before deceased's death;
 - i. If claim is for spousal benefits, the form requests:
 - i. Name, address, and date of birth of spouse;
 - ii. Copy of marriage certificate;
 - iii. Date and place of marriage to deceased;
 - iv. History of prior marriages of deceased and deceased's spouse, including copies of divorce decrees; and
 - v. Statement of living arrangements at time of deceased's death, including reason for living apart at time of death, if applicable;
 - j. If claim is for a dependent child, the form requests:
 - i. Name, date of birth, and address of child at time of deceased's death;
 - ii. List of children in care and custody of current spouse; and
 - iii. Statement of whether unborn child is expected and date expected;
 - k. If claim is for dependent other than a child, the form requests:
 - i. Name and address of other dependent,
 - ii. Relationship of other dependent to deceased, and
 - iii. Statement of the nature and extent of dependency; and
 - l. Date, telephone number, and signature of dependent or authorized representative of dependent.
 9. Request to leave the state form requests:
 - a. Employee, insurance carrier, and claim identification;
 - b. Reason for requesting to leave Arizona;
 - c. Dates leaving and returning to Arizona;
 - d. Out-of-state address;
 - e. Name and telephone number of attending physician; and
 - f. Date and signature of the employee or the employee's authorized representative.
 10. Request to change doctors form requests:
 - a. Employee, insurance carrier, and claim identification;

- b. Reason for requesting change of doctor;
 - c. Name and phone number of claimant's current doctor;
 - d. Name and phone number of doctor claimant requests to change to; and
 - e. Date and signature of the employee or the employee's authorized representative.
11. Complaint of bad faith and unfair claim processing practices requests:
- a. Employee, employer, and insurance carrier identification;
 - b. Description of the alleged bad faith or unfair claim processing practices;
 - c. Date of the complaint; and
 - d. Name, address, and telephone number of the person signing the complaint.
12. Certification of employer's drug and alcohol testing policy requests:
- a. Employer's certification as described under A.R.S. § 23-1021(F),
 - b. Name and federal identification number of the employer, and
 - c. Name of all subsidiaries and locations of the employer.
- C. Optional use of a form described in subsection (B) does not affect any requirement under the Act or this Article.
- D. Forms or format for the forms described in this Section are available from the Commission.
- E. Forms prescribed under this Section shall not be changed, amended, or otherwise altered without the prior written approval of the Commission.

Historical Note

Former Rule 6. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). Amended effective August 28, 1992 (Supp. 92-3). R20-5-106 recodified from R4-13-106 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3). Amended by final rulemaking at 15 A.A.R. 991, effective June 2, 2009 (Supp. 09-2).

R20-5-107. Manner of Completion of Forms and Documents

- A. An individual completing a form or document shall fill out the form or document legibly in ink or by typewriter.
- B. A party or a party's authorized representative shall sign any form or document that is required by the Act, this Article, or other law to be signed.
- C. Unless otherwise provided in this Article, if a party is required to sign a form or document, the Commission shall not accept a typewritten name or stamped signature.
- D. If, within the time period prescribed by law, a party files an incomplete form or document, or files an instrument other than a form or document when a form or document is required, the Commission shall serve notice to the party that the form or document fails to comply with this Section. The Commission deems the report or document timely filed if the party files a properly completed and signed form or document within 14 days after the Commission serves the notice described in this subsection.

Historical Note

Former Rule 7. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-107 recodified from R4-13-107 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-108. Confidentiality of a Commission Claims File; Reproduction and Inspection of a Commission Claims File

- A. Except as provided in this Section, a claims file maintained by the Commission is private and confidential and the Commission shall not make the claims file available for inspection and copying. For purposes of this Section, "claims file" means the official record maintained by the Commission for a claimant's industrial injury including the worker's report of injury, employer's report of injury, worker and physician's report of injury, and all other reports, records, instruments, videotapes, audiotapes, transcripts, and other matters scanned or otherwise placed into the file.
- B. Except as provided in subsections (D) and (E), the Commission shall make a Commission claims file relating to a current or prior claim of a claimant available for inspection and copying by any party to any proceeding currently or previously before the Commission involving the same claimant.
- C. Except as provided in subsections (D) and (E), the Commission shall not make a Commission claims file available to a non-party for inspection and copying unless the Commission receives a court order or written authorization signed by the affected claimant or the affected claimant's authorized representative.
- D. The Commission shall make a transcript contained in a Commission claims file available for inspection and copying if:
 - 1. The person requesting to inspect and copy the transcript is a person authorized under subsections (B) or (C); and
 - 2. The transcript concerns a hearing related to a claim that is not in litigation.
- E. The Commission shall make a transcript contained in a Commission claims file available only for inspection if:
 - 1. The person requesting to inspect and copy the transcript is a person authorized under subsections (B) or (C); and
 - 2. The transcript concerns a hearing related to a claim currently in litigation.
- F. The Commission shall provide copies at a charge of \$.25 per page.
- G. A Commission claims file shall not be removed from a Commission office unless in the custody of an authorized representative of the Commission.

Historical Note

Former Rule 8. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). Amended effective August 28, 1992 (Supp. 92-3). R20-5-108 recodified from R4-13-108 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-109. Admission into Evidence of Documents Contained in a Commission Claims File

- A. If a party or an administrative law judge considers a document contained in a Commission claims file, including a transcript of a prior proceeding, necessary or appropriate for hearing purposes, the administrative law judge shall receive a copy of the document into evidence if the document is otherwise admissible.
- B. With the permission of the administrative law judge, instead of submitting a copy of the document into evidence, a party may refer to the document's location on the Commission's optical disk imaging system by providing an accurate description of the document that includes the claimant's claim number and image document identification number the Commission assigns to the document.

Historical Note

Former Rule 9. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-109 recodified

from R4-13-109 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-110. Employer Duty to Report Fatality

If an employee dies as a result of an injury by accident arising out of and in the course of employment, the employer shall report the death to the Commission's claims division by telephone, telegram, or electronic filing, no later than the next business day following the death. The report shall state the name of the employee, when, how, and where the accident occurred, and the nature of the condition causing the accident. This Section does not limit or affect an employer's duty to report a death to the Arizona Occupational Safety and Health Division of the Commission as required under R20-5-637.

Historical Note

Former Rule 10. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-110 recodified from R4-13-110 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-111. Request for Autopsy

If a claim is filed for compensation for death from an industrial injury and an autopsy is requested, the expense of the autopsy shall be borne by the requesting party.

Historical Note

Former Rule 11. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-111 recodified from R4-13-111 (Supp. 95-1).

R20-5-112. Physician's Initial Report of Injury

- A.** A physician shall complete and file with the Commission a physician's initial report of injury under A.R.S. § 23-908(A) within eight days after first providing treatment to an injured worker. The physician shall report the injury:
 1. Using Commission form 102 (worker's and physician's report of injury), or
 2. Attaching to form 102 a medical report that contains the information required in form 102.
- B.** The physician shall sign and date form 102 or the medical report attached to form 102. The signature of the physician may be typewritten or stamped on this form.
- C.** If a claimant uses form 102 to initiate a claim, either the injured worker or the injured worker's authorized representative shall sign the worker's portion of form 102.

Historical Note

Former Rule 12. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). Amended effective August 28, 1992 (Supp. 92-3). R20-5-112 recodified from R4-13-112 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-113. Physician's Duty to Provide Signed Reports; Rating of Impairment of Function; Restriction Against Interruption or Suspension of Benefits; Change of Physician

- A.** If a claimant's disability extends beyond seven days, every physician who attends, treats, or examines the claimant shall provide to the insurance carrier, self-insured employer, or special fund division, at least once every 30 days while the claimant's disability continues, a personally signed report describing the:
 1. Claimant's condition,
 2. Nature of treatment,
 3. Expected duration of disability, and
 4. Claimant's prognosis.

- B.** When a physician discharges a claimant from treatment, the physician:

1. Shall determine whether the claimant has sustained any impairment of function resulting from the industrial injury. The physician should rate the percentage of impairment using the standards for the evaluation of permanent impairment as published by the most recent edition of the American Medical Association in Guides to the Evaluation of Permanent Impairment, if applicable; and
2. Shall provide a final signed report to the insurance carrier, self-insured employer, or special fund division that details the rating of impairment and the clinical findings that support the rating.

- C.** A carrier, self-insured employer, and special fund division shall not interrupt or suspend a claimant's temporary disability compensation benefits because a physician fails to comply with any requirement of subsection (A).

- D.** A carrier, self-insured employer, and special fund division may withhold payment to a physician for services rendered to a claimant until the physician complies with subsection (A).

- E.** Upon application of a party, the Commission shall authorize a change of physician if:

1. The Commission determines that the health, life, or recovery of a claimant is retarded, endangered, or impaired;
2. The attending physician agrees to the change or is unavailable to continue treatment;
3. The Commission determines that the relationship between the attending physician and claimant renders further progress or improvement unlikely;
4. The Commission determines that the claimant's recovery may be expedited by a change of physician or conditions of treatment; or
5. The insurance carrier agrees to the change.

- F.** Except as provided in A.R.S. § 23-1070 and this subsection, a claimant who is examined by a physician under A.R.S. § 23-908(E) is not required to obtain written authorization to change to another physician. If, however, the claimant continues to see, or treat with, a physician who the claimant initially saw or treated with under A.R.S. § 23-908(E), then that physician is an attending physician and the claimant shall obtain written authorization to change under A.R.S. § 23-1071(B) if the claimant seeks to change to another physician.

Historical Note

Former Rule 13. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-113 recodified from R4-13-113 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-114. Examination at Request of Commission, Carrier or Employer; Motion for Relief

- A.** If the Commission or a party requests an examination of a claimant by a physician, the party requesting the examination shall serve the claimant, or if represented, the claimant's attorney, with notice of the time, date, place, and physician conducting the examination at least 15 days before the scheduled date of the examination.
- B.** If a claimant unreasonably fails to attend or promptly advise of the claimant's inability to attend an examination under this Section, the party requesting the examination may charge the claimant or deduct from the claimant's entitlement to present or future temporary or permanent disability compensation, any reasonable expense of the missed appointment.

- C. A party adverse to a party who schedules a medical examination may offer into evidence the report of any medical examination as provided in R20-5-155 or within five days after the adverse party receives the report, subject to the right of cross-examination by the party who scheduled the examination.
- D. If a carrier, self-insured employer, or special fund division requests an examination of a claimant's mental or physical condition under A.R.S. § 23-1026, the carrier, self-insured employer, or special fund division shall immediately, upon receipt of the report of the examination, provide a copy of the report to the claimant or the claimant's authorized representative. If the mental condition of an unrepresented claimant is examined under A.R.S. § 23-1026, the carrier, self-insured employer, or special fund division may, in its discretion, provide the report to the claimant's treating physician rather than to the claimant.
- E. To protect a claimant from annoyance, embarrassment, oppression, or undue burden or expense, the Commission may order, upon good cause shown, one or both of the following:
 1. That the examination not be held; or
 2. That the examination may be conducted only on specified terms and conditions, including a designation of the time, place, and examining physician.
- F. A claimant requesting protection under subsection (E) shall file a motion with the presiding administrative law judge or chief administrative law judge if a judge has not been assigned to the case, within three days after the claimant receives notice of the examination. The claimant shall serve a copy of the motion on all parties. The party requesting the examination shall have three days after receiving the motion to file a response. The party shall serve the response on the claimant or, if represented, the claimant's attorney of record.

Historical Note

Former Rule 14. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-114 recodified from R4-13-114 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-115. Request to Leave the State

- A. The effective date of an order granting or denying a request to leave the state under A.R.S. § 23-1071(A) is the date a claimant files a request to leave the state with the Commission.
- B. For purposes of A.R.S. § 23-1071(A):
 1. "While the necessity of having medical treatment continues" means the period of time in which a claimant asserts an entitlement to temporary compensation, or active medical, surgical, or hospital benefits;
 2. "Leave the state" means to travel across the state border, except when the logical or nearest medical facility is situated across the state border; and
 3. "From the date the employee first requested the written approval" means from the date the claimant's request is filed with the Commission.

Historical Note

Former Rule 15. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-115 recodified from R4-13-115 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-116. Payment of Claimant's Travel Expenses When Directed to Report for Medical Examination or Treatment

- A. If a claimant is directed by a carrier, self-insured employer, or special fund division to report for a medical examination or

treatment in a locality other than either the claimant's current place of residence or employment, the carrier, self-insured employer, or special fund division shall pay, in advance, the claimant's travel expenses from either the claimant's current place of residence or employment, whichever route of travel is required.

- B. For purposes of this Section, "travel expenses" means those expenses required to be paid under A.R.S. § 23-1026.
- C. The carrier, self-insured employer, or special fund division shall calculate travel expenses using the current rates applicable to state employees.

Historical Note

Former Rule 16. Amended subsections (A) and (B) effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). Correction to subsection (A) as certified effective March 1, 1987 (Supp. 88-4). R20-5-116 recodified from R4-13-116 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-117. Medical, Surgical, Hospital, and Burial Expenses

- A. A carrier, self-insured employer, or special fund division, shall pay bills for medical, surgical, and hospital benefits provided under A.R.S. § 23-901 et seq. according to applicable medical and surgical fee schedules adopted by the Commission and in effect at the time the services are rendered. A physician or provider of nursing, hospital, drug or other medical services shall itemize and submit a bill for payment only to the responsible carrier, self-insured employer, or special fund division.
- B. A claimant shall not be responsible to pay any disputed amounts between the medical provider and the carrier, self-insured employer, or special fund division.
- C. If a claimant pays a bill described in subsection (A), the responsible carrier, self-insured employer, or special fund division shall reimburse the claimant the amount allowed by the fee schedules, provided that the claimant presents receipted vouchers or other proof of payment to support the claim for reimbursement.
- D. If an insured employer pays a bill described in subsection (A), the responsible carrier or self-insured employer shall reimburse the employer the amount allowed by the fee schedules, provided that the employer presents receipted vouchers or other proof of payment to support the claim for reimbursement.
- E. An insurance carrier, self-insured employer, or special fund division may pay any authorized burial expenses directly to the funeral service professional.
- F. If an employee's dependent pays burial expenses, the responsible carrier, self-insured employer, or special fund division shall reimburse the dependent the amount authorized by A.R.S. § 23-1046 provided that the dependent presents proof of payment to support the claim for reimbursement.
- G. If an insured employer pays burial expenses, the responsible carrier or self-insured employer shall reimburse the employer to the extent authorized by A.R.S. § 23-1046 provided that the employer presents proof of payment to support the claim for reimbursement.

Historical Note

Former Rule 17. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-117 recodified from R4-13-117 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-118. Effective Date of Notices of Claim Status and Other Determinations; Attachments to Notices of Claim Status; Form of Notices of Claim Status

- A. If a notice of claim status accepting a claim for benefits is final, any subsequent notice of claim status that changes a claimant's amount of, or entitlement to, compensation or medical, surgical, or hospital benefits shall not have a retroactive effect for more than 30 days from the date a carrier or self-insured employer issues the subsequent notice of claim status. This subsection does not apply to a subsequent notice that affects the entitlement to or amount of death benefits. The Commission may for good cause relieve a carrier or self-insured employer of the effect of this subsection.
- B. If a notice of claim status or other determination issued by a carrier, self-insured employer, or special fund division, is based upon a physician's report:
 - 1. The carrier or self-insured employer shall attach a copy of the physician's complete report to the notice of claim status or other determination sent to the Commission; and
 - 2. The carrier, self-insured employer, or special fund division shall attach a copy of the physician's complete report to the notice of claim status or other determination served on a party, except as provided in R20-5-114(D).
- C. If a carrier, self-insured employer, or special fund division pays compensation to a claimant:
 - 1. The carrier or self-insured employer shall close the claim by issuing a notice of claim status; and
 - 2. The special fund division shall close the claim by issuing a notice of determination.
- D. The inadvertent failure of a carrier, self-insured employer, or special fund division to comply with subsection (B) shall not affect the validity of a notice or determination if the carrier, self-insured employer, or special fund division issuing the notice or determination had in its possession at the time the notice or determination is issued a medical report consistent with the notice or determination.

Historical Note

Former Rule 18. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). Amended effective August 28, 1992 (Supp. 92-3). R20-5-118 recodified from R4-13-118 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-119. Notice of Third-party Settlement

- A. Except as otherwise provided by law, if an employer is insured for workers' compensation insurance and a claimant, or in the event of death, the claimant's dependent, elects to proceed against a third party, the claimant shall notify the appropriate workers' compensation carrier, or self-insured employer, of any settlement or judgment in the third party suit and the basis upon which the claimant and third party agree to disburse the proceeds of the settlement or judgment.
- B. If an employer is uninsured for workers' compensation insurance and a claimant, or in the event of death, the claimant's dependent, elects to proceed against a third party, the claimant shall notify the special fund division of any settlement or judgment in the third party suit and the basis upon which the claimant and third party agree to disburse the proceeds of the settlement or judgment.
- C. If a lawsuit is filed against a third party, the claimant or the claimant's attorney shall provide copies of pleadings and all offers of settlement to the workers' compensation carrier, self-insured employer, or special fund division to whom notice is required under subsections (A) and (B).

Historical Note

Former Rule 19. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-119 recodified from R4-13-119 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-120. Settlement Agreements, Compromises and Releases

- A. No settlement agreement, compromise, or waiver of rights of a workers' compensation claim, will be valid unless approved by the Commission.
- B. The acceptance of any payments or the signing of a settlement agreement, compromise, release or waiver of rights, unless approved by the Commission, shall not release the employer or his insurance carrier from any obligation imposed by the Workers' Compensation Law.
- C. The carrier or employer shall not be entitled to a credit for any sums paid to an employee under a settlement agreement which has not been approved by the Commission.

Historical Note

Former Rule 20. Amended subsections (A) and (B) effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-120 recodified from R4-13-120 (Supp. 95-1).

R20-5-121. Present Value and Basis of Calculation of Lump Sum Commutation Awards

- A. The Commission shall calculate the present value of an award that is commuted to a lump sum under R20-5-122. The Commission shall not include in the present value calculation compensation paid before the filing of a lump sum commutation petition. The Commission shall use the filing date of a lump sum commutation petition to compute the present value of an award.
- B. The Commission shall calculate the present value of an award at least annually, whether payable for a period of months or based upon the life of the employee, using the United States Life Tables, 2003, National Vital Statistics Reports, Vol. 54, Number 14, April 19, 2006, revised March 28, 2007, Table 1 incorporated by reference, and discounted at the rate established by the Commission. This incorporation does not include any later amendments or editions of the incorporated matter. A copy of this referenced material is available for review at the Commission and may be obtained from the U.S. Department of Health and Human Services, Centers for Disease Control. The rate established by the Commission is based on the following formula: The mean average of the three-month Treasury Bill rate on December 31 of each of the five years prior to July 1 of the current year. The rate, once calculated, is effective until the Commission calculates a new rate under this subsection. The discount rate is published in the minutes of the Commission meeting establishing the rate and is available upon request from the Commission.

Historical Note

Former Rule 21. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-121 recodified from R4-13-121 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3). Amended by final rulemaking at 10 A.A.R. 724, effective February 3, 2004 (Supp. 04-1). Amended by final rulemaking at 11 A.A.R. 2973, effective July 12, 2005 (Supp. 05-3). Amended by final rulemaking at 13 A.A.R. 4139, effective November 6, 2007 (Supp. 07-4).

R20-5-122. Lump Sum Commutation

- A. A petition for a lump sum commutation in an unscheduled case shall not be approved unless the carrier approves of such petition.
- B. If the lump sum commutation petition is approved by the carrier, the Commission's primary consideration in passing upon the petition will be whether more net income per month will be generated after receipt of the lump sum than the applicant is presently receiving. The granting of a lump sum petition will only be granted if the facts demonstrate a reasonable basis for financial betterment or rehabilitation of the claimant.
- C. The burden of proving that the commutation of compensation satisfies the criteria in (B) is on the applicant.

Historical Note

Former Rule 22. Amended subsections (A) and (B) effective March 1, 1987, filed February 26, 1987 (Supp. 87-1).
R20-5-122 recodified from R4-13-122 (Supp. 95-1).

R20-5-123. Rejection of the Act

If an employee serves upon an employer written notice under A.R.S. § 23-906, rejecting the provisions of the Act, the employer shall keep one copy of the rejection in the employer's business records.

Historical Note

Former Rule 23. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-123 recodified from R4-13-123 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-124. Rejection Not Applicable to New Employment

- A. An election by an employee to reject the Act is not binding upon the employee in a new employment by another employer or following re-employment by the same employer.
- B. If an employee is continuously employed and the employer changes workers' compensation insurance carriers, or form of doing business, the prior rejection is valid and remains in full force and effect.

Historical Note

Former Rule 24. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-124 recodified from R4-13-124 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-125. Rejection Before an Employer Complies with A.R.S. §§ 23-961(A) and 23-906(D)

An employee's rejection of the Act received by an employer before the employer complies with the requirements of A.R.S. §§ 23-961(A) or 23-906(D) is valid and continues in full force and effect whether the employer subsequently obtains workers' compensation coverage under A.R.S. § 23-961(A), posts the notice required under A.R.S. § 23-906(D), or makes available the forms required under A.R.S. § 23-906(D).

Historical Note

Former Rule 25. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-125 recodified from R4-13-125 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-126. Revocation of Rejection

- A. An employee who rejects the Act may revoke that rejection by serving upon the employee's employer an original and one copy of a written notice of revocation. The written revocation

shall state that the employee revokes the employee's prior rejection of the Act.

- B. Within five days after receiving a written notice of revocation, an insured employer shall file with the employer's carrier, or workers' compensation pool, a copy of the notice of revocation. The employee has all rights to compensation and benefits provided by the Act for any injury that occurs after the employee serves the revocation notice upon the employer.

Historical Note

Former Rule 26. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-126 recodified from R4-13-126 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-127. Insurance Carrier Notification to Commission of Coverage

- A. Every insurance carrier authorized to underwrite workers' compensation insurance in Arizona shall, within five days after undertaking to insure an employer, report that information to the Commission. The carrier shall provide the information on or in the same format as Commission form 0006. Form 0006 is available upon request from the Commission.
- B. Failure to comply with this Section does not affect the validity of coverage.

Historical Note

Former Rule 27. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). Amended effective August 28, 1992 (Supp. 92-3). R20-5-127 recodified from R4-13-127 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-128. Medical Information Reproduction Cost Limitation; Definition of Medical Information

- A. A health care provider shall not charge more than \$.25 per page plus \$10 per hour in associated clerical costs for reproduction of medical information when a party, an authorized representative of a party, or an entity that is authorized by a claimant in a workers' compensation matter makes a request for that information under A.R.S. § 23-908(C).
- B. This Section applies to all A.R.S. § 23-908(B) health care providers providing medical services to injured claimants including health care providers that contract with copying services, recordkeeping services, or other similar services for the reproduction of medical information. For purposes of this Section, fees for reproduction of medical information charged by these services are considered the same as if the reproduction fees are charged by a health care provider.
- C. For purposes of this Section, "medical information" means:
 - 1. A communication recorded in any form or medium and maintained for the purpose of patient care, diagnosis, or treatment, including a report, note, order, test result, photograph, videotape, X-ray, and billing record;
 - 2. A report of an independent medical examination that describes patient care or treatment;
 - 3. A psychological record;
 - 4. A medical record held by a health care provider including a medical record prepared by another provider; and
 - 5. A recorded communication between emergency medical personnel and medical personnel concerning the care or treatment of a person.
- D. For purposes of this Section, "medical information" does not include:
 - 1. Materials that are prepared in connection with utilization review, peer review, or quality assurance activities,

- including records that a health care provider prepares under A.R.S. §§ 36-441, 36-445 or 36-2402; and
2. Recorded telephone and radio calls to and from a publicly operated emergency dispatch office relating to requests for emergency services or reports of suspected criminal activity.

Historical Note

Former Rule 28. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-128 recodified from R4-13-128 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-129. Carrier or Workers' Compensation Pool Determinations Binding upon its Insured or Member; Self-Rater Exception

- A. The Commission deems an insurance carrier or workers' compensation pool the agent of an employer insured by the carrier or workers' compensation pool.
- B. The Commission also deems any action or determination taken or made by the insurance carrier or workers' compensation pool binding upon the employer. The employer may not protest or petition the Commission for relief concerning an action or determination taken by the employer's insurance carrier or workers' compensation pool unless the employer notifies the carrier or workers' compensation pool, and the Commission in writing that the employer disagrees with the carrier's or worker's compensation pool's action or determination within the time described in A.R.S. § 23-947.
- C. This Section does not apply to employers insured under a Self-Rating Insurance Plan.

Historical Note

Former Rule 29. Amended subsection (A) effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-129 recodified from R4-13-129 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-130. Claims Office Location and Function; Requirements of Maintaining an Out-of-State Claims Office

- A. Except as provided in subsection (B), each carrier that has or is underwriting workers' compensation insurance in Arizona, and each employer and workers' compensation pool that has been granted authority to act as a self-insurer by the Commission, shall maintain a workers' compensation claims office in Arizona. A carrier, self-insured employer, and self-insured workers' compensation pool shall process and pay workers' compensation claims and maintain the workers' compensation claims files described in R20-5-131 in its Arizona office. A carrier, self-insured employer, and self-insured workers' compensation pool shall notify the claims division of the Commission of the address of the Arizona claims office.
- B. Except as provided in subsections (C) and (D), a carrier or self-insured employer may request authorization from the Commission to maintain an out-of-state claims office. The Commission shall grant a carrier or self-insured employer authorization to maintain an out-of-state claims office no later than 20 days after the carrier or self-insured employer provides satisfactory evidence of the following:
 1. Existence of a toll-free telephone line to the out-of-state claims office;
 2. Completion of Commission claims division's training by the individuals responsible for claims processing at the out-of-state office; and

3. Designation of a financial institution located in Arizona that will cash on demand checks issued by the out-of-state claims office.
- C. The Commission shall not permit a self-insured workers' compensation pool to maintain a claims office out-of-state.
- D. The Commission shall rescind its authorization to maintain an out-of-state claims office if a carrier or self-insured employer no longer meets the requirements of subsection (B) or fails to process and pay claims as required under the Act and this Article.
- E. A carrier or self-insured employer maintaining an out-of-state claims office shall print the carrier's or self-insured employer's toll-free telephone number to the out-of-state claims office on all notices of claim status or other determinations issued by the out-of-state claims office. Failure to print the toll-free telephone number on a notice or other determination as required by this subsection does not affect the validity of the notice or determination.
- F. For claims processing purposes, a carrier, self-insured employer, or self-insured workers' compensation pool may have more than one designated representative provided the carrier, self-insured employer, or self-insured workers' compensation pool:
 1. Notifies the Commission at the time an insurance policy is issued or authorization to self-insure is granted; and
 2. Notifies the Commission each time that the insurance policy or authorization to self-insure is renewed.

Historical Note

Former Rule 30. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-130 recodified from R4-13-130 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-131. Maintenance of Carrier and Self-insured Employer Claims Files; Contents; Inspection and Copying; Exchange of Medical Reports; Authorization to Obtain Medical Records

- A. A carrier and self-insured employer shall maintain a workers' compensation claims file for each claimant. A carrier and self-insured employer shall include in a workers' compensation claims file all employer's reports, medical and hospital reports, awards, orders, notices of claims status, wage data, and all other items affecting the claim required by law to be maintained by a carrier or self-insured employer.
- B. Subject to subsection (C), all parties, authorized representatives of parties, and authorized representatives of the Commission may inspect and copy items contained in a carrier's or self-insured employer's claims file within five days from the date the item is filed in the claims file.
- C. If a carrier or self-insured employer maintains a claims file at an out-of-state claims office, the carrier or self-insured employer shall make the claims file available for copying and inspection to the persons listed in subsection (B) within 10 days after receiving a request for the file at a location in Arizona designated by the carrier or self-insured employer.
- D. A carrier or self-insured employer shall furnish copies of a claims file within 10 days after receiving a request from any party, authorized representative of a party, and authorized representative of the Commission at a charge not to exceed \$.25 per page. A carrier or self-insured employer may require prepayment of the copying charges if the requester or authorized representative has an account with the carrier or self-insured employer that is more than 30 days overdue.
- E. A carrier or self-insured employer is not required to maintain a claims file, or produce for inspection and copying:

1. Documents or matters representing the work product of the carrier or self-insured employer;
 2. Documents or matters representing the work product of a carrier's or self-insured's attorney; or
 3. Investigation and rehabilitation reports.
- F. All medical records concerning a claimant's mental or physical condition that are in a party's possession shall be furnished, upon request, to another party in the same Commission proceeding.
- G. Within 10 days of a request, a claimant shall provide to a party in a Commission proceeding involving the claimant, a release of information authorizing any attending, treating, or examining physician to provide records described in A.R.S. § 23-908(C).

Historical Note

Former Rule 31. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-131 recodified from R4-13-131 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-132. Parties' Notice to Commission of Intention to Impose Liability upon A.R.S. § 23-1065 Special Fund

If the notices required by A.R.S. § 23-1065 are not given to the Commission, the Commission shall not be bound by the testimony and evidence presented at a hearing as it relates to the imposition of liability upon the special fund.

Historical Note

Former Rule 32. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-132 recodified from R4-13-132 (Supp. 95-1).

R20-5-133. Claimant's Petition to Reopen Claim

- A. A petition to reopen filed with the Commission under A.R.S. § 23-1061(H) shall be in writing, signed, and dated by the claimant or the claimant's authorized representative. A petition to reopen form is available from the Commission upon request.
- B. A claimant shall provide to the Commission a copy of a medical report supporting the disability or condition justifying the reopening of the claim.
- C. If the Commission does not receive the medical report described in subsection (B) within 14 days of receipt of a petition to reopen, the Commission shall notify all parties, in writing, that it has received a petition to reopen without the required medical report. A carrier or self-insured employer is not required to act on a petition to reopen that is received without the required medical report.
- D. If the Commission receives a medical report in support of a petition to reopen and a claimant does not file a petition to reopen within 14 days of receipt of the medical report, the Commission shall forward the medical report to the carrier or self-insured employer for information purposes only. A carrier or self-insured employer is not required to take any action upon receipt of the medical report.
- E. If the Commission receives a medical report in support of a petition to reopen from an out-of-state physician and a party objects to the report at least 20 days before a scheduled hearing, the Commission shall not consider the report or place the report in evidence unless the party submitting the report produces the author of the report for cross-examination either at the hearing or at a deposition. The party submitting into evidence the medical report prepared by an out-of-state physician shall pay the expenses of a deposition under this subsection.

Historical Note

Former Rule 33. Amended subsections (A), (C), (D) and (E) effective March 1, 1987, filed February 26, 1987

(Supp. 87-1). Amended effective August 28, 1992 (Supp. 92-3). R20-5-133 recodified from R4-13-133 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-134. Petition for Rearrangement or Readjustment of Compensation Based Upon Increase or Reduction of Earning Capacity

- A. A petition for rearrangement or readjustment of compensation filed with the Commission under A.R.S. § 23-1044(F) shall be in writing. A form is available from the Commission upon request.
- B. A party or a party's authorized representative shall sign a petition for rearrangement or readjustment and include in the petition:
 1. A statement of the basis upon which the rearrangement or readjustment of compensation is sought, and
 2. Documentation in support of the petition.
- C. The petition shall be signed by the employee or the employee's authorized representative, the employer, or, in the case of an insurance carrier, by its authorized representative, and shall include a statement of the basis upon which the rearrangement of compensation is sought accompanied by supportive documentary evidence.
- D. If a self-insured employer, carrier, special fund division, or uninsured employer requests a hearing protesting the Commission's determination under A.R.S. § 23-1044(F) and the claimant resides outside of Arizona, the Commission may order the self-insured employer, carrier, special fund division, or uninsured employer to pay the claimant's transportation and living expenses to attend any scheduled hearing.

Historical Note

Former Rule 34. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). Amended effective August 28, 1992 (Supp. 92-3). R20-5-134 recodified from R4-13-134 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-135. Requests for Hearing; Form

- A. Any interested party or the party's authorized representative, except as otherwise provided by law or this Article, may request a hearing on a claim. A request for hearing shall be in writing.
- B. A Request for Hearing form is available upon request from the Commission and requests the following:
 1. Employee, employer, insurance carrier, authorized representative, and claim identification;
 2. Issue upon which the request for hearing is filed;
 3. Requests for subpoenas of witnesses;
 4. Desired location and length of time for the hearing;
 5. Signature and address of requesting party.

Historical Note

Former Rule 35. Amended subsections (A) and (B) effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). Amended effective August 28, 1992 (Supp. 92-3). R20-5-135 recodified from R4-13-135 (Supp. 95-1).

R20-5-136. Time Within Which Requests for Hearing Shall be Filed

All requests for hearing shall be filed with the Commission as required under A.R.S. § 23-947 or other applicable law.

Historical Note

Former Rule 36. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-136 recodified from R4-13-136 (Supp. 95-1). Amended by final

rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-137. Service of a Request for Hearing

A party filing a request for hearing shall serve a copy of the party's request for hearing upon all other parties at the same time that the party files the request for hearing with the Commission. The failure to serve a copy of a request for hearing upon other parties does not affect the validity of the hearing request.

Historical Note

Former Rule 37. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-137 recodified from R4-13-137 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-138. Hearing Calendar and Assignment to Administrative Law Judge; Notification of Hearing

- A. The chief administrative law judge shall maintain a hearing calendar. The chief administrative law judge shall ensure that a request for hearing filed in accordance with this Article is:
 1. Placed on the hearing calendar, and
 2. Assigned to an administrative law judge who is designated as the presiding administrative law judge.
- B. A presiding administrative law judge may hold a hearing at an earlier date than required under A.R.S. § 23-941(D), if all parties to the proceeding agree.

Historical Note

Former Rule 38. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-138 recodified from R4-13-138 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-139. Administrative Resolution of Issues by Stipulation Before Filing a Request for Hearing

- A. At any time before the filing of a request for hearing, parties may resolve issues by written stipulation. The parties shall file the stipulation with the Commission for approval or other action as may be appropriate.
- B. If the Commission determines that a written stipulation is reasonably supported by the facts, the Commission may approve the stipulation or enter an appropriate award without a request for hearing or hearing.

Historical Note

Former Rule 39. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-139 recodified from R4-13-139 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-140. Informal Conferences

- A. A presiding administrative law judge may hold an informal conference to:
 1. Resolve and dispose of disputed issues;
 2. Narrow or limit the scope of the issues to be considered at a subsequent hearing;
 3. Simplify the method of proof at a hearing; or
 4. Eliminate the need for hearing if the facts appear to be uncontested.
- B. A party may request that a pending hearing be disposed of by an informal conference, by filing a written request that:
 1. Specifies the purpose for the conference consistent with subsection (A), and
 2. Does not contain any argument regarding the merits of the case.

- C. If the presiding administrative law judge determines that an informal conference is appropriate, the judge shall give notice to the parties of the time and place of the conference. The presiding administrative law judge may, without a request from a party, schedule an informal conference by giving five days notice to the parties of the time, place, and subject matter of the informal conference. The parties may waive the five day notice requirement of this subsection.
- D. If a presiding administrative law judge disposes of issues in controversy at an informal conference, the presiding administrative law judge may enter an award without convening a hearing.
- E. If a presiding administrative law judge disposes of, narrows, or limits some, but not all issues in controversy, the presiding administrative law judge shall prepare and mail to the parties a statement setting forth the issues to be resolved at a hearing. The presiding administrative law judge shall limit the hearing to the issues contained in the statement unless at the hearing all parties and, the presiding administrative law judge agree that the judge may consider issues beyond the scope of the statement.
- F. Upon request by a party or upon a presiding administrative law judge's own motion, the presiding administrative law judge may order the parties to file a joint statement listing the disputed issues to be considered at formal hearing. The presiding administrative law judge shall give the parties at least 10 days to file the statement and shall order the parties to file the statement three to 10 days before the first scheduled hearing.

Historical Note

Former Rule 40. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-140 recodified from R4-13-140 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-141. Subpoena Requests for Witnesses; Objection to Documents or Reports Prepared by Out-of-State Witness

- A. Subpoena requests for witnesses.
 1. Subpoena request for non-medical witness. A party may request a presiding administrative law judge to issue a subpoena to compel the appearance of a non-medical witness by filing a written request with the presiding administrative law judge at least 10 days before the date of the first scheduled hearing.
 2. Subpoena request for expert medical witness. A party may request a presiding administrative law judge to issue a subpoena to compel the appearance of an expert medical witness by filing a written request with the presiding administrative law judge at least 20 days before the date of the first scheduled hearing.
 3. Statement of expected testimony. In the discretion of the presiding administrative law judge, the judge may order the party requesting a subpoena to file within five days of the order a written statement summarizing the substance of the testimony expected of the witness.
 4. Issuance of Subpoena. A presiding administrative law judge shall issue a subpoena requested under this Section if the judge determines that the testimony of the witness is material and necessary and, if applicable:
 - a. The party files a timely statement under subsection (A)(3); or
 - b. The party shows at or before the first scheduled hearing that good cause exists for the party's failure to respond timely to the judge's order under subsection (A)(3).

5. Service of a subpoena. The Commission may serve a subpoena by mail unless the party requesting the subpoena requests personal service. If a party requests personal service of a subpoena, the Commission shall prepare the subpoena and the party requesting personal service shall:
 - a. Ensure that the subpoena is served in the same manner as in a civil action; and
 - b. Pay all expenses of the service.
- B. A presiding administrative law judge shall not grant a party a continued hearing because a subpoenaed witness fails to appear at hearing unless the party filed a timely request for subpoena as required by subsection (A). If a party timely requested a subpoena for a witness who fails to appear at a scheduled hearing, the presiding administrative law judge may grant a continued hearing if the party requesting the subpoena demonstrates that:
 1. The testimony of the witness is material and necessary, and
 2. Good cause is shown as to why the witness failed to appear.
- C. Witness Fees.
 1. If a non-medical witness requests a witness fee, the party requesting the subpoena shall pay the non-medical witness fees and mileage provided for witnesses in civil actions in the Superior Court. If more than one party subpoenas the same witness, the parties shall divide the witness fee equally.
 2. The Commission shall pay the witness fee to a medical witness under the Commission's medical fee schedule after the presiding administrative law judge approves the fee.
- D. Objection to an out-of-state physician's report.
 1. A presiding administrative law judge shall not consider or place into evidence a timely filed physician's report authored by a physician residing outside Arizona if a party files an objection to that report at least 20 days before the scheduled hearing, unless the party submitting the report produces the author for cross-examination either at the hearing or at a deposition.
 2. Nothing in R20-5-143(G) precludes a party from taking or submitting into evidence a deposition of a physician taken under this subsection.
 3. The party submitting into evidence a report of an out-of-state physician shall pay the expenses of a deposition taken under this subsection.
- E. Objection to document prepared by out-of-state non-medical witness.
 1. A presiding administrative law judge shall not consider or place into evidence a timely filed document prepared by a non-medical witness who resides outside Arizona if a party files an objection to that document at least seven days before the scheduled hearing unless the party submitting the document produces the author for cross-examination either at the hearing or at a deposition.
 2. Nothing in R20-5-143 precludes a party from taking or submitting into evidence a deposition within the time limits set by a presiding administrative law judge.
 3. The party submitting into evidence a document prepared by an out-of-state non-medical witness shall pay the expenses of a deposition taken under this subsection.
- F. If a presiding administrative law judge approves, the testimony of a party's out-of-state non-medical or expert medical witness may be taken telephonically.

Historical Note

Former Rule 41. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-141 recodified

from R4-13-141 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-142. In-State Oral Depositions

- A. A party may take the oral deposition of another party or a witness residing in Arizona by serving a Notice of Deposition by Oral Examination upon the deponent and every party at least 10 days before the date of the oral deposition and at least 40 days before the first scheduled hearing.
- B. A party may file with the presiding administrative law judge a written objection to the taking of an oral deposition within five days after service of the Notice of Deposition. If no request for hearing has been filed, a party shall file the written objection with the chief administrative law judge. The party objecting to the deposition shall:
 1. State the basis for objecting to the deposition; and
 2. Serve a copy of the party's objections on all parties.
- C. The oral deposition shall not commence until the presiding administrative law judge rules on the written objection. The presiding administrative law judge shall rule on the written objection to the taking of an oral deposition within seven days after a party files a written objection by:
 1. Ordering the deposition to proceed;
 2. Ordering the deposition not be taken; or
 3. Entering any other appropriate protective order.
- D. The party taking the deposition shall comply with the Arizona Rules of Civil Procedure governing the taking of depositions.
- E. The expense of any deposition shall be borne by the party taking the deposition but shall not include the expense of any other interested party.
- F. A presiding administrative law judge shall not cancel or continue a hearing because a party fails to take or complete a deposition under this Section.
- G. A deposition taken under this Section shall only be used to impeach a witness during a hearing, except that, in the exercise of discretion, the presiding administrative law judge may admit a deposition into evidence for another purpose if:
 1. The deponent is deceased at the time of the hearing, or
 2. All parties agree.
- H. A party may take a telephonic deposition under this Section either by agreement of the parties or by order of the presiding administrative law judge in the exercise of the judge's discretion.

Historical Note

Former Rule 42. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-142 recodified from R4-13-142 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-143. Out-of-State Oral Depositions

- A. A party shall obtain permission from a presiding administrative law judge before taking an out-of-state oral deposition of another party or a witness by filing a written request with the presiding administrative law judge that contains:
 1. The name and address of the party or witness to be deposed, and
 2. Each reason why the party's or witness' testimony is necessary.
- B. The party requesting permission to take the out-of-state deposition shall serve a copy of the request upon each party.
- C. If no objection to the request for permission to take the deposition is filed under subsection (D) the presiding administrative law judge shall, within seven days from the date of the request, grant or deny permission to take the deposition.

- D.** A party may file with the presiding administrative law judge a written objection to the taking of an out-of-state oral deposition within five days after being served with a request to take the out-of-state deposition. The party objecting to the out-of-state deposition shall:
1. State the basis for objecting to the deposition; and
 2. Serve a copy of the party's objections on each party.
- E.** The oral deposition shall not commence until the presiding administrative law judge rules on the written objection. The presiding administrative law judge shall rule on the written objection to the taking of an out-of-state oral deposition within seven days after a party files the written objection by:
1. Ordering the deposition to proceed,
 2. Ordering the deposition not be taken, or
 3. Entering any other appropriate protective order.
- F.** A party shall not take more than two depositions per hearing under this Section unless a presiding administrative law judge, upon a showing of good cause, approves the taking of additional depositions.
- G.** In the exercise of discretion, the presiding administrative law judge may admit into evidence a deposition taken under this Section if the transcript of the deposition is filed with the Commission at least five days before any scheduled hearing or as otherwise directed by the presiding administrative law judge. If the transcript of the deposition is not timely filed under this subsection, the administrative law judge shall not consider the deposition for any purpose unless the parties and the administrative law judge agree that the deposition may be considered.
- H.** Parties may take telephonic depositions under this Section either by agreement of the parties or by order of a presiding administrative law judge in the exercise of the administrative law judge's discretion.
- I.** A party taking a deposition taken under this Section shall comply with R20-5-142(A), (D), (E) and (F).

Historical Note

Former Rule 43. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-143 recodified from R4-13-143 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-144. Written Interrogatories

- A.** After a party files a request for hearing with the Commission, any party may serve written interrogatories upon another party. A party shall serve written interrogatories at least 40 days before the scheduled hearing.
- B.** A party shall not serve more than 25 interrogatories, including subsections.
- C.** A party shall serve answers to the interrogatories upon all parties within 10 days after service of the interrogatories. A party shall not file answers to the interrogatories with the Commission.
- D.** A presiding administrative law judge shall not cancel or continue a hearing because a party fails to answer interrogatories under this Section.
- E.** A party shall only use written interrogatories served under this Section to impeach a witness during a hearing, except that, in the exercise of discretion, the presiding administrative law judge may admit the interrogatory answers into evidence for another purpose if the party answering the interrogatories is deceased at the time of the scheduled hearing.

Historical Note

Former Rule 44. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-144 recodified from R4-13-144 (Supp. 95-1). Amended by final

rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-145. Refusal to Answer or Attend; Motion to Compel; Sanctions Imposed

- A.** If a party or deponent refuses to answer any question asked at a deposition under R20-5-142 or R20-5-143, the party asking the question shall either complete the deposition in other matters or adjourn the deposition. With notice to all persons affected by the deponent's refusal to answer a question, the party asking the question may apply to the presiding administrative law judge for an order compelling the deponent to answer the question.
- B.** If a party refuses to answer an interrogatory served under R20-5-144, the party serving the interrogatory may submit the interrogatory to the presiding administrative law judge and apply for an order compelling the answer.
- C.** If a presiding administrative law judge issues an order compelling an answer under subsection (A) or (B) and finds that a refusal to answer is without substantial justification, the presiding administrative law judge shall require the party or witness refusing to answer or the authorized representative advising that party or witness not to answer, or both of them, to pay to the party asking the question:
1. Reasonable attorney's fees incurred to obtain the order compelling the answer, and
 2. Reasonable expenses that will be incurred to obtain the requested answer.
- D.** If a presiding administrative law judge denies a motion to compel an answer under subsection (A) or (B), and finds that the motion was made without substantial justification, the presiding administrative law judge shall require the party filing the motion, or the parties' authorized representative advising that party to make the motion, or both of them, to pay to the party or witness refusing to answer, reasonable attorney's fees incurred in opposing the motion.
- E.** In addition to the sanctions authorized under R20-5-157, a presiding administrative law judge may, upon a party's motion, impose the following sanctions upon a party if the party, or an officer or managing agent of that party, willfully fails to appear for a deposition after being served with proper notice of the deposition, or fails to serve answers to interrogatories after proper service of the interrogatories:
1. Strike out all or any part of a document filed by the party;
 2. Dismiss the action or proceeding, or any part of the action or proceeding;
 3. Order the suspension or forfeiture of compensation; or
 4. Preclude the introduction of evidence.
- F.** The party filing a motion under subsections (A), (B), or (E) shall attach to the motion:
1. The statement required under R20-5-105(E) and
 2. A proposed order that includes the relief requested and a service page with the names and addresses of all parties served.

Historical Note

Former Rule 45. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-145 recodified from R4-13-145 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-146. Repealed

Historical Note

Former Rule 46. R20-5-146 recodified from R4-13-146 (Supp. 95-1). Section repealed by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17,

2001 (Supp. 01-3).

R20-5-147. Videotape Recordings and Motion Pictures

- A. A party proposing to offer a videotape recording or motion picture into evidence at a Commission hearing shall provide written notice to the Commission and all parties at least 40 days before the first scheduled hearing.
- B. If a party serves a written request to view a videotape recording or motion picture upon the party proposing to submit the videotape recording or motion picture into evidence, the party proposing to offer the videotape recording or motion picture into evidence shall provide the necessary facilities and equipment to allow the other party to view the videotape recording or motion picture no later than 25 days before the first scheduled hearing.
- C. A presiding administrative law judge may admit into evidence a videotape recording or motion picture if the videotape recording or motion picture:
 - 1. Is a reasonable and accurate representation of the scene, person, object, or action portrayed; and
 - 2. Will aid in the understanding of the issues before the presiding administrative law judge.
- D. The party submitting the videotape recording or motion picture into evidence shall ensure that commentary, interrogation, dialogue, or testimony are not a part of the videotape recording or motion picture.
- E. A presiding administrative law judge shall not cancel or continue a hearing because a party fails to view a videotape recording or motion picture as provided in this Section.
- F. This Section does not apply to:
 - 1. Videotape recordings or motion pictures obtained by surveillance, or
 - 2. Videotape recordings or motion pictures of medical procedures performed by a physician.

Historical Note

Former Rule 47. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-147 recodified from R4-13-147 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-148. Burden of Presentation of Evidence; Offer of Proof

- A. A party shall rest at the conclusion of the presentation of the party's evidence. If there is a dispute as to which party has the burden of proof, the presiding administrative law judge shall direct who has the burden of proof.
- B. If a presiding administrative law judge prohibits a witness from answering a question, the presiding administrative law judge shall permit an offer of proof in the form of an avowal or in writing.

Historical Note

Former Rule 48. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-148 recodified from R4-13-148 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-149. Presence of Claimant at Hearing; Notice of a Parties' Non-Appearance at Hearing; Assessment of Hearing Costs for Non-Appearance

- A. A claimant, whether or not represented by an attorney, shall appear personally at any hearing without the necessity of subpoena unless excused by the presiding administrative law judge.
- B. Subject to subsection (A), at least three days before a scheduled hearing a party shall notify the presiding administrative

law judge of any non-appearance by a party or party's authorized representative that requires the judge to cancel or reschedule the hearing.

- C. If a party fails to notify the presiding administrative law judge as required under subsection (B), the presiding administrative law judge may order the party or the party's authorized representative to reimburse the Commission for hearing expenses and costs incurred by the Commission including fees of expert medical witnesses and other witness fees.

Historical Note

Former Rule 49. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-149 recodified from R4-13-149 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-150. Joinder of a Party

- A. An administrative law judge may join as a party any person, firm, corporation, or other entity in favor of whom or against whom a right to relief may exist and over whom the Commission may acquire jurisdiction.
- B. Joinder may be made upon application of any party or upon the presiding administrative law judge's own motion.
- C. A party seeking to join another person, firm, corporation, or other entity shall file a motion requesting joinder with the presiding administrative law judge at least 30 days before hearing. The moving party shall serve a copy of the motion upon the person, firm, corporation, or other entity for whom joinder is requested, and upon all other parties.
- D. If the requirements of this Section are met, the presiding administrative law judge shall join as a party the person, firm, corporation, or other entity for whom joinder is requested and shall issue a notice advising the parties of the joinder.

Historical Note

Former Rule 50. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-150 recodified from R4-13-150 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-151. Special Appearance

Any party against whom a claim may exist under the Act, or against whom a contingent liability may exist under the Act, and over whom the Commission has not acquired jurisdiction, may enter a special appearance. A special appearance made under this Section does not invoke the jurisdiction of the Commission.

Historical Note

Former Rule 51. R20-5-151 recodified from R4-13-151 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-152. Resolution of Issues by Stipulation After the Filing of a Request for Hearing; Notice of Resolution; Assessment of Hearing Costs

- A. Subject to the requirement of subsection (D), parties may stipulate to any fact or issue after a party files a request for hearing. The stipulation may be in writing or made orally at the time of hearing.
- B. A stipulation is binding upon the parties unless a presiding administrative law judge or the Commission grants the parties permission to withdraw the stipulation.
- C. If a stipulation is not reasonably supported by the evidence, a presiding administrative law judge or the Commission, may set aside or refuse to accept the stipulation and proceed to determine the true facts.

- D. A party shall notify a presiding administrative law judge of any stipulation, compromise or settlement agreement, or withdrawal of a hearing request that makes a hearing unnecessary at least three days before a scheduled hearing.
- E. The presiding administrative law judge may order a party or parties to reimburse the Commission for hearing expenses and costs incurred by the Commission including fees of expert medical witnesses and other witness fees if a party fails to notify the presiding administrative law judge as required under subsection (D).

Historical Note

Former Rule 52. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-152 recodified from R4-13-152 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-153. Exclusion of Witnesses

Any party may request that all other witnesses except the parties be excluded from the hearing until called to testify. The presiding administrative law judge may, in the judge's discretion, grant or deny the request. If the request is granted, the presiding administrative law judge shall admonish each witness not to discuss the witness's testimony with anyone other than attorneys on the case.

Historical Note

Former Rule 53. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-153 recodified from R4-13-153 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-154. Correspondence to Administrative Law Judge

A person submitting correspondence, including subpoena requests, to an administrative law judge concerning a matter pending before the administrative law judge, shall contemporaneously serve a copy of the correspondence upon all other parties, or if represented, the parties' authorized representatives. The administrative law judge shall not consider correspondence or subpoena requests to be evidence except by agreement of all parties to the matter.

Historical Note

Former Rule 54. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-154 recodified from R4-13-154 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-155. Filing of Medical and Non-Medical Reports Into Evidence; Request for Subpoena to Cross-examine Author of Report Submitted into Evidence; Failure to Timely Request Subpoena for Author

- A. Except as provided in R20-5-114(C), a party filing a medical report or hospital record into evidence ("medical report") that is not already contained in the Commission's claims file, shall file the medical report with the presiding administrative law judge at least 25 days before the first scheduled hearing.
- B. A party filing into evidence a document, report, instrument, or other written matter not described in subsection (A) ("non-medical report") that is not already contained in the Commission's claims file, shall file the non-medical report with the presiding administrative law judge at least 15 days before the first scheduled hearing.
- C. The party filing a medical or non-medical report into evidence shall serve a copy of the report to all other parties.
- D. A presiding administrative law judge shall not receive into evidence any medical or non-medical report that is not filed as required under this Section. If the report has been placed in the

Commission's claims file, the presiding administrative law judge shall remove the report from the Commission's claims file and return the report to the filing party.

- E. The presiding administrative law judge may suspend the requirements of this Section;
 1. Upon a showing of good cause; or
 2. If the parties agree that the judge may accept the medical or non-medical report into evidence.
- F. The party filing a medical or non-medical report under this Section shall file a cover letter with the report stating:
 1. The party's identity;
 2. The reports filed; and
 3. Proof of service of the reports upon the other parties.
- G. A party seeking to cross-examine the author of any medical or non-medical report filed into evidence shall request a subpoena under R20-5-141.
- H. If a party fails to timely request a subpoena under this Section and R20-5-141, the party waives the right to cross-examine the author of any medical or non-medical report filed into evidence and the presiding administrative law judge shall admit the medical or non-medical report in evidence.

Historical Note

Former Rule 55. Amended subsections (A) and (D) effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-155 recodified from R4-13-155 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-156. Continuance of Hearing

- A. A party may request a continuance of a scheduled hearing. If a party shows good cause, a presiding administrative law judge may grant a request that a hearing be continued.
- B. If at the conclusion of a hearing a party seeks to continue the hearing to introduce additional evidence, the party shall state specifically and in detail:
 1. The nature and substance of the additional evidence,
 2. The names and addresses of additional witnesses, and
 3. The reason the party was unable to produce the evidence or witnesses at the hearing.
- C. A presiding administrative law judge may deny a request for a continuance under subsection (B) if the presiding administrative law judge determines that, with the exercise of due diligence, the evidence or testimony could have been produced or the evidence or testimony would be cumulative, immaterial, or unnecessary.
- D. A presiding administrative law judge may, on the judge's own motion, continue a hearing and order further examinations or investigations that the judge determines are warranted.
- E. If more than 40 days before the first scheduled hearing, a presiding administrative law judge reschedules the hearing discovery and filing deadlines under this Article shall be calculated with respect to the new hearing date.
- F. If less than 40 days before the first scheduled hearing, a presiding administrative law judge reschedules the hearing discovery and filing deadlines under this Article shall be calculated with respect to the original hearing date.

Historical Note

Former Rule 56. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-156 recodified from R4-13-156 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-157. Sanctions

- A. A presiding administrative law judge may impose the following sanctions against any party or authorized representative of

a party who fails to comply with this Article or fails to comply with an order of the presiding administrative law judge or Commission:

1. Dismissal of the party's request for hearing;
2. Refusal to permit the introduction of evidence by the party; or
3. Assessment of reasonable attorney's fees and costs against the sanctioned party or authorized representative of a party.

- B.** If a party shows good cause, a presiding administrative law judge or the Commission may relieve a party of sanctions imposed under subsection (A).

Historical Note

Former Rule 57. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-157 recodified from R4-13-157 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-158. Service of Awards and Other Matters

- A.** An award, decision, order, subpoena, notice, document, or other matter required by the Act, this Article, or other law to be served shall be made upon a party or, if represented, the party's authorized representative. Service upon the authorized representative is service upon the party.
- B.** Service may be made and is deemed complete by:
1. Depositing the document or matter in the United States mail, with postage prepaid, addressed to the party served at the address as shown by the records of the Commission; or
 2. Personal service in the same manner as a summons is served in a civil action.
- C.** Proof of service may be made by an affidavit or oral testimony of the person making such service.

Historical Note

Former Rule 58. Amended subsection (C) effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-158 recodified from R4-13-158 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-159. Record for Award or Decision on Review

A presiding administrative law judge's award or decision under A.R.S. § 23-942 or award or decision upon review under A.R.S. § 23-943 shall be based upon:

1. The record as it exists at the conclusion of the hearings, and
2. Any memoranda provided under A.R.S. § 23-943(E) or requested by the presiding administrative law judge.

Historical Note

Former Rule 59. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-159 recodified from R4-13-159 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-160. Application to Set Attorney Fees Under A.R.S. § 23-1069

- A.** For purposes of A.R.S. § 23-1069, "final disposition of a case" occurs when all compensation benefits have been released to a claimant.
- B.** A claimant or attorney filing an application for attorney's fees under A.R.S. § 23-1069 shall serve notice of the application to all parties, including if applicable, the insurance carrier, self-insured employer, or special fund division.

- C.** Upon the filing of an application, the attorney and claimant shall, provide information to the Commission to enable the Commission to award reasonable attorney's fees.
- D.** Attorney's fees awarded under this Section shall be set by the Commission, an administrative law judge, or other authorized representative of the Commission.

Historical Note

Former Rule 60. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-160 recodified from R4-13-160 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-161. Stipulations for Extensions of Time

Stipulations for extensions of time in which to file papers or briefs in the various courts shall be received and signed by the Chief Counsel or other members of the Legal Department.

Historical Note

Former Rule 61. R20-5-161 recodified from R4-13-161 (Supp. 95-1).

R20-5-162. Legal Division Participation

The chief counsel and other members of the legal staff of the Commission who participate in proceedings or matters under the Act and this Article do so on behalf of the Commission.

Historical Note

Former Rule 62. R20-5-162 recodified from R4-13-162 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-163. Bad Faith and Unfair Claim Processing Practices

- A.** For purposes of A.R.S. § 23-930, an employer, self-insured employer, insurance carrier, or claims processing representative commits "bad faith" if the employer, self-insured employer, insurance carrier, or claims processing representative:
1. Institutes a proceeding or interposes a defense that is not:
 - a. Well-grounded in fact;
 - b. Warranted by existing law; or
 - c. A good faith argument for the extension, modification, or reversal of existing law;
 2. Unreasonably delays:
 - a. Payment of benefits; or
 - b. Authorization for, or receipt of, medical benefits or treatment;
 3. Unreasonably underpays benefits;
 4. Unreasonably terminates benefits;
 5. Intentionally misleads a claimant as to applicable statutes of limitation, benefits, or remedies available to the claimant under the Act or under this Article; or
 6. Unreasonably interferes with or obstructs the claimant's right to choose the claimant's attending physician, except in cases involving a self-insured employer under A.R.S. § 23-1070.
- B.** For purposes of A.R.S. § 23-930, an employer, self-insured employer, insurance carrier, or claims processing representative commits "unfair claim processing practices" if the employer, self-insured employer, insurance carrier, or claims processing representative:
1. Unreasonably issues a notice of claim status without adequate supporting information in its possession or available to it;
 2. Unreasonably fails to acknowledge communications from the Commission, an unrepresented claimant, or a claimant's attorney with respect to a claim;

3. Fails to act reasonably and promptly upon communications from the Commission, an unrepresented claimant, or a claimant's attorney with respect to a claim;
 4. Directly advises a claimant not to consult or obtain the services of an attorney; or
 5. Communicates directly, for an improper purpose, with a claimant represented by an attorney.
- C.** A person alleging bad faith or unfair claim processing practices ("complainant") shall file a written complaint with the claims manager of the Commission. The complainant, or the complainant's authorized representative, shall sign the complaint.
- D.** The complaint shall describe the specific actions of the employer, self-insured employer, insurance carrier, or claims processing representative, that are alleged to constitute bad faith or unfair claim processing practices. A complaint form is available upon request from the Commission.
- E.** Upon receipt of a complaint under this subsection, the claims manager of the Commission shall serve the complaint upon all parties.
- F.** If the Commission acts on its own motion under A.R.S. § 23-930(A), the claims manager shall mail a notice of alleged bad faith or unfair claim processing practices to the claimant or the claimant's authorized representative and the:
1. Employer;
 2. Self-insured employer;
 3. Insurance carrier; or
 4. Claims processing representative.
- G.** The person or entity named in a complaint or notice served under A.R.S. § 23-930 and this Section shall file with the claims manager a written response to the complaint or notice, within 30 days after service by the Commission of the complaint or notice.
- H.** The person or entity filing a written response shall serve a copy of the response upon the complainant, or the complainant's authorized representative, if represented.
- I.** If the person or entity named in a complaint or notice served under A.R.S. § 23-930 and this Section fails to file a written response, the Commission shall consider the absence of a response a denial of the allegations of the complaint or notice.
- J.** Upon receipt of a written response, or upon the expiration of 30 days if no response is filed, the Commission shall enter an award as it deems, in its discretion, appropriate under A.R.S. §§ 23-930(B) or (C).

Historical Note

Adopted as an emergency effective February 1, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-1). Emergency expired. Amended and readopted as an emergency effective April 29, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-2). Readopted without change as an emergency effective August 1, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-3). Readopted without change as an emergency effective November 9, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Amended and readopted as an emergency effective July 11, 1989 (Supp. 89-3). Adopted as a permanent rule effective October 4, 1989 (Supp. 89-4). R20-5-163 recodified from R4-13-163 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-164. Human Immunodeficiency Virus, Hepatitis C, Methicillin-resistant *Staphylococcus Aureus*, Spinal Meningitis and Tuberculosis; Significant Exposure; Employee Notification; Reporting; Documentation; Forms

- A.** An employer subject to the Act shall notify its employees of the requirements of A.R.S. §§ 23-1043.02, 23-1043.03, and 23-1043.04 by posting the Commission notices titled "Work Exposure to Bodily Fluids" and "Work Exposure to methicillin-resistant *Staphylococcus Aureus* (MRSA), Spinal Meningitis, or Tuberculosis (TB)" in a conspicuous place immediately next to the "Notice to Employees" notice required under A.R.S. § 23-906(D).
- B.** Properly posted "Work Exposure to Bodily Fluids" and "Work Exposure to Methicillin-resistant *Staphylococcus Aureus* (MRSA), Spinal Meningitis, or Tuberculosis (TB)" notices constitute sufficient notice to employees of the requirements of a prima facie case under A.R.S. §§ 1043.02(B), 23-1043.03(B), and 23-1043.04(B).
- C.** An employer's insurance carrier, claims processor, or workers' compensation pool shall provide the notices specified in subsection (A) to the employer. These notices are also available from the Commission upon request.
- D.** An employer shall make readily available to its employees the Commission form described in R20-5-106 titled "Report of Significant Work Exposure to Bodily Fluids or Other Infectious Material." An employer's insurance carrier, claims processor, or workers' compensation pool shall provide the "Report of Significant Work Exposure to Bodily Fluids or Other Infectious Material" to the employer. This form is also available from the Commission upon request.
- E.** If an employee sustains a significant exposure as defined in A.R.S. §§ 23-1043.02(G), 23-1043.03(G), or 23-1043.04(H)(2), the employee shall complete, date, and sign a "Report of Significant Work Exposure to Bodily Fluids or Other Infectious Material" form. The employee or employee's authorized representative shall give to the employer the completed, dated, and signed form. The employer shall return one copy of the completed form to the employee or to the employee's authorized representative. Nothing in this subsection limits the requirements to report an injury or file a claim under the Act.
- F.** If an employee submits a written report of a significant exposure to an employer, but does not use the Commission form titled "Report of Significant Work Exposure to Bodily Fluids or Other Infectious Material," the employer shall provide the employee the Commission form within five calendar days after receiving the employee's initial written report.
- G.** The date of the receipt by the employer or its authorized representative of the employee's initial report is the date used to compute the time period prescribed in A.R.S. §§ 23-1043.02(B)(2), 23-1043.03(B)(2), and 23-1043.04(B)(2) if:
1. The initial report contains the information required in the "Report of Significant Work Exposure to Bodily Fluids or Other Infectious Material" form, or
 2. The employee gives to the employer the completed Commission form within 10 calendar days after the employee's receipt of the Commission form.
- H.** Failure or refusal by the employer to provide the Commission form to the employee shall not be a defense to a prima facie claim under A.R.S. §§ 23-1043.02(B), 23-1043.03(B), and 23-1043.04(B).
- I.** In investigating the circumstances and facts surrounding an employee's report to an employer of a significant exposure under A.R.S. §§ 23-1043.02(C), 23-1043.03(C), and 23-1043.04(C), the employer, or its carrier, or any employees, agents or contractors of either the employer or carrier, shall not

disclose to any person, except as authorized or required by law, that the reporting employee, or any witness or alleged source of exposure, may have or did contract the human immunodeficiency virus, acquired immune deficiency syndrome, hepatitis C, methicillin-resistant *Staphylococcus aureus*, spinal meningitis, or tuberculosis. However, an employer, its carrier or their respective attorneys, may:

1. Direct an agent to investigate the employee's report of significant exposure, and
2. Communicate with the investigating agent about the conduct and results of the investigation.

- J. As required under the federal Occupational Safety and Health Standard for Bloodborne Pathogens, 29 CFR 1910.1030, an employer shall pay for the testing required by A.R.S. § 23-1043.02.

Historical Note

Adopted effective April 9, 1992 (Supp. 92-2). R20-5-163 recodified from R4-13-163 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3). Amended by final rulemaking at 15 A.A.R. 991, effective June 2, 2009 (Supp. 09-2).

ARTICLE 2. SELF-INSURANCE REQUIREMENTS FOR INDIVIDUAL EMPLOYERS AND WORKERS' COMPENSATION POOLS ORGANIZED UNDER A.R.S. §§ 11-952.01(B) AND 41-621.01

R20-5-201. Definition of Self-insurer

"Self-insurer" or "self-insured" means an individual employer or a workers' compensation pool as defined in A.R.S. §§ 11-952.01(B) or 41-621.01(A) that is authorized by the Commission to self-insure for workers' compensation.

Historical Note

Former Rule I. Section repealed, new Section adopted effective July 6, 1993 (Supp. 93-3). R20-5-201 recodified from R4-13-201 (Supp. 95-1). Amended effective October 9, 1998 (Supp. 98-4).

R20-5-202. Self-insurance Application; Requirements

- A. All applicants who initially apply for self-insurance on or after the certification of the 1993 rule amendments by the Attorney General and filing of those amendments with the Secretary of State shall:

1. Complete, date, sign, and file with the Commission an application for authority to self-insure on a form that can be obtained from the Commission and contains the following information:
 - a. Applicant identification including names, addresses, corporation, subsidiary, and partnership information;
 - b. Nature of business;
 - c. History of business in Arizona and elsewhere;
 - d. Payroll data;
 - e. Work force data;
 - f. Insurance data;
 - g. Claims history;
 - h. Method proposed to finance self-insurance liability and reserves;
 - i. Program for compliance with occupational safety and health standards, rules, and laws of this state;
 - j. Program to finance medical, surgical, and hospital benefits including information on organization responsible for processing claims;
 - k. Names and addresses of Arizona agents upon whom legal notice of proceedings before the Commission is served;
 - l. Authorization for signator;

- m. Authorization by corporate resolution, or board of trustees resolution, if applicable; and
- n. Statement attesting to the truthfulness of the information in the application.

2. Maintain an office in Arizona. Payroll reports and other materials relating to the calculation of premiums shall be readily available at this office for inspection and audit by the Commission or its authorized representative.

3. In the first year of operation, obtain a guaranty bond and specific excess insurance or excess of loss insurance in an amount as provided in R20-5-206(D)(1) to adequately protect against catastrophic losses. Starting with the second year of operation, an individual self-insurer shall choose one of the two options provided in R20-5-206(D). The insurance shall contain:
 - a. A 60-day notice of termination; and
 - b. A provision that insolvency of the self-insurer does not relieve the excess insurer of liability assumed under the contract.

- B. An individual applicant for self-insurance that is not a member of a workers' compensation pool, in addition to complying with subsection (A) of this rule, shall:

1. Have been engaged in business in Arizona for at least five years prior to the date of application.
2. Provide an annual payroll in this state of at least \$2,000,000 (this payroll may include the combined payrolls of all subsidiary companies carried under the self-insurance authorization; the requirements of this subsection do not apply to political subdivisions of this state) and meet either of the following thresholds:
 - a. Total reported assets of at least \$50,000,000; or
 - b. Combination of \$10,000,000 in net worth and a cash flow ratio of .25.

3. Provide the Commission with an internally certified copy of the employer's audited or reviewed financial statements for the most current and prior two years. The Commission's review of the applicant's financial statements includes the following:
 - a. Calculation of the following ratios:
 - i. Cash Flow Ratio - Cash flow from operations divided by current liabilities which is an indication of the ability of the applicant to meet current obligations out of cash flow.
 - ii. Current Ratio - Current assets divided by current liabilities which indicate the applicant's ability to service current obligations.
 - iii. Debt Status Ratio - Net worth divided by total liabilities which indicate the proportion of funds supplied by the applicant relative to the funds supplied by creditors.
 - iv. Profitability Ratio - Profit before taxes, divided by total assets, multiplied by 100 which measures the return on assets and the efficiency of assets employed by the firm.
 - v. Quick Ratio - Cash and equivalents, plus trade receivables, divided by current liabilities which express the degree to which the applicant's liabilities are covered by the most liquid current assets.
 - vi. Working Capital Ratio - Working capital divided by sales which measures the sufficiency of working capital to support sales.
 - b. Comparison of the applicant's ratios with the ratios of existing self-insurers in the same or a closely related industry.
 - c. Review of notes to the financial statement.

- d. Review of management report of operation and other information published in the annual statement.
 4. Provide the Commission with the names of all other jurisdictions in which it has been granted authority to self-insure and the effective dates of such authorization.
 5. Provide the Commission with the names of all other jurisdictions in which its application to self-insure has been denied or its authority to self-insure has been suspended or revoked, and the dates and reasons for such denials, suspensions, or revocations.
- C.** In addition to the requirements of subsection (A), a workers' compensation pool applicant for self-insurance shall:
1. File with the application for self-insurance a completed indemnity agreement on a form that can be obtained from the Commission, signed by a duly authorized agent of the pool jointly and severally binding the pool and each of its members to comply with the provisions of A.R.S. Title 23, Chapter 6 and rules adopted pursuant to Chapter 6. The indemnity agreement shall contain the following information:
 - a. Name of the group, with names of trustees and members;
 - b. Amount of the corporate surety bond;
 - c. Name of the service agent of the group, including a description of the agent's duties and responsibilities; and
 - d. Statement that the group will defend and assume liabilities in the name of and on behalf of any member of the group.
 2. Provide a copy of the most recently audited financial report of the pool prepared by a certified public accountant, including a copy of the examination report prepared by the Department of Insurance and that Department's recommendations, if any.
 3. Provide the names and addresses of the members of the board of trustees of the pool.
 4. Provide the agreement indicating the terms and conditions of coverage within the pool including any exclusions of coverage.
 5. An intergovernmental agreement filed with the Commission pursuant to A.R.S. § 11-952.01(G)(7) shall contain the provisions of A.R.S. § 11-952.01(I).
2. Provide a continuation certificate for the guaranty bond or letter of credit signed by an authorized representative of the surety or bank. The amount of the bond, letter of credit, or securities shall equal the amount submitted on the Option Election form.
 3. Submit a copy of the most recent certified annual financial statement at least 30 days prior to the anniversary date of the authorization to self-insure. A parent company that has executed a guaranty for a subsidiary shall also submit a copy of its most recent certified annual financial statement within the same time period required by this subsection.
 4. Provide a Guaranty To Satisfy Compensation Claims Under Workers' Compensation Act in Arizona form as provided in R20-5-206(C) completed, signed, and dated by the parent company of a subsidiary self-insurer if the parent company of the self-insurer is different from the last filing approved by the Commission.
- B.** All workers' compensation pool applicants for self-insurance renewal authority shall:
1. Provide information to the Commission as required under subsections (A)(1), (2), and (3).
 2. Provide an updated indemnity agreement pursuant to R20-5-202(C)(2) for changes occurring since the last filing approved by the Commission.
- C.** All applicants for renewal shall continue to maintain an office in Arizona as described in R20-5-202(A)(2).
- D.** The Commission's analysis for renewal includes the following:
1. A review of the items required by R20-5-202(A).
 2. A review of the claims profile which includes a review of the preceding year's claims filed, claims denied, and denial rate. Denial rates in excess of 8% require additional analysis by the Commission's Claims Division to establish the reasons for the denials.
 3. A review of the self-insurer's financial profile which includes a review of the financial data as described in R20-5-202(B)(3).

Historical Note

Former Rule III. Section repealed, new Section adopted effective July 6, 1993 (Supp. 93-3). R20-5-203 recodified from R4-13-203 (Supp. 95-1).

R20-5-204. Denial of Authorization to Self-insure

If the Commission denies an application for authorization to self-insure for failure to comply with A.R.S. § 23-961(A)(2) or for failure to comply with the requirements of R20-5-202 or R20-5-203, the Commission shall issue an Order to the applicant refusing authorization to self-insure. An appeal of such denial may be made pursuant to A.R.S. § 23-945.

Historical Note

Former Rule IV. Section repealed, new Section adopted effective July 6, 1993 (Supp. 93-3). R20-5-204 recodified from R4-13-204 (Supp. 95-1).

R20-5-205. Resolution of Authorization

If the Commission grants authorization to self-insure, a Resolution of Authorization to Self-insure will be issued. The issuance of the Resolution shall be conditioned upon the deposit with the Commission, prior to the effective date stated in the Resolution, of the bonds or other securities specified by A.R.S. § 23-961(A)(2) and this Article.

Historical Note

Former Rule V. Section repealed, new Section adopted effective July 6, 1993 (Supp. 93-3). R20-5-205 recodified from R4-13-205 (Supp. 95-1).

Historical Note

Former Rule II. Section repealed, new Section adopted effective July 6, 1993 (Supp. 93-3). R20-5-202 recodified from R4-13-202 (Supp. 95-1).

R20-5-203. Self-insurance Renewal Application; Requirements

- A.** All individual applicants for self-insurance renewal authority shall:
1. Complete, date, sign, and file with the Commission an Option Election form that can be obtained from the Commission when providing a bond or other security as required by R20-5-206(D) for the payment of workers' compensation liabilities. The Option Election form shall list the following:
 - a. Total outstanding workers' compensation accrued liabilities for all previous periods of self-insurance;
 - b. Amount of future reserves;
 - c. Amount of calculated bond based on the amount of total estimated future liability x 125%.
- For those self-insurers complying with R20-5-206(D)(1), the self-insurer shall additionally provide a certificate of excess insurance.

R20-5-206. Posting of Guaranty Bond; Effective Date; Execution; Subsidiary Company Guaranty Bond; Parent Company Guaranty; Bond Amounts

- A. Any guaranty bond filed with the Commission shall bear the same effective date as the effective date of the Resolution of Authorization to Self-insure and shall be for a minimum of one year, subject to annual renewal.
- B. A guaranty bond shall be made by a company authorized and licensed to transact the business of fidelity and surety insurance in Arizona. The guaranty bond shall be executed by a duly authorized agent of the surety and be countersigned by a licensed resident agent. A bond form can be obtained from the Commission and contains the following information:
1. Applicant identification;
 2. Amount of the bond;
 3. Conditions of the bond obligations; and
 4. Statement regarding responsibility for fees and costs associated with collection of the bond and responsibility for payment of any award or judgment against the surety.
- C. For the Commission to issue a Resolution of Authorization to Self-insure to a subsidiary company, the parent company shall first execute a guaranty for the subsidiary on a form that can be obtained from the Commission. The parent company shall submit its most recent audited financial statement to the Commission for analysis to determine the ability of the parent company to meet its obligations under the guaranty and under A.R.S. § 23-961(A)(2). The guaranty shall state that the parent company agrees and guarantees on behalf of the subsidiary that any and all liabilities against the subsidiary, under or by virtue of the Workers' Compensation Laws of Arizona, shall be promptly and fully paid, and the subsidiary company has on deposit a guaranty bond or securities. The guaranty for a subsidiary company, and the Resolution of Authorization to Self-insure issued to such subsidiary company, shall be valid and effective only as long as the parent company has on file with the Commission a valid guaranty to satisfy compensation claims of the subsidiary. A parent company is one which owns sufficient stock in the subsidiary company to control the subsidiary and does not mean a company in which all or a majority of the stockholders are the same as in the subsidiary. The guaranty shall be accompanied by a verified certificate as to stock ownership of the subsidiary, a certified copy of the charter or articles of incorporation of the parent company and a certified copy of the resolution of the directors of the parent company authorizing a designated officer to execute the guaranty.
- D. In compliance with this Article and the Workers' Compensation Laws of Arizona, an individual self-insurer that is not a member of a workers' compensation pool shall post either:
1. A minimum \$250,000 guaranty bond and a specific excess reinsurance policy with a self-insured retention of \$250,000 and a policy limit of liability of not less than \$10,000,000.
 2. A guaranty bond equal to 125% of the total outstanding accrued liability as reflected in the Option Election form from the self-insurer to the Commission or a minimum guaranty bond in the amount of \$100,000, whichever is greater. The total outstanding accrued liabilities shall be determined by certification from the self-insurer for the Commission's approval.
- E. In compliance with this Article and the Workers' Compensation Laws of Arizona, a workers' compensation pool shall post a guaranty bond equal to 125% of the total outstanding accrued liability as reflected in the Option Election form from the self-insured pool to the Commission or a minimum guaranty bond in the amount of \$100,000, whichever is greater.

The total outstanding accrued liabilities shall be determined by certification from the self-insured pool for the Commission's approval.

Historical Note

Former Rule VI; Amended effective February 27, 1975 (Supp. 75-1). Section repealed, new Section adopted effective July 6, 1993 (Supp. 93-3). R20-5-206 recodified from R4-13-206 (Supp. 95-1).

R20-5-207. Posting of Securities in Lieu of Guaranty Bond; Registration; Deposit

- A. In lieu of posting a guaranty bond as provided in R20-5-206, the self-insurer may deposit with the Commission for transmittal to the State Treasurer bonds of the United States.
- B. Any securities deposited with the State Treasurer shall be registered to: "The Industrial Commission of Arizona, in trust for the fulfillment by ----- of its obligations under the Arizona Workers' Compensation Laws. The securities shall be held by the State Treasurer, as custodian subject to the order of, and in trust for, The Industrial Commission of Arizona, with the power in the Commission to collect or order collection of the principal as it becomes due, to sell or order the sale of these securities or any part of these securities, and to apply or order the application of the proceeds to the payment of any award rendered against the self-insurer in the event of the default in the payment of its obligations. The interest coupons on such securities shall be remitted by the Commission to the self-insurer upon request as they mature.
- C. The securities deposited in compliance with subsections (A) and (B) shall have a face value at maturity in the amount specified by the Commission.

Historical Note

Former Rule VII. Section repealed, new Section adopted effective July 6, 1993 (Supp. 93-3). R20-5-207 recodified from R4-13-207 (Supp. 95-1).

R20-5-208. Posting Other Securities

If the Commission accepts securities other than those specified in R20-5-207, including letters of credit, these securities shall be registered in the same manner as provided in R20-5-207.

Historical Note

Former Rule VIII. Section repealed, new Section adopted effective July 6, 1993 (Supp. 93-3). R20-5-208 recodified from R4-13-208 (Supp. 95-1).

R20-5-209. Authorization Limitation

If the Resolution of Authorization to Self-insure is validated by a deposit of acceptable securities, or by a guaranty bond, the resolution shall remain in full force and effect for a period of one year unless revoked by the Commission.

Historical Note

Former Rule IX. Section repealed, new Section adopted effective July 6, 1993 (Supp. 93-3). R20-5-209 recodified from R4-13-209 (Supp. 95-1).

R20-5-210. Continuation of Authorization

If timely and sufficient application for renewal is made pursuant to R20-5-203, the existing authorization to self-insure shall continue, subject to compliance with A.R.S. Title 23, Chapter 6 and this Article, until the renewal application has been finally determined by the Commission.

Historical Note

Former Rule X. R20-5-210 recodified from R4-13-210 (Supp. 95-1).

R20-5-211. Revocation of Authorization; Notice of Insolvency; Notice of Change of Ownership

- A.** The Commission may revoke a resolution of authorization to self-insure for good cause. Good cause includes:
1. The impairment of the solvency of the self-insurer.
 2. The failure of the self-insurer to respond within 10 days of a demand by the Commission to substitute a satisfactory guaranty bond or securities when in the Commission's judgment the bond or securities on deposit are unsatisfactory or insufficient in amount or character.
 3. The failure of the self-insurer to pay tax assessments levied by the Commission within 30 days of the due dates prescribed by A.R.S. §§ 23-961 and 23-1065.
 4. The failure of the self-insurer to promptly provide the Commission within 60 days the reports required by the Commission under this Article concerning the business, operations, employees, wages, injuries, and other subjects under Commission jurisdiction.
 5. The failure to comply with state workers' compensation laws.
 6. The failure of the self-insurer to pay or comply with any award of the Commission within 30 days after the award becomes final.
 7. The willful misstating of any material fact in a payroll report, injury report, or other report or statement made to the Commission.
 8. The deliberate refusal of the self-insurer to comply with Commission rules.
 9. The failure of the workers' compensation pool to notify the Commission within 30 days before termination or cancellation that a member has been terminated or cancelled.
 10. The failure of the workers' compensation pool to notify the Commission within 30 days of receipt of notification that, as a result of the annual audit or examination by the Director of the Department of Insurance, it appears that the assets of the pool are insufficient to enable the pool to discharge its legal liabilities and other obligations and the resulting notification by the Director of the Department of Insurance to the administrator and board of trustees of the workers' compensation pool of the insufficiency and the Director's list of recommendations to abate the deficiency.
 11. The failure of the pool to comply with the recommendation of the Director of the Department of Insurance within 60 days of the date of notice as prescribed in A.R.S. §§ 11-952.01(L) and 41-621.01(J).
- B.** The self-insurer shall notify the Commission within 24 hours of any bankruptcy filing under federal law or insolvency proceeding under any state's laws.
- C.** The self-insurer shall notify the Commission within 24 hours of any change in the ownership status of the employer.

Historical Note

Former Rule XI. Section repealed, new Section adopted effective July 6, 1993 (Supp. 93-3). R20-5-211 recodified from R4-13-211 (Supp. 95-1).

R20-5-212. Notice of Revocation of Resolution of Authorization to Self-insure

The registration and deposit in the United States mail of a Notice of Revocation of the Resolution of Authorization to Self-insure, addressed to the last known address of the employer as shown by the records of the Commission, and signed by the Commission, shall be deemed to constitute actual delivery of such notice to a self-insurer.

Historical Note

Former Rule XII. Section repealed, new Section adopted effective July 6, 1993 (Supp. 93-3). R20-5-212 recodified from R4-13-212 (Supp. 95-1).

R20-5-213. Substitution of Bond or Securities

No bond or other security deposited as a condition precedent to validating a Resolution of Authorization to Self-insure shall be returned nor shall any substitution be allowed, except upon written order of the Commission. No return of such bond or other security shall be authorized except upon proof that the employer has placed with the Commission an amount or amounts as determined by the Commission to be sufficient to provide for the present value of all death benefits, awards, and determinations previously made by the Commission or the self-insurer, with an adequate contingency amount to apply to reopened claims that have been closed and become final during the period of self-insurance.

Historical Note

Former Rule XIII. Section repealed, new Section adopted effective July 6, 1993 (Supp. 93-3). R20-5-213 recodified from R4-13-213 (Supp. 95-1).

R20-5-214. Rating Plans Available for Self-insurers

- A.** Any of the following rating plans are available to self-insured employers for the purpose of calculating the taxes required by A.R.S. §§ 23-961(G) and 23-1065(A).
1. Fixed Premium Plan
 2. Ex-medical Plan
 3. Guaranteed Cost Plan
 4. Retrospective Rating Plan
- B.** The provisions of the rating plans apply only to operations and payroll in Arizona, and all such operations in Arizona shall be combined as a single base for the calculation of any premium modifications to all such operations.

Historical Note

Former Rule XIV. Section repealed, new Section adopted effective July 6, 1993 (Supp. 93-3). R20-5-214 recodified from R4-13-214 (Supp. 95-1).

R20-5-215. Fixed Premium Plan: Definition; Formula; Eligibility

- A.** A Fixed Premium Plan means a plan in which neither losses nor incurred loss reserves are used for calculation. The only discount is for premium size.
- B.** The formula for calculation of the fixed premium plan is as follows: Payroll x Applicable Rate Less Premium Discount.
- C.** Fixed Premium Plan shall be the exclusive plan available to:
1. Those self-insurers electing this plan.
 2. Those self-insurers whose annual net taxable premium does not exceed \$100,000 annually.
 3. Those self-insurers not eligible for any other plan authorized by the Commission for rating purposes.

Historical Note

Former Rule XV. Section repealed, new Section adopted effective July 6, 1993 (Supp. 93-3). R20-5-215 recodified from R4-13-215 (Supp. 95-1).

R20-5-216. Ex-medical Plan: Definition; Formula; Eligibility; Modification

- A.** An Ex-Medical Plan means a plan for premium calculation which provides for rate revisions based upon the self-insurer operating a medical facility with a program for providing medical, surgical, or hospital services to all of the self-insurer's employees for their benefit and that has complied with the requirements specified in A.R.S. § 23-1070. Neither losses nor incurred loss reserves are used in such plan.

- B. The formula for calculation of the Ex-Medical Plan is as follows: $[(\text{Payroll} \times \text{Applicable Rate}) \times (1 - \text{Ex-Medical Factor})]$ less Premium Discount.
- C. Only those self-insurers whose program for medical, surgical, or hospital services has been authorized by the Commission are eligible to utilize this plan, for premium calculation.
- D. To be eligible for this plan the self-insurer's annual net taxable premium must exceed \$100,000.

Historical Note

Former Rule XVI. Section repealed, new Section adopted effective July 6, 1993 (Supp. 93-3). R20-5-216 recodified from R4-13-216 (Supp. 95-1).

R20-5-217. Guaranteed Cost Plan: Definition; Formula; Eligibility; Cost of Calculation

- A. A Guaranteed Cost Plan means a plan providing for the direct relationship, on an annual basis, of the premium for tax purposes and the experience modification developed to reflect the loss payment and incurred loss experience of the self-insured employer. Loss data for three complete years must be provided to calculate the experience modification factor. This plan shall be calculated annually and the premium shall not be subject to further adjustment during the subsequent year.
- B. The formula for the calculation of the Guaranteed Cost Plan is as follows: $\text{Payroll} \times \text{Applicable Rate} \times \text{Experience Modification Factor}$ Less Premium Discount.
- C. Only those self-insurers who satisfy all of the following requirements shall be eligible to use the Guaranteed Cost Plan:
 - 1. The submission of data concerning paid loss determinations and incurred loss reserves for each workers' compensation claimant. The information is used to calculate an experience modification factor for the self-insurer. Three years of loss data shall be formulated to calculate the experience modification factor.
 - 2. An annual net taxable premium exceeding \$100,000.

Historical Note

Former Rule XVII. Section repealed, new Section adopted effective July 6, 1993 (Supp. 93-3). R20-5-217 recodified from R4-13-217 (Supp. 95-1).

R20-5-218. Retrospective Rating Plan: Definition; Formula; Eligibility

- A. Retrospective rating plan means a plan providing for the relationship between the premium for tax purposes, the experience modification factor developed to reflect the loss payment and incurred loss experience of the self-insured employer, and the actual incurred losses for the tax year. This plan is to be calculated annually and the premiums shall not be subject to further adjustment during the tax year.
- B. The formula for calculating the retrospective rating plan is as follows: $[\text{Payroll} \times \text{Applicable Rate} \times \text{Experience Modification Factor} \times \text{Basic Premium Factor} + (\text{losses current year} + \text{adjusted losses previous year}) \times \text{loss conversion factor}] \times \text{Tax Multiplier} = \text{Net Taxable Premium (NTP)}$. The NTP is subject to a maximum and minimum premium level depending on which one of the four rating option plans specified in the rating systems filed by the rating organization used by the State Compensation Fund pursuant to A.R.S. Title 20, Chapter 2, Article 4 is used.
- C. Only those self-insurers who satisfy all of the following requirements shall be eligible to use the retrospective rating plan:
 - 1. The submission of data concerning paid loss determinations and incurred loss reserved for each worker's compensation claimant. The information is used to calculate

an experience modification factor for the self-insurer. Four years of loss data must be formulated. The oldest three years of data is used to calculate the rate and the most current year's data is used in the actual tax calculation.

- 2. An annual net taxable premium exceeding \$100,000.

Historical Note

Former Rule XVIII. Section repealed, new Section adopted effective July 6, 1993 (Supp. 93-3). R20-5-218 recodified from R4-13-218 (Supp. 95-1).

R20-5-219. Payment of Taxes by Self-insurers

The tax payments described in A.R.S. §§ 23-961(G) through (J) and 23-1065(A) shall be processed in accordance with the following:

- 1. All self-insurers shall submit their payroll, loss, medical, and other information to the Commission by January 31 of each year.
- 2. All self-insurers shall pay their annual taxes on or before March 31 based on premiums calculated for the preceding calendar year. The payment for each tax shall not be less than \$250.00 per year.
- 3. Those self-insurers who paid \$2,000.00 or more for the administrative fund tax (A.R.S. § 23-961(G)) for the preceding calendar year shall pay a quarterly tax in the following year. One of two methods can be used to calculate the payment. The first method is a quarterly payment of 25% of the tax calculated for the previous year. The second method is based on actual payroll and premiums calculated for each quarter. Those self-insured employers who paid \$2,000.00 or more for the Special Fund tax (A.R.S. § 23-1065(A)) for the preceding calendar year must pay a quarterly tax using the same methods to calculate payment. The quarterly payments are due April 30, July 31, October 31, and January 31 for the periods ending March 31, June 30, September 30, and December 31, respectively.
- 4. Upon calculation of the annual taxes, it shall be determined by the Commission if the self-insured employer has overpaid or underpaid its taxes. If the total of the quarterly payments is less than the actual taxes calculated for the year, then the amount representing the difference is due on or before March 31. If the total of the quarterly payments exceeds the amount of the actual taxes calculated for the year, a refund will be paid to the self-insurer.
- 5. If the self-insurer fails to pay the annual or quarterly taxes when due, a penalty of the greater of \$25.00 or 5% of the tax or payment due plus interest at the rate of 1% per month from the date the tax or payment was due shall be paid by the self-insurer.

Historical Note

Former Rule XIX. Section repealed, new Section adopted effective July 6, 1993 (Supp. 93-3). R20-5-219 recodified from R4-13-219 (Supp. 95-1).

R20-5-220. Basis; Definitions

For determining the premium for purposes of R20-5-214, the Commission shall utilize as the basis for classifications, rating procedures, and plans those specified in the rating systems filed by the rating organization used by the State Compensation Fund pursuant to A.R.S. Title 20, Chapter 2, Article 4.

Historical Note

Former Rule XX. Section repealed, new Section adopted effective July 6, 1993 (Supp. 93-3). R20-5-220 recodified from R4-13-220 (Supp. 95-1).

R20-5-221. Book and Record Review by the Commission

All reports, books, and records of the self-insurer relating to classifications, payroll, incurred loss reserves, and procedures for development of statistical information for the development of rating information are subject to review by the Commission and its authorized representatives. If, in the judgment of the Commission, reports, records, and data relating to payroll or claims are not valid or credible, the Commission reserves the right to require correction of procedure and data to better determine the information needed to evaluate the rating programs.

Historical Note

Former Rule XXI. Section repealed, new Section adopted effective July 6, 1993 (Supp. 93-3). R20-5-221 recodified from R4-13-221 (Supp. 95-1).

R20-5-222. Audits; Cost of Audit

The Commission may, at any time upon three working days' notice, perform or have performed for its benefit an audit of the payroll, loss payment, and loss reserve records for incurred losses of the self-insurer for the purpose of determining the scope and adequacy of the maintained records. The entire cost of the audit will be borne by the self-insurer.

Historical Note

Former Rule XXII. Section repealed, new Section adopted effective July 6, 1993 (Supp. 93-3). R20-5-222 recodified from R4-13-222 (Supp. 95-1).

R20-5-223. Time-frames for Processing Initial and Renewal Applications for Authorization to Self-insure**A. Administrative completeness review.**

1. Initial application.
 - a. The Administration Division shall review an initial application for authority to self-insure within 20 days of receipt of the application to determine whether the application contains the information required by A.R.S. § 23-961 and this Article.
 - b. The Administration Division shall inform an applicant by written notice whether the application is complete within the time-frame provided in this subsection. If the application is incomplete, the Administration Division shall include in its written notice to the applicant a complete list of the missing information.
 - c. The Administration Division shall deem the application withdrawn if an applicant fails to file a complete application within 45 days of being notified by the Administration Division that the application is incomplete, unless the applicant obtains an extension to provide the missing information under subsection (D).
2. Renewal application.
 - a. The Administration Division shall review a renewal application for authority to self-insure within 20 days of receipt of the application to determine whether the application contains the information required by A.R.S. § 23-961 and this Article.
 - b. The Administration Division shall inform a self-insurer by written notice whether the application is complete within the time-frame provided in subsection (A)(2)(a). If the application is incomplete, the Administration Division shall include in its written notice to the self-insurer a complete list of the missing information.
 - c. The Administration Division shall deem the application withdrawn if a self-insurer fails to file a complete application within 45 days of being notified by

the Administration Division that the application is incomplete, unless the self-insurer obtains an extension to provide the missing information under subsection (D).

B. Substantive review.

1. Initial application. Within 70 days after the Administration Division determines an initial application complete, the Commission shall determine whether an initial application for authority to self-insure meets the substantive criteria of A.R.S. § 23-961 and this Article and shall issue an order granting or denying authority to self-insure.
2. Renewal application. Within 40 days after the Administration Division determines a renewal application complete, the Commission shall determine whether a renewal application for authority to self-insure meets the substantive criteria of A.R.S. § 23-961 and this Article and shall issue an order granting or denying authority to self-insure.

C. Overall review.

1. Initial application. The overall review period shall be 90 days, unless extended under A.R.S. § 41-1072 et seq.
2. Renewal application. The overall review period shall be 60 days, unless extended under A.R.S. § 41-1072 et seq.

- D. If an applicant or self-insurer cannot timely submit to the Administration Division information to complete an initial or renewal application, the applicant or self-insurer may obtain an extension to submit the missing information by filing a written request with the Administration Division no later than 40 days after receipt of the notice from the Administration Division that the initial or renewal application is incomplete. The written request for an extension shall state the reasons the applicant or self-insurer is unable to meet the 45-day deadline. If an extension will enable the applicant or self-insurer to assemble and submit the missing information, the Administration Division shall grant an extension of not more than 30 days and provide written notice of the extension to the applicant or self-insurer.

Historical Note

Former Rule XXIII. Section repealed effective July 6, 1993 (Supp. 93-3). R20-5-223 recodified from R4-13-223 (Supp. 95-1). New Section adopted October 9, 1998 (Supp. 98-4).

R20-5-224. Computation of Time

- A. In computing any period of time prescribed or allowed by this Article, the day of the act or event from which the designated period of time begins to run shall not be included. The last day of the period computed shall be included unless it is a Saturday, Sunday, or legal holiday, in which event the period runs until the end of the next day which is not a Saturday, Sunday, or legal holiday. When the period of time prescribed or allowed is less than 11 days, intermediate Saturdays, Sundays, and legal holidays shall be excluded in the computation.
- B. Except as otherwise provided by law, the Commission may extend time limits prescribed by this Article for good cause.

Historical Note

Former Rule XXIV. Section repealed effective July 6, 1993 (Supp. 93-3). R20-5-224 recodified from R4-13-224 (Supp. 95-1). New Section adopted effective October 9, 1998 (Supp. 98-4).

ARTICLE 3. PRIVATE EMPLOYMENT AGENTS**R20-5-301. Definitions**

In addition to the definitions provided in A.R.S. § 23-521, the following definitions apply to this Article:

“Advertising” means any material, means, or medium used by a licensed employment agent for solicitation or promotion of business. This includes business cards, notices, or announcements in newspapers, radio, television, brochures, pamphlets, gift items, and signs. It also includes referral cards, invoices, letterheads, or other forms if the forms are used in combination with solicitation or promotion of business.

“Applicant” means any individual, including a talent or model, seeking the services of a licensed employment agent.

“Applicant-paid fee” means a sum of money or value that is collected from an applicant for receiving employment services from a licensed employment agent.

“Bona fide job order” means an employer’s or company’s written or oral authorization to a licensed employment agent to refer an applicant to the employer.

“Business manager” means a person, firm, corporation, or association whose services to a talent or model are limited to giving financial advice or managing the business affairs of the talent or model.

“Candidate” means a person, firm, corporation, or association, applying for an employment agent license.

“Career counseling service” means a person, firm, corporation, or association that provides career assistance, career management, job search assistance, evaluation or planning, information and advice on all career decisions including vocational guidance and employment counseling, interview preparation, or other information to enable an individual to secure employment, but does not include the following:

- A provider of job referral services;

- A provider of vocational rehabilitation as defined in A.R.S. § 23-501;

- A person, firm, corporation, or association that prepares resumes and documents in support of resumes without providing career counseling or referral services;

- A public or private educational institution;

- A psychologist licensed or certified in this state who provides career guidance and counseling to patients as part of the psychologist’s practice;

- A person engaged in the practice of social work, counseling, or marital and family therapy as those terms are defined in A.R.S. § 32-3251, who provides career guidance and counseling as part of the social work, counseling, marital or family therapy;

- A physician licensed in this state who provides career guidance and counseling to patients as part of the physician’s practice;

- A priest, minister, rabbi or other clergy who provides career guidance and counseling as part of the clergy’s practice; and

- An attorney licensed in this state who provides career guidance and counseling as part of the attorney’s practice.

“Career counselor” means an individual working in a career counseling service to provide career assistance, career management, job search assistance, career evaluation or planning, or information and advice on all career decisions including vocational guidance and employment counseling, interview preparation, or other information to enable an individual to

secure employment. An employee of a career counseling service whose duties are primarily clerical in nature is not a career counselor.

“Commission” means the Industrial Commission of Arizona.

“Company” means a business that obtains applicants from a licensed talent and/or modeling agency.

“Complaint” means an oral or written communication made to the Department or to the Commission by any person alleging improper conduct by a licensed employment agent.

“Council” means the Arizona Employment Advisory Council.

“Department” means the Labor Department of the Industrial Commission of Arizona.

“Director” means the Director of the Industrial Commission of Arizona.

“Electronic media service” means a business that lists applications, resumes, or job openings on a computerized network or system.

“Engagement” means the employment of an individual as an actor, entertainer, model, or performer in an entertainment enterprise.

“Entertainment enterprise” means theater, motion pictures, radio, television, opera, ballet, modeling, circus, vaudeville or variety act, or other performance- or exhibition-oriented business.

“License” means a document issued by the Commission that authorizes a person to conduct business as an employment agent.

“Labor contractor” means an employer as defined under A.R.S. Title 23, Chapter 6, who leases or provides temporary workers to a customer or client.

“Licensed employment agent” or “licensee” means an employment agent defined in A.R.S. § 23-521(A) who holds a valid license issued by the Commission under A.R.S. § 23-521 et seq.

“Managing agent” means a person, firm, corporation, or association that is designated by a licensed employment agent to be in charge of the operation of an employment agency or any of its branches or divisions.

“Model” means an individual who is employed to display, by wearing, clothes or other merchandise.

“Personal manager” means a person, firm, corporation, or association whose services are limited to counseling or advising a talent or model in connection with the talent’s or model’s professional career.

“Placement counselor” means an individual working in a placement counseling service to assist an applicant to obtain employment by providing career counseling services, referral services, or registry services. An employee of a licensed employment agent whose duties are primarily clerical in nature is not a placement counselor.

“Placement counseling service” means a person, firm, corporation, or association that provides career counseling services, referral services, or registry services.

“Referral service” means a person, firm, corporation, or association that refers an applicant to employment upon receipt of a bona fide job order.

“Secretary” means the Director of the Industrial Commission of Arizona Labor Department who serves as the Secretary for the Employment Advisory Council.

“Talent” means an individual rendering performing services in an entertainment enterprise, including musicians.

“Talent or modeling agency or agent” means a person, firm, corporation, or association that provides employment information to a talent or model for the purpose of securing an engagement for the talent or model.

Historical Note

Former Rule I. R20-5-301 recodified from R4-13-301 (Supp. 95-1). Section R20-5-301 repealed; new Section R20-5-301 adopted effective September 9, 1998 (Supp. 98-3).

R20-5-302. Computation of Time

- A. In computing any period of time prescribed or allowed by this Article, the Commission shall not include the day of the act or event from which the period of time begins to run. The Commission shall include the last day of the period computed unless it is a Saturday, Sunday, or legal holiday in which event, the period shall run until the end of the next day that is not a Saturday, Sunday, or legal holiday. When the period of time prescribed or allowed is less than 11 days, the Commission shall exclude intermediate Saturdays, Sundays, and legal holidays in the computation of time.
- B. Except as otherwise provided by law, the Commission may extend time limits prescribed by this Article for good cause.

Historical Note

Former Rule II; Amended effective March 9, 1981 (Supp. 81-2). R20-5-302 recodified from R4-13-302 (Supp. 95-1). Section R20-5-302 repealed; new Section R20-5-302 adopted effective September 9, 1998 (Supp. 98-3).

R20-5-303. Forms Prescribed by the Commission

The Commission shall make the following forms, which contain the information listed, available upon request.

1. Initial application for employment agent license:
 - a. Name of candidate, including other names used by the candidate;
 - b. Personal identifying information of candidate;
 - c. Residence, length of residence, and place of prior residency of candidate;
 - d. Employment history of candidate, including work history and experience as an employment agent;
 - e. Personal references of candidate;
 - f. Felony and misdemeanor convictions of candidate;
 - g. Name, trade name, divisions and all other names under which candidate intends to do business;
 - h. Proposed location of all business sites;
 - i. Organizational structure of business;
 - j. Names and addresses of all persons or firms having a financial interest in the business and the percentage of financial interest of each person's or firm's share;
 - k. Job classifications of proposed clientele;
 - l. Fee rates and schedules of business;
 - m. Names and addresses of all persons who will be involved in the management and supervision of the business at all locations of the business;
 - n. Information relating to Workers' Compensation Insurance; and
 - o. Request for education records; and
 - p. Request for military discharge records.
2. Business financial statement:
 - a. Name of candidate;
 - b. Business address of candidate; and
 - c. Disclosure of financial information of candidate that pertains to financial stability or irregularity, misappropriation, conversion, irregular withholding or accounting of money belonging to another person.
3. Personal financial statement:
 - a. Name of candidate or managing agent;
 - b. Home address of candidate or managing agent; and
 - c. Disclosure of personal financial information of candidate or managing agent that pertains to financial stability or irregularity, misappropriation, conversion, irregular withholding or accounting of money belonging to another person.
4. Supplemental application:
 - a. Name and telephone number of managing agent, including other names used by the managing agent;
 - b. Name of private employment agent with whom the managing agent intends to associate;
 - c. Personal identifying information of managing agent;
 - d. Residence, length of residence, and place of prior residency of managing agent;
 - e. Employment history of managing agent, including work history and experience as an employment agent;
 - f. Personal references of managing agent;
 - g. Felony and misdemeanor convictions of managing agent; and
 - h. Request for education records; and
 - i. Request for military discharge records.
5. Renewal application for employment agent license:
 - a. Name, address, and telephone number of licensee seeking renewal;
 - b. Position of licensee with employment agent business;
 - c. Name, trade name, including abbreviations of name or trade name, of licensee seeking renewal;
 - d. Current legal business status of licensee seeking renewal;
 - e. Name of managing agent;
 - f. Type of business to be renewed;
 - g. Address of all business sites of licensee;
 - h. Name of all divisions operated by licensee;
 - i. Names and addresses of other businesses operated by licensee;
 - j. Number of placement counselors employed by licensee during preceding year;
 - k. Schedule of fees and rules implemented by licensee and any changes in the schedule of fees and rules during the preceding year;
 - l. List of changes made to forms required by A.R.S. § 23-521 et seq. and this Article in the preceding year;
 - m. Information pertaining to complaints received in the preceding year by the licensee; and
 - n. Information pertaining to compliance with the Arizona workers' compensation laws.

Historical Note

Former Rule III; Amended effective March 9, 1981 (Supp. 81-2). R20-5-303 recodified from R4-13-303 (Supp. 95-1). Section R20-5-303 repealed; new Section R20-5-303 adopted effective September 9, 1998 (Supp. 98-3).

R20-5-304. Time-frames for Processing Initial and Renewal Applications for Employment Agent License by Commission

- A. Administrative completeness review.

1. The Department shall review an initial or renewal application for employment agent license within 15 days of receipt of the application to determine whether the application contains the information required by A.R.S. § 23-521 et seq. and this Article. The Department shall inform the candidate or licensee by written notice whether the application is deemed complete or deficient within the time-frame provided in this subsection. The Department shall deem the application withdrawn if the candidate or licensee fails to file a complete application within 45 days of being notified by the Department that the application is incomplete or deficient. A candidate or licensee can request an extension of time to file a complete application by filing a written request with the Department before the Department deems the application withdrawn. For good cause shown, the Department may grant an extension of time by serving written notice of the extension upon the candidate or licensee.
- B. Substantive review.**
1. Initial applications. Within 120 days after an initial application is deemed complete, the Commission shall determine whether the initial application for employment agent license meets the substantive criteria of A.R.S. § 23-521 et seq. and this Article and shall issue a written order granting or denying the license.
 2. Renewal applications. Within 60 days after a renewal application is deemed complete, the Commission shall determine whether the renewal application for employment agent license meets the substantive criteria of A.R.S. § 23-521 et seq. and this Article and shall issue a written order refusing to renew the license or grant the renewal by issuing a new license.
- C. Overall Review.**
1. Initial application. Within 135 days after receipt of an initial application for an employment agent license, the Commission shall issue an order denying or granting the initial license.
 2. Renewal application. Within 75 days after receipt of a renewal application for an employment agent license, the Commission shall issue an order refusing to renew the license or grant the renewal by issuing a new license.
- Historical Note**
- Former Rule IV; Amended effective March 9, 1981 (Supp. 81-2). R20-5-304 recodified from R4-13-304 (Supp. 95-1). Section R20-5-304 repealed; new Section R20-5-304 adopted effective September 9, 1998 (Supp. 98-3).
- R20-5-305. Filing Requirements for Initial Application for Employment Agent License**
- A.** Initial application for employment agent license.
1. A candidate shall complete an initial application on forms approved by the Commission.
 2. A candidate shall file an application for an employment agent license with the Department. An application is considered filed when it is received at the office of the Department and stamped by the Department with the date of filing.
 3. An application shall be typewritten or written in legible text.
 4. The individual completing the application shall sign and date the application and have the signature notarized.
 5. The individual completing and signing the application shall verify that the information contained in and submitted with the application is true and correct.
- B.** If a candidate intends to do business as a sole proprietorship, then the candidate shall include the following information with the application for an initial employment agent license:
1. A supplemental application completed by all managing agents of the candidate. All supplemental applications shall comply with the requirements of subsection (A);
 2. A personal financial statement completed by the candidate;
 3. A business financial statement completed by the candidate;
 4. Education records of the candidate and all managing agents;
 5. Military discharge records of the candidate and all managing agents;
 6. A \$5000 surety bond or a \$1000 cash deposit. If a cash deposit is submitted, the candidate shall increase the deposit to \$5000 before a license is issued. The candidate may replace the cash deposit with a \$5000 surety bond;
 7. A copy of the registration of the trade name through the Arizona Secretary of State;
 8. Completion of the written examination required by A.R.S. § 23-526 with a passing grade by the candidate and all managing agents. An 80% grade is required to pass the examination;
 9. A copy of the franchise agreement, if the proposed business is a franchise; and
 10. A copy of the sale or purchase agreement, if the candidate is purchasing an existing employment agent business.
- C.** If a candidate intends to do business as a partnership, the candidate shall include the following information with the application for an initial employment agent license:
1. A supplemental application completed by all partners and managing agents of the candidate. All supplemental applications shall comply with the requirements of subsection (A);
 2. A personal financial statement for each partner and prepared by each partner;
 3. A business financial statement completed by all partners;
 4. Education records of all partners and all managing agents;
 5. Military discharge records of all partners and all managing agents;
 6. A \$5000 surety bond or a \$1000 cash deposit. If a cash deposit is submitted, the candidate shall increase the deposit to \$5000 before a license is issued. The candidate may replace the cash deposit with a \$5000 surety bond;
 7. A copy of the registration of the trade name through the Arizona Secretary of State;
 8. A copy of the partnership agreement;
 9. A copy of the franchise agreement, if the proposed business is a franchise;
 10. A copy of the sale or purchase agreement, if the candidate is purchasing an existing employment agent business;
 11. Completion of the written examination required by A.R.S. § 23-526 with a passing grade by the candidate and all managing agents. An 80% grade is required to pass the examination;
- D.** If the candidate intends to do business as a corporation, an officer of the corporation shall complete and sign the initial application for employment agent license and shall include the following information in the candidate's application:
1. A supplemental application completed by all managing agents of the candidate. All supplemental applications shall comply with the requirements of subsection (A);
 2. A business financial statement of the corporation;

3. Education records of all managing agents and the officer completing the application for employment agent license;
 4. Military discharge records of all managing agents and the officer completing the application;
 5. A \$5000 surety bond or a \$1000 cash deposit. If a cash deposit is submitted, the candidate shall increase the deposit to \$5000 before a license is issued. The candidate may replace the cash deposit with a \$5000 surety bond;
 6. Completion of the written examination required by A.R.S. § 23-526 with a passing grade by the candidate and all managing agents. An 80% grade is required to pass the examination;
 7. Certified resolution of the corporation authorizing the application for an employment agent license and naming the individuals authorized to act on behalf of the corporation;
 8. A copy of the candidate's articles of incorporation on file with the Arizona Corporation Commission;
 9. A copy of the franchise agreement, if the proposed business is a franchise;
 10. A copy of the sale or purchase agreement, if the candidate is purchasing an existing employment agent business; and
 11. A copy of the registration of the trade name through the Arizona Secretary of State.
- E.** A candidate shall include with an application for initial employment agent license a schedule of fees and charges as described in A.R.S. § 23-530(A).
- F.** A candidate shall include with an application for initial employment agent license a copy of all rules and regulations as described in A.R.S. § 23-530(A).
- G.** A candidate shall include with an application for initial employment agent license sample forms of the following documents:
1. Receipts;
 2. Contracts;
 3. Job order forms; and
 4. Other documents that relate in any manner to the fee that is charged an applicant.

Historical Note

Former Rule V; Former Section R4-13-305 renumbered and amended as Section R4-13-306, new Section R20-5-305 adopted effective March 9, 1981 (Supp. 81-2). R20-5-305 recodified from R4-13-305 (Supp. 95-1). Section R20-5-305 repealed; new Section R20-5-305 adopted effective September 9, 1998 (Supp. 98-3).

R20-5-306. Written Examination

- A.** Except as otherwise provided in this Article, all individuals required by A.R.S. § 23-526 and this Article to take the written examination described in A.R.S. § 23-526(B), shall complete the examination within 12 months before filing an initial application for employment agent license with the Department. The Commission shall not grant an employment agent license unless all individuals required by A.R.S. § 23-526 and this Article to take the written examination have answered correctly 80% of the questions asked in the examination.
- B.** The Department shall give notice of the time and place of the written examination upon request.
- C.** Examination results are valid for a period of 12 months. If after 12 months, the individual taking the examination does not use the results in support of an application for an employment agent license, then that individual shall be required to retake the examination.

Historical Note

Former Rule VI. Former Section R4-13-306 renumbered and amended as Section R4-13-307, former Section R4-

13-305 renumbered and amended as Section R4-13-306 effective March 9, 1981 (Supp. 81-2). R20-5-306 recodified from R4-13-306 (Supp. 95-1). Section R20-5-306 repealed; new Section R20-5-306 adopted effective September 9, 1998 (Supp. 98-3).

R20-5-307. Renewal of Employment Agent License

- A.** A licensee can apply for renewal of an employment agent license under A.R.S. § 23-528 by filing a completed renewal application with the Department before the date of the expiration of the license. In addition to the information described in R20-5-303(5), a licensee shall include the renewal license fee in A.R.S. § 23-528(B).
- B.** The Commission shall deem an employment agent license expired if a renewal application is not filed with the Department before the expiration date of the employment agent license. If an employment agent license expires, the formerly licensed agent shall file a new application which meets the requirements of this Article for an initial application.
- C.** If a timely and complete renewal application is filed with the Department under this Article, the Commission shall consider the existing employment agent license valid, subject to compliance with A.R.S. § 23-531 et seq. and this Article, until a new license is issued or an order of the Commission refusing to renew becomes final.

Historical Note

Former Rule VII. Former Section R4-13-307 renumbered as Section R4-13-309, former Section R4-13-306 renumbered and amended as Section R4-13-307 effective March 9, 1981 (Supp. 81-2). R20-5-307 recodified from R4-13-307 (Supp. 95-1). Section R20-5-307 repealed; new Section R20-5-307 adopted effective September 9, 1998 (Supp. 98-3).

R20-5-308. Substantive Review of Initial or Renewal Application for Employment Agent License

- A.** When a completed initial or renewal application for employment agent license is filed, the Department shall investigate the candidate or licensee to verify whether the information contained in and submitted with the initial or renewal application for employment agent license is accurate and complies with the requirements of A.R.S. § 23-521 et seq. and this Article. The Department shall also conduct an investigation of the candidate or licensee, in accordance with A.R.S. § 23-523(3) and § 23-524, to determine whether the candidate or licensee has a history or record of any of the following:
1. Dishonesty;
 2. Financial instability or irregularity, including a record of misappropriation, conversion, or irregular withholding or accounting of money belonging to another;
 3. Incompetence;
 4. Gross negligence;
 5. Bribery;
 6. Willful or repeated disregard of the requirements of A.R.S. Title 23, Chapter 3, Article 2;
 7. Source of injury or loss to the public; or
 8. Lack of education, experience, training, or skill to enable the candidate, licensee, or managing agent to competently discharge the duties and responsibilities of a licensed employment agent.
- B.** The Department shall verify that all individuals who are required by this Article to take the written examination required by A.R.S. § 23-526(B) have received a passing score of 80%.
- C.** The Department shall present the findings of its investigation described in subsections (A) and (B) to the Council. The Council shall make its recommendation regarding an initial or

renewal application for employment agent license based on the information submitted by the candidate or licensee and the investigation of the Department. Under the authority of A.R.S. § 23-522.02, the Council shall recommend that an application for an initial or renewal license be denied if the Council finds one or more of the following conditions:

1. Material misrepresentation or fraud in the initial or renewal application;
 2. The candidate, licensee, or managing agent has a history or record of dishonesty;
 3. The candidate, licensee, or managing agent has a history or record of financial instability or irregularity, including a record of misappropriation, conversion or irregular withholding or accounting of money belonging to another;
 4. The candidate, licensee, or managing agent has a history or record of incompetence;
 5. The candidate, licensee, or managing agent has a history or record of gross negligence;
 6. The candidate, licensee, or managing agent has a history or record of bribery;
 7. The candidate, licensee, or managing agent has a history or record of willful or repeated disregard of the requirements of A.R.S. Title 23, Chapter 3, Article 2;
 8. The candidate, licensee, or managing agent has a history or record of causing, directly or indirectly, injury or loss to the public; or
 9. The candidate, licensee, or managing agent lacks the education, experience, training, or skill to enable the candidate, licensee, or managing agent to competently discharge the duties and responsibilities of a licensed employment agent.
- D.** The Department shall present the recommendation of the Council pertaining to an initial application to the Commission. The Department shall also present to the Commission the recommendation of the Council that denies a renewal application. If the Council recommends that a renewal application be granted, the Department is not required to present the recommendation to the Commission. In that event, the Department shall notify the licensee of the approval by sending the licensee a renewed license.

Historical Note

Former Rule VIII. Former Section R4-13-308 renumbered as Section R4-13-310, new Section R4-13-308 adopted effective March 9, 1981 (Supp. 81-2). R20-5-308 recodified from R4-13-308 (Supp. 95-1). Section R20-5-308 repealed; new Section R20-5-308 adopted effective September 9, 1998 (Supp. 98-3).

R20-5-309. Decision by the Commission on an Initial or Renewal Application for Employment Agent License

- A.** In addition to the requirements imposed by A.R.S. § 23-521 et seq., the Commission shall consider the following before granting or denying an initial or renewal employment agent license:
1. The information submitted by the candidate or licensee,
 2. The findings of the investigation by the Department, and
 3. The recommendation of the Council.
- B.** Under the authority in A.R.S. §§ 23-523 and 23-524, the Commission shall deny an application for an initial or renewal license if the Commission finds one or more of the following conditions:
1. Material misrepresentation or fraud in the initial or renewal application;
 2. The candidate, licensee, or managing agent has a history or record of dishonesty;

3. The candidate, licensee, or managing agent has a history or record of financial instability or irregularity, including a record of misappropriation, conversion or irregular withholding or accounting of money belonging to another;
 4. The candidate, licensee, or managing agent has a history or record of incompetence;
 5. The candidate, licensee, or managing agent has a history or record of gross negligence;
 6. The candidate, licensee, or managing agent has a history or record of bribery;
 7. The candidate, licensee, or managing agent has a history or record of willful or repeated disregard of the requirements of A.R.S. Title 23, Chapter 3, Article 2;
 8. The candidate, licensee, or managing agent has a history or record of causing, directly or indirectly, injury or loss to the public; or
 9. The candidate, licensee, or managing agent lacks the education, experience, training, or skill to enable the candidate, licensee, or managing agent to competently discharge the duties and responsibilities of a licensed employment agent.
- C.** The Commission shall issue written findings and an order granting or denying an employment agent license.
- D.** If the Commission denies an employment agent license, the Department shall serve a copy of the Commission's written findings and order upon the candidate or licensee within five days of the date the Commission issues its findings and order.
- E.** If the Commission grants a renewal application for employment agent license, then the Department shall provide the licensee with a renewed license within five days of the date the Commission issues its written findings and order.
- F.** If the Commission grants an initial application for employment agent license, the Department shall provide the candidate with written notification of that approval. The written notification shall include a statement that the license approved by the Commission will be issued upon receipt of the annual fee required under A.R.S. § 23-528 and that the approval will expire within 45 days unless the fee is paid.

Historical Note

Former Rule IX. Former Section R4-13-309 repealed, former Section R4-13-307 renumbered as Section R4-13-309 effective March 9, 1981 (Supp. 81-2). R20-5-309 recodified from R4-13-309 (Supp. 95-1). Section R20-5-309 repealed; new Section R20-5-309 adopted effective September 9, 1998 (Supp. 98-3).

R20-5-310. Payment of Initial License Fee under A.R.S. § 23-528

- A.** The Commission shall not issue an initial employment agent license granted under this Article until the candidate pays the license fee required under A.R.S. § 23-528.
- B.** A candidate shall pay the license fee required under A.R.S. § 23-528 within 45 days of the date the Commission grants the initial application for employment agent license.
- C.** If a candidate fails to pay the license fee required under A.R.S. § 23-528 within the time provided in this Section, the Commission shall deem the order approving an initial application for employment agent license expired. In that event, the Commission shall require the candidate to file a new application if the candidate still seeks licensing as an employment agent.

Historical Note

Former Rule X. Former Section R4-13-310 renumbered and amended as Section R4-13-312, former Section R4-13-308 renumbered as Section R4-13-310 effective March 9, 1981 (Supp. 81-2). R20-5-310 recodified from

R4-13-310 (Supp. 95-1). Section R20-5-310 repealed; new Section R20-5-310 adopted effective September 9, 1998 (Supp. 98-3).

R20-5-311. Right to Request a Hearing

- A.** A candidate or licensee shall have 30 days from the date the Commission findings and order is served under R20-5-309 to request a hearing.
- B.** A request for hearing shall be in writing and signed by the candidate or licensee or the candidate's or licensee's legal representative. The candidate or licensee shall file the request for hearing with the Department.
- C.** The Commission shall deem its findings and order final if a request for hearing is not received by the Department within the time specified in subsection (A).

Historical Note

Former Rule XI. Former Section R4-13-311 repealed, new Section R4-13-311 adopted effective March 9, 1981 (Supp. 81-2). R20-5-311 recodified from R4-13-311 (Supp. 95-1). Section R20-5-311 repealed; new Section R20-5-311 adopted effective September 9, 1998 (Supp. 98-3).

R20-5-312. Hearing Rights and Procedures

- A. Burden of proof.**
 - 1. Except as provided in subsection (A)(2) and R20-5-324, in all proceedings arising out of A.R.S. Title 23, Chapter 3, Article 2, the candidate or licensee shall have the burden of proof to establish that it has met the requirements of A.R.S. § 23-521 et seq. and this Article.
 - 2. In revocation and suspension hearings, the Commission shall have the burden of proof to establish that the licensee committed the acts described in A.R.S. § 23-529(A).
- B. Roles of Chair and Chief Counsel.**
 - 1. The Chair of the Commission or designee shall preside over hearings held under this Article. Except as otherwise provided in this Section, the Chair shall apply the provisions of A.R.S. § 41-1062 to hearings held under this Article and shall have the authority and power of a presiding officer as described in A.R.S. § 41-1062.
 - 2. The Chief Counsel of the Commission shall represent the Commission in hearings held before the Commission. Upon direction of the Chair of the Commission and on behalf of the Commission, the Chief Counsel shall issue all notices and subpoenas required under this Section. In the discretion of the Chief Counsel, the Chief Counsel may assign an attorney from the Legal Division of the Commission to represent the Department.
- C. Appearance by a party.**
 - 1. Except as otherwise provided by law, the parties may appear on their own behalf or through counsel.
 - 2. When an attorney appears or intends to appear before the Commission, the attorney shall notify the Commission, in writing, of the attorney's name, address, and telephone number and the name and address of the person on whose behalf the attorney appears.
- D. Filing and service.**
 - 1. For purposes of this Section, a document is deemed filed when the Commission receives the document. All documents required to be filed in this Section with the Commission shall be served upon the Chief Counsel of the Industrial Commission and upon all parties to the proceeding.
 - 2. Except as otherwise provided in A.R.S. § 23-521, et seq. and this Article, service of all documents upon the Commission, candidate, licensee or applicant shall be by per-

sonal service or by mail. Personal service includes delivery upon the Commission or party. Service by mail includes every type of service except personal service and is complete on mailing.

- E. Notice of hearing.**
 - 1. The Commission shall give the parties at least 20 days notice of hearing.
 - 2. A notice of hearing shall be in writing and mailed to the address of the candidate or licensee as shown on the application for employment agent license or upon the candidate's or licensee's representative if a notice of appearance has been filed by the representative. In the case of a fee dispute hearing, a notice of hearing shall be mailed to the address of the applicant as shown on the complaint and the licensee as shown on the answer, if an answer is filed. If no answer is filed, then the notice of hearing shall be sent to the last known mailing address of the licensee as shown on the records of the Commission.
 - 3. A notice of hearing shall comply with the requirements in A.R.S. § 41-1061(B).
- F. Evidence.**
 - 1. The civil rules of evidence do not apply to hearings held under this Section.
 - 2. The parties may make opening and closing statements with the permission of the Commission if the statements will be helpful to a determination of the issues.
 - 3. All witnesses at a hearing shall testify under oath or affirmation.
 - 4. The parties may present evidence and conduct cross-examination of witnesses.
 - 5. Documentary evidence may be received into evidence and shall be filed no later than 15 days before the date of the hearing. Upon request or upon direction from the Chair of the Commission, the Commission may issue a subpoena to the author of any document submitted into evidence to appear and testify at the hearing.
 - 6. Upon written request by a party or upon direction from the Chair of the Commission, the Commission may issue a subpoena requiring the attendance and testimony of a witness whose testimony is material. A subpoena shall be requested no later than 10 days before the date of the hearing.
 - 7. Upon written request by a party or upon direction from the Chair of the Commission, the Commission may issue a subpoena duces tecum requiring the production of documents or other tangible evidence. The written request by a party shall contain a statement explaining the general relevance, materiality, and reasonable particularity of the documentary or other tangible evidence and the facts to be proved by them.
- G. Transcript of Proceedings.** Hearings before the Commission shall be stenographically reported or mechanically recorded. Any party desiring a copy of the transcript shall obtain a copy from the court reporter.

Historical Note

Former Rule XII. Former Section R4-13-312 renumbered as Section R4-13-314, former Section R4-13-310 renumbered and amended as Section R4-13-312 effective March 9, 1981 (Supp. 81-2). R20-5-312 recodified from R4-13-312 (Supp. 95-1). Section R20-5-312 repealed; new Section R20-5-312 adopted effective September 9, 1998 (Supp. 98-3).

R20-5-313. Decision Upon Hearing by Commission

- A.** A decision of the Commission to deny an initial or renewal application shall be based upon the grounds in R20-5-309(B)

and shall be made by a majority vote of the quorum of Commission members present when the decision is rendered at a public meeting.

- B. A decision of the Commission to revoke or suspend a license shall be based upon the grounds in A.R.S. § 23-529 and shall be made by a majority vote of the quorum of Commission members present when the decision is rendered at a public meeting.
- C. A decision of the Commission under R20-5-322(D) shall be based upon the grounds in R20-5-322(B) and shall be made by a majority vote of the quorum of Commission members present when the decision is rendered at a public meeting.
- D. Within 30 days after the Commission renders a decision at a public meeting, the Commission shall issue a written decision upon hearing which shall include findings of fact and conclusions of law, separately stated.
- E. A Commission decision is final unless a candidate or licensee requests review under R20-5-314 within 30 days from the date the written decision is issued.

Historical Note

Former Rule XIII. Former Section R4-13-313 renumbered and amended as Section R4-13-318 effective March 9, 1981 (Supp. 81-2). R20-5-313 recodified from R4-13-313 (Supp. 95-1). New Section adopted effective September 9, 1998 (Supp. 98-3).

R20-5-314. Request for Review

- A. A party may request review of a Commission decision issued under R20-5-313 by filing with the Commission a written request for review no later than 30 days after the written decision is mailed to the parties.
- B. A request for review shall be based upon one or more of the following grounds which have materially affected the rights of a party:
 - 1. Irregularities in the hearing proceedings or any order or abuse of discretion depriving the party seeking review of a fair hearing;
 - 2. Misconduct by the Department, Council, Commission, or any party to the hearing;
 - 3. Accident or surprise which could not have been prevented by ordinary prudence;
 - 4. Newly discovered material evidence that could not have been discovered with reasonable diligence and produced at the hearing;
 - 5. Excessive or insufficient sanctions or penalties imposed at hearing;
 - 6. Error in the admission or rejection of evidence, or errors of law occurring at, or during the course of, the hearing;
 - 7. Bias or prejudice of the Department, Council, or Commission; or
 - 8. That the order, decision, or findings of fact are not justified by the evidence or are contrary to law.
- C. A request for review shall state the specific facts and laws in support of the request and shall specify the relief sought by the request.
- D. The Commission shall issue a decision upon review no later than 30 days after receiving a request for review.
- E. The Commission's decision upon review is final unless a candidate or licensee seeks judicial review as provided in A.R.S. § 12-901 et seq.

Historical Note

Former Section R4-13-312 renumbered as Section R4-13-314 effective March 9, 1981 (Supp. 81-2). R20-5-314 recodified from R4-13-314 (Supp. 95-1). Section R20-5-314 repealed; new Section R20-5-314 adopted effective September 9, 1998 (Supp. 98-3).

R20-5-315. Procedure for Investigation and Disposition of Complaints Filed Under A.R.S. § 23-529

- A. A complaint described in A.R.S. § 23-529 shall be filed with the Department within 90 days of the date on which the event giving rise to the complaint occurred.
- B. Upon receipt of a complaint, the Department shall conduct a thorough investigation of the facts relative to the alleged misconduct including obtaining a response from the licensee that is the subject of the complaint. If, upon completion of its investigation, the Department determines that there is sufficient evidence to warrant a revocation or suspension hearing, the Department shall present its findings to the Commission. If the Commission agrees with the Department that there is sufficient evidence to warrant a revocation or suspension hearing, the Commission shall direct the secretary of the Commission to serve the subject licensee with a verified complaint under A.R.S. § 23-529. In addition to the requirements set forth in A.R.S. § 23-529, the verified complaint shall contain the factual findings of the Department and a statement that the Commission shall consider the failure of the licensee to appear at hearing to be an admission of the factual findings in the verified complaint.
- C. Except as provided in A.R.S. § 23-529, A.A.C. R20-5-312, R20-5-313, and R20-5-314 govern hearing rights and procedures for revocation and suspension hearings.

Historical Note

Adopted effective March 9, 1981 (Supp. 81-2). R20-5-315 recodified from R4-13-315 (Supp. 95-1). Section R20-5-315 repealed; new Section R20-5-315 adopted effective September 9, 1998 (Supp. 98-3).

R20-5-316. Reissuance of Employment Agent License After Suspension under A.R.S. § 23-529(D)

- A. An employment agent, whose license has been suspended, may file a request with the Commission after the Commission's decision suspending the license is deemed final asking that the license be reissued. The request for reissuance shall be filed with the Department and shall include the following:
 - 1. The grounds and facts supporting the request for reissuance;
 - 2. All action taken by the formerly licensed employment agent to correct, remedy, or address the reason that the Commission suspended the license; and
 - 3. All information required in an initial application, unless unchanged, in which case a verified statement that the information required for an initial employment agent license is true and correct as originally submitted.
- B. The Department shall review the request for reissuance of employment agent license for administrative completeness within 15 days of receipt of the request.
- C. Within 60 days after the expiration of the time-frame described in subsection (B), the Commission shall conduct a hearing to determine whether the previously suspended license should be reissued. The Commission shall reissue the suspended license if it appears by substantial evidence that the licensee has corrected or remedied the reason that the Commission suspended the license and the licensee has not engaged in any acts in violation of A.R.S. Title 23, Chapter 3, Article 2 or this Article during the time that the license was suspended.
- D. R20-5-312, R20-5-313 and R20-5-314 govern hearing rights and procedure for this Section.

Historical Note

Adopted effective March 9, 1981 (Supp. 81-2). R20-5-316 recodified from R4-13-316 (Supp. 95-1). Section

R20-5-316 repealed; new Section R20-5-316 adopted effective September 9, 1998 (Supp. 98-3).

R20-5-317. Amendment of Employment Agent License

- A.** A licensee shall apply to the Department for an amendment to its employment agent license 30 days before:
 - 1. Changing the name under which the employment agent license is issued; or
 - 2. Changing the location of the employment agency.
- B.** The Department shall review a request for amendment and shall issue an amended license 15 days after receipt of a licensee's current license and the following, if applicable:
 - 1. If the licensee changes the name of the employment agency, the licensee shall submit an amendment or rider of the surety bond showing the new name; or
 - 2. If the licensee changes the licensee's trade name, the licensee shall submit a copy of the registration of the new trade name with the Arizona Secretary of State and submit an amendment or rider of the surety bond showing the new name.
- C.** Transfer or sale of license prohibited.
 - 1. A licensee shall not transfer to another the licensee's employment agent license.
 - 2. A licensee shall not sell the licensee's employment agent license. A purchaser of a licensee's business shall not operate the applicant-paid fee business until the purchaser is licensed by the Commission under A.R.S. § 23- 521 et seq. and this Article.
- D.** Before a licensee changes its legal status or form of doing business, the licensee shall file an initial application for an employment agent license for the new business.
- E.** Relinquishment of license.
 - 1. A licensee shall give the Department 30 days written notice before terminating or discontinuing business as an employment agent.
 - 2. After receipt of a notice of intent to terminate or discontinue, the Department shall conduct an investigation of the licensee's operation to determine whether the operations are in order and in compliance with A.R.S. § 23-521 et seq. and this Article.
 - 3. If the Department determines that the licensee's operations are in order it shall notify the licensee and the company issuing the surety bond that the Department approves the discontinuance of the licensee's business and cancellation of the bond. If the licensee has made a cash deposit, the Department shall instruct the State Treasurer to return the cash deposit. After the Department notifies the licensee of its approval to discontinue business, the licensee shall return its license to the Department for cancellation.
 - 4. If, after an investigation of the licensee's operation, the Department determines that the licensee's operation is not in order (for example, pending claims, refund claims), the Department shall not approve the cancellation of the surety bond or return of the licensee's cash deposit until the licensee resolves all pending matters to the satisfaction of the Department.
- F.** Cancellation of the bond by the surety.
 - 1. The Department shall provide written notice to a licensee within five days of a notice of cancellation of the bond by the surety. A licensee shall submit a new bond or cash deposit to the Department at least 10 days before the existing bond is canceled.
 - 2. If a licensee fails to provide to the Department a new bond or cash deposit within 10 days before the cancellation of the existing bond, the Department shall advise the licensee in writing that the licensee may not act as an

employment agent from the date of the cancellation until the date a new bond or cash deposit is received by the Department.

- 3. The repeated failure to maintain a surety bond or cash deposit at all times constitutes gross negligence and cause for disciplinary action under A.R.S. § 23-529.
- G.** Disassociation of managing agent.
 - 1. A licensee shall notify the Department within 10 days if any managing agent is disassociated from a licensee.
 - 2. At the time of disassociation, a licensee shall appoint another managing agent unless an existing managing agent will be managing the employment agency without replacement of the disassociating managing agent.
 - 3. A newly appointed managing agent shall complete and file a supplemental application within 30 days of appointment.
 - 4. A newly appointed managing agent shall take and pass the written examination required by A.R.S. § 23-526 and R20-5-306.
 - 5. The Department shall advise a licensee whether an application filed by a newly appointed managing agent is deemed complete within 10 days from the date the application is filed. The Department shall issue findings and an order approving or disapproving the appointment of the newly appointed managing agent within 45 days of the date that the licensee is notified the application is complete. The Department shall disapprove the appointment of the new managing agent if the Department finds one or more of the following conditions:
 - a. Material misrepresentation or fraud in the newly appointed managing agent's supplemental application;
 - b. The newly appointed managing agent has a history or record of dishonesty;
 - c. The newly appointed managing agent has a history or record of financial instability or irregularity including a record of misappropriation, conversion, or irregular withholding or accounting of money belonging to another;
 - d. The newly appointed managing agent has a history or record of incompetence;
 - e. The newly appointed managing agent has a history or record of gross negligence;
 - f. The newly appointed managing agent has a history or record of bribery;
 - g. The newly appointed managing agent has a history or record of willful disregard of the requirements of A.R.S. Title 23, Chapter 3, Article 2;
 - h. The newly appointed managing agent has a history or record of injury or loss to the public; or
 - i. The newly appointed managing agent lacks the education, experience, training, or skill to enable the newly appointed managing agent to competently discharge the duties and responsibilities of a managing agent.
 - 6. The Department shall deem its findings and order issued under subsection (G) final unless the licensee requests a hearing before the Commission within 30 days of the date that the findings and order is issued. The request for hearing shall be in writing, signed by the licensee or the licensee's legal representative and filed with the Commission. The Commission shall consider the factors in subsection (G) when approving or disapproving the appointment of a new managing agent. R20-5-312, R20-5-313, and R20-5-314 shall govern hearing rights and

procedure for a request for hearing filed under this subsection.

Historical Note

Adopted effective March 9, 1981 (Supp. 81-2). R20-5-317 recodified from R4-13-317 (Supp. 95-1). Section R20-5-317 repealed; new Section R20-5-317 adopted effective September 9, 1998 (Supp. 98-3).

R20-5-318. Form of Books, Registers and Records

- A.** A licensee shall keep true and correct records of all the business transactions related to the business of an employment agency, including records documenting all bona fide job orders or referrals and copies of all advertisements of the licensee. The licensee shall ensure that all records are legible, understandable and maintained in the office of the licensee for at least three years.
- B.** In addition to the requirements of subsection (A), a licensee shall maintain a summary record of the licensee's job orders and referrals for the prior three years which is recorded on a form containing the following:
1. Name of the individual communicating the job order;
 2. Name of the individual communicating the job referral;
 3. Date of the job order and the job referral;
 4. Name of the individual recording the job order and job referral;
 5. Name and address of employer or company placing the job order;
 6. Name of individual to whom the applicant is to report for an interview;
 7. Job title and basic requirements of the job contained in job order and referral; and
 8. Name of applicant referred.

Historical Note

Former Section R4-13-313 renumbered and amended as Section R4-13-318 effective March 9, 1981 (Supp. 81-2). R20-5-318 recodified from R4-13-318 (Supp. 95-1). Section R20-5-318 repealed; new Section R20-5-318 adopted effective September 9, 1998 (Supp. 98-3).

R20-5-319. Form and Requirements of Contracts

- A.** Contract terms and provisions. A licensee shall ensure that all contracts between a licensee and applicant set forth in clear and unambiguous terms the respective rights and obligations of the applicant and licensee and include the following:
1. The name and address of the applicant and licensee;
 2. A list of the current schedule of fees and charges described in A.R.S. § 23-530(A) and submitted to the Commission;
 3. A clear statement defining when the applicant becomes obligated for the payment of a fee;
 4. A clear statement describing the circumstances under which the applicant is entitled to an adjustment, waiver, or refund of a fee;
 5. A clear statement describing the services performed by the licensee, including if applicable, the duration of the contract;
 6. A statement that the employment agency is licensed, bonded, operates under the laws of Arizona, and is regulated by the Industrial Commission of Arizona;
 7. An acknowledgment by the applicant that the applicant has received a copy of the signed contract; and
 8. Except for contracts between an applicant and a talent or modeling agent, a statement that employment is considered to be temporary when within 90 days after employment begins the employment is terminated through "no

fault" of the applicant, or the applicant voluntarily terminates the employment with "just cause."

9. The following statement shall be included in all contracts between an applicant and career counseling service in no smaller than 10 point bold face type: 'No verbal or written promise or guarantee of any job or employment is made or implied under the terms of the contract'.
- B.** An applicant is deemed to have accepted a position when the applicant agrees with an employer or company to start work at an agreed-upon wage.
- C.** Except for contracts between an applicant and a talent or modeling agent, all placements are considered permanent unless the contract expressly states otherwise or within 90 days after employment begins the employment is terminated through "no fault" of the applicant, or the applicant voluntarily terminates the employment with "just cause."
- D.** A licensee shall provide the applicant a copy or duplicate original of all documents signed by either or both the applicant and licensee.
- E.** The duration and terms of a contract entered into by a talent or modeling agent and applicant shall not exceed two years. A contract may be renewed or terminated by mutual consent of the parties.
- F.** If a term of a contract entered into by a talent or modeling agent, or applicant provides that the applicant's compensation is paid directly to the talent or modeling agent by a company, the talent or modeling agent shall pay the applicant the compensation received, less the talent or modeling agent's fee, no later than seven days after receiving the compensation from the company.
- G.** A talent or modeling agent shall not specify in a contract with an applicant a higher rate of commission than that which is on file with the Department.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

R20-5-320. Bona Fide Job Order

- A.** A licensee shall not offer or represent to an applicant a specific position without having a bona fide job order.
- B.** A licensee shall not misrepresent any matter in connection with a bona fide job order.
- C.** A licensee shall not initiate contact with any applicant at the applicant's current place or places of employment for any reason related to the licensee's employment agency business without the applicant's written permission.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

R20-5-321. Bona Fide Job Referral

- A.** A referral from a licensee, other than a talent or modeling agent, is bona fide when all of the following are completed:
1. The licensee informs the applicant of the name and location of an employer that has placed a bona fide job order, including the name of the individual to whom the applicant will report for an interview;
 2. The licensee informs the applicant of the job specifications and salary range, including the nature, terms, and conditions of the position;
 3. The licensee informs the employer of the applicant's name and qualifications; and
 4. The employer and applicant agree, either directly or by authorized arrangement of the licensee, to meet for an interview.
- B.** A referral from a talent or modeling agent is bona fide when all of the following are completed:

1. The talent or modeling agent informs the applicant of the name and location of a company that has placed a bona fide job order;
2. The talent or modeling agent informs the applicant of the time and duration of the contracted engagement and the amount to be paid to the applicant for the engagement; and
3. The talent or modeling agent gives the applicant a description of the entertainment or services to be performed by the applicant, including the nature, terms, and conditions of the position, and if applicable, the number of performances per day or week required of the applicant.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

R20-5-322. Submission and Approval of Fee Schedule and Receipts by Commission

- A. The Department shall not approve a fee schedule or receipt submitted by a candidate or licensee unless the schedule or receipt is in a form that is reasonably understandable by applicants.
- B. The Department shall consider the following factors in determining the reasonableness of a fee under A.R.S. § 23-530(B):
 1. The fee customarily charged in the locality for similar employment services;
 2. The time and labor required of the candidate or licensee;
 3. The skill required to perform the employment services properly; and
 4. The experience, reputation, and ability of the candidate or licensee performing the employment services.
- C. A licensee may change its schedule of fees by filing an amended schedule of fees with the Department. The licensee shall not use the amended schedule of fees until the schedule has been approved by the Department.
- D. Except as provided in R20-5-308, the Department shall review a licensee's amended schedule of fees within 30 days from the date of filing and shall issue a written order approving or disapproving the schedule of fees. The Commission shall deem an order approving or disapproving the schedule of fees final unless a licensee requests a hearing within 30 days after the order is issued. R20-5-312, R20-5-313, and R20-5-314 shall govern hearings held under this subsection.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

R20-5-323. Fees for Services

- A. Under A.R.S. § 23-530 and subject to subsection (D), a licensee, other than a talent or modeling agent or career counselor, may charge an applicant a fee when any of the following occur:
 1. The applicant accepts employment as a result of a bona fide job order;
 2. The applicant accepts employment as a result of a bona fide job order and fails to report for work, except when justifiable circumstances prevent the applicant from reporting to work. For purposes of this Section 'justifiable circumstances' include death of an applicant or family member, serious physical or psychological illness or condition of an applicant or family member or 'just cause' as defined in R20-5-323(F);
 3. The applicant fails to secure or does not accept a position to which the applicant was originally referred but accepts another position with that employer or with any employer to whom the first employer refers the applicant within six

months as a result of the original referral by the licensee; and

4. The applicant informs another person of the availability of the position described in the referral by the licensee and that person accepts the position within six months after the date of the referral.
- B. Under A.R.S. § 23-530 and subject to subsection (D), a talent or modeling agent may charge an applicant a fee when the applicant receives compensation from the company to whom the applicant is sent under a bona fide referral.
- C. Under A.R.S. § 23-530 and subject to subsection (D), a career counselor may either charge an applicant a fee after the applicant receives services from the career counselor, or require payment in advance of services, if the career counselor provides a prompt refund to the applicant when services are not provided.
- D. Computation of a fee by a licensee other than a talent or modeling agent or career counselor.
 1. A licensee shall not charge a full fee but may charge an adjusted fee to an applicant who starts work but before the expiration of 90 days stops work for the following reasons:
 - a. The applicant or family member dies,
 - b. The applicant or family member suffers a serious physical or psychological illness or condition,
 - c. The applicant is discharged 'without fault', or
 - d. The applicant resigns with 'just cause'.
 2. A licensee shall not charge more than 50% of the scheduled fee to an applicant who fails to report to work without good reason or voluntarily terminates employment without just cause within 30 days of starting employment.
- E. For purposes of computing a fee, termination "for cause" or "with fault" means a lawful or legal termination "for cause" or "with fault" under the laws of this State which may include termination for the following reasons:
 1. Unexcused absence from work;
 2. Intentional violation of employer work rules; or
 3. Incapacitation or inability to perform work duties due to alcohol, drugs, or illegal substances or agents.
- F. For purposes of computing a fee, an applicant has "just cause" for voluntarily terminating employment when the conditions of employment were either misrepresented or withheld from the applicant and those conditions, if known, would cause the applicant to reasonably refuse employment.
- G. Refund of a fee.
 1. A licensee shall immediately refund to an applicant the entire fee paid by the applicant if following a bona fide job order the applicant is not permitted to, or is unable to start work, as a result of justifiable circumstances as defined in R20-5-323(A)(2).
 2. A licensee shall immediately refund to an applicant the entire fee paid by the applicant if the licensee fails to provide or deliver the services or products agreed upon in the contract between the licensee and applicant.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

R20-5-324. Fee Disputes

- A. Complaint alleging refund dispute.
 1. An applicant alleging that a licensee has failed to refund a fee that the applicant is entitled to receive may file a written notarized complaint with the Department. The written complaint shall be filed within 90 days of demanding a refund from the licensee. The applicant shall make the written complaint under oath and include the following information:

- a. The name and address of the applicant;
 - b. The name and address of the licensee against whom the complaint is filed;
 - c. The factual allegations of the applicant along with any supporting documentation;
 - d. The relief requested by the applicant; and
 - e. All steps taken to informally resolve the dispute between the applicant and licensee.
2. The Department shall serve the licensee a copy of the complaint by certified mail within five days of receipt of the complaint.
- B. Answer.**
1. A licensee shall respond to a complaint filed against it by filing an answer with the Department within 10 days after the complaint is mailed.
 2. The licensee shall attach to the licensee's answer copies of all receipts, agreements, or contracts relevant to the dispute.
 3. The Department shall mail the applicant a copy of the licensee's answer within 10 days of receipt of the answer.
- C. Investigation and determination by Department.**
1. The Department shall investigate the allegations contained in a complaint and answer to determine whether a fee charged by the licensee complies with A.R.S. § 23-521 et seq. and this Article. At the request of the parties or on its own motion, the Department may schedule an informal meeting between the applicant, licensee and Director of the Department. The Department shall convene the informal meeting for the purpose of obtaining information to assist the Department in its investigation of the refund dispute.
 2. Within 90 days after receipt of the answer, or the complaint if no answer is filed, the Department shall issue written findings and an order setting forth its determination of the refund dispute.
 3. The Department shall mail a copy of its findings and order upon the applicant and licensee by mail at the last known address of the applicant and licensee.
 4. The Department shall deem its findings and order final unless within 30 days from the date the findings and order is mailed, the applicant or licensee, or an authorized representative of the applicant or licensee, requests a hearing before the Commission.
- D. Commission Hearing and Decision.**
1. Hearing rights and procedures shall be governed by R20-5-312.
 2. An applicant shall have the burden to establish that the applicant is entitled to a refund.
 3. Based on the evidence presented at hearing, the Commission shall determine whether the fee charged by the licensee complies with the requirements of A.R.S. § 23-521 et seq. and this Article entitling the applicant to a refund of the fee. The Commission shall issue written findings and an order setting forth its determination. The Commission decision is final unless a party requests review within 30 days from the date the decision is issued.
 4. A party may request review of a Commission decision issued under this subsection by filing with the Commission a written request for review no later than 30 days after the written decision is mailed to the parties. The request for review shall be based upon one or more of the grounds set forth in R20-5-314 (B) that have materially affected the rights of a party. The request for review shall state the specific facts and laws in support of the request and shall specify the relief sought by the request.

5. The Commission shall deem its decision upon review final unless an applicant or licensee seeks review as required by A.R.S. § 23-532(C).

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

R20-5-325. Determining Right of Referral and Placement

As between two licensees, the licensee entitled to a fee is the licensee that first completes a bona fide referral. However, if after the expiration of six months from the date of a referral by a licensee to an employer, no active interest or consideration is being given the applicant by the employer through the original referral, and a second licensee, who has a bona fide job order from the employer, refers the same applicant to the same employer and the applicant secures employment as a result of the second referral, the second licensee is entitled to the fee.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

R20-5-326. Advertising

In addition to the provisions of A.R.S. § 23-534, the Department shall deem advertising false, misleading, or misrepresentative if the advertisement fails to conform to the following requirements:

1. An advertisement shall carry the name under which the agency is licensed to do business and shall state that the business is an applicant-paid service or includes an applicant-paid service. An agent may abbreviate in an advertisement "applicant-paid service" as "app-pd svc." An agent may abbreviate in an advertisement the name under which the agency is licensed to do business provided that an agent does not abbreviate its licensed name by using initials only unless initials are a part of the name under which the agent is licensed;
2. If an advertisement is for a specific position, it shall be based upon an actual bona fide job order with the licensee and available at the time the advertisement is printed;
3. An advertisement shall not use a post office box number, a press box number, an associate name, an employer or counselor name, a telephone number only, or any other "blind" address;
4. An advertisement shall be canceled when a position is known to be filled or when knowledge is available that the position is not available;
5. A position shall not be advertised at maximum pay only. A position may be advertised at a range from minimum to maximum, or by the words "to a maximum or \$" or "to \$." The word "open" or the symbol "\$\$\$" may not be used as a substitute for the salary of any position or positions in an advertisement;
6. An advertised position that requires or may require travel 50 miles beyond the city in which the newspaper or medium is published shall state that the position is not local;
7. A job title shall appear in an advertisement and shall be reasonably descriptive in accordance with the type of work to be performed;
8. An advertisement for a position within the agency itself shall indicate the agency is the employer;
9. An advertisement shall not state "guarantees a job," "guaranteed results," or words of similar import;
10. If the advertisement is a display or promotional advertisement and does not list a particular position, it shall carry the licensed name of the licensed employment agency;
11. An advertisement shall not state or imply that the licensed employment agency has access to an 'unpublished job market' or 'hidden job market'; and

12. An advertisement for a career counseling service shall not state or imply the following:
 - a. The existence of specific or general job openings;
 - b. Special contacts;
 - c. The success performance of clients in percentage terms;
 - d. Prospective increase in income as a result of utilizing the career counseling service;
 - e. The number of interviews or job offers likely to be obtained as a result of utilizing the career counseling service; and
 - f. The time within which it is likely that a new position will be found.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

R20-5-327. Labor Contractors

A labor contractor is not considered a private employment agent provided the labor contractor does not charge a fee to the worker who is contracted to the labor contractor's customer or client and meets the definition of a labor contractor under this Article.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

R20-5-328. Talent and Modeling Agencies

- A. All talent or modeling agencies meeting the definition of an employment agent in A.R.S. § 23-521(A) are subject to the provisions of A.R.S. § 23-521 et seq. and this Article, except that the Department shall not consider the following activities as conducting the business of a talent agent in this state if no fees are charged to applicants for:
 1. The production of theatrical or musical arts or stage shows consisting of responsibility for an entire program;
 2. Acting as exclusive business or personal manager for a talent and not referring talent and models to jobs; or
 3. Casting services.
- B. A talent or modeling agency shall investigate any company who offers employment to a talent or model to reasonably ensure that the company has not defaulted in the payment of salaries, fees, or other compensation to talents and models the company has employed.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

R20-5-329. Employment Agencies Acting Without a License

- A. The Department shall investigate the nature and scope of the business of any person, firm, corporation, or association when the person, firm, corporation, or association appears to meet the definition of an "employment agent" in A.R.S. § 23-521, but is operating without an employment agent license.
- B. The Department's investigation may include requesting written reports from the person, firm, corporation, or association in question, inspecting relevant records, and securing statements or depositions from witnesses.
- C. If, after a thorough investigation, the Department determines that the person, firm, corporation, or association is conducting the business of an employment agent in Arizona without an employment agent license, the Department shall submit the entire record of its investigation, along with the Department's findings, to the appropriate law enforcement agency for criminal prosecution in accordance with the provisions of A.R.S. § 23-536.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

ARTICLE 4. ARIZONA BOILERS AND LINED HOT WATER HEATERS**R20-5-401. Applicability**

This Article applies to all boilers, lined hot water heaters and pressure vessels operated in Arizona, except the following:

1. Boilers, lined hot water heaters and pressure vessels regulated by the United States Government;
2. Boilers, lined hot water heaters and pressure vessels operated in private residences or apartment complexes of not more than six units; and
3. Boilers, lined hot water heaters and pressure vessels operated on Indian reservations.
4. A lined hot water heater that does not exceed any of the following:
 - a. Heat input of 200,000 BTU per hour,
 - b. Water temperature of 210° F, and
 - c. Nominal water containing capacity of 120 gallons.

Historical Note

Former Rules B-1.1 and B-1.2. Former Section R4-13-401 repealed, new Section R4-13-401 adopted effective April 12, 1979 (Supp. 79-2). Section R4-13-401 repealed, new Section adopted effective April 9, 1992 (Supp. 92-2).

R20-5-401 recodified from R4-13-401 (Supp. 95-1).

Amended effective October 9, 1998 (Supp. 98-4).

Amended by final rulemaking at 15 A.A.R. 1496, effective August 18, 2009 (Supp. 09-3).

R20-5-402. Definitions

In this Article, unless the text otherwise requires:

1. "Act" means A.R.S. Title 23, Chapter 2, Article 11.
2. "Alteration" means any change in the item described on the original manufacturer's data report which affects the pressure-containing capability of the boiler or pressure vessel, including but not limited to:
 - a. Non physical changes such as an increase in the maximum allowable working pressure either internal or external, or
 - b. A reduction in minimum design temperature of a boiler or pressure vessel requiring additional mechanical tests.
3. "ANSI" means American National Standards Institute, Inc., located at 25 W. 43rd Street, 4th Floor, New York, NY 10036 or at <http://www.ansi.org/>.
4. "Apartment house" means a building with multiple family dwelling units, not used for commercial purposes, including condominiums and townhouses, where boilers are located in a common area outside of the individual dwelling units, such as a boiler room.
5. "Applicant" means an individual requesting permission to act as a special inspector under A.R.S. § 23-485.
6. "ASME Code" means the American Society of Mechanical Engineers Boiler and Pressure Vessel Code, Sections I, II, IV, V, VIII and IX, published by ASME International.
7. "ASME International" means a not for profit professional organization that promotes the art, science and practice of mechanical and multidisciplinary engineering and allied sciences throughout the world.
8. "Authorized Inspector" means an authorized representative under A.R.S. § 23-471(1) or a special inspector under A.R.S. § 23-485.
9. "Authorized representative" means the boiler chief or boiler inspector employed by the Division.
10. "Blowdown tank" or "Blowdown separator" means an ASME-stamped vessel designed to receive discharged

- steam or hot water from a boiler blowoff or blowdown piping system.
11. "Boiler" means a closed vessel in which fluid is heated for use external to itself by the direct application of heat resulting from the combustion of fuel, solid, liquid, or gaseous, or by the use of electricity.
12. "Certificate of Competency" means a person who has passed the National Board Exam.
13. "Certificate Inspection" means an internal inspection, when construction allows; otherwise, it means as complete an inspection as possible.
14. "Condemned" means a boiler or lined hot water heater that has been inspected and found to be unsafe by the Director or authorized inspector and has been stamped or tagged with the code XXX AZ8 XXX.
15. "CSD-1" means Controls and Safety Devices for Automatically Fired Boilers, published by ASME International, incorporated by reference in R20-5-404(A)(4).
16. "Direct fired jacketed steam kettle" means a pressure vessel with inner and outer walls that is subject to steam pressure and stress, is used to boil or heat liquids or to cook food, and falls under the scope of Section VIII, Division 1, Appendix 19 (Electrically Heated or Gas Fired Jacketed Steam Kettles) of the ASME Boiler and Pressure Vessel Code incorporated by reference in R20-5-404(A).
17. "External inspection" means an examination of a boiler or lined hot water heater performed by an authorized inspector when the boiler or lined hot water heater is in operation.
18. "Forced circulation hot water heater" means a hot water heater used for potable water, a hot water heater requiring movement of water to prevent overheating and failure of the tubes or coils, and has no definitive waterline.
19. "Fully attended power boiler" means a power boiler that is operated by an individual who meets the requirements of R20-5-408(C), and whose primary function is the care, maintenance, and operation of the boiler and the equipment associated with the boiler system.
20. "High temperature water boiler" means a boiler in which water is heated and operates at a pressure in excess of 160 psig (1.1 MPa) and/or temperature in excess of 250° F.
21. "Historical boilers" means steam boilers of riveted construction, preserved, restored, or maintained for hobby or demonstration use.
22. "Inspection certificate" means a document issued by the Division for the operation of a boiler, lined hot water heater or direct fired jacketed steam kettles when a certificate inspection has been successfully completed.
23. "Internal inspection" means a complete examination of the internal and external surfaces of a boiler or lined hot water heater by an authorized inspector after the boiler or lined hot water heater is shut down.
24. "Lined hot water heater" means the same as lined hot water storage heater defined in A.R.S. § 23-471(10) as a vessel which is closed except for openings through which water can flow, that includes the apparatus by which heat is generated and on which all controls and safety devices necessary to prevent pressures greater than 160 psig (1100 kPa gage) and water temperature greater than 210° F are provided, in which potable water is heated by the combustion of fuels, electricity, or any other heat source and removed for external use.
25. "MAWP" means maximum allowable working pressure.
26. "National Board Commissioned Inspector" means an individual who holds a valid and current National Board Commission issued by the National Board of Boiler and Pressure Vessel Inspectors, 1055 Crupper Avenue, Columbus, OH 43229-1183.
27. "National Board Registration Number" means a unique number issued to a boiler, hot water heater or pressure vessel by the manufacturer and recorded with the National Board of Boiler and Pressure Vessel Inspectors.
28. "NFPA" means National Fire Protection Association.
29. "Non-Standard Boiler" means any boiler, hot water heater or pressure vessel that is not constructed or maintained to the standards incorporated by reference of this Article.
30. "Owner" or "Operator" means any individual or organization, including this state and all political subdivisions of this state, who have title, control or duty to control, the operation of one or more boilers, lined hot water heaters or pressure vessels.
31. "Portable boiler" means a boiler permanently affixed to a trailer with wheels, that is totally self-contained while operating, and not attached to any other object either by pipe, hose or wire.
32. "Relief valve" means an ASME-stamped automatic pressure relieving device designed for liquid service which is actuated by the pressure upstream of the valve and opens further with an increase in pressure above the stamped pressure.
33. "Repairs" means work necessary to restore a boiler, lined hot water heater or pressure vessel to operating condition that complies with this Article.
34. "Safety relief valve" means an ASME-stamped automatically pressure-actuated relieving device designed for use either as a safety valve or as a relief valve.
35. "Safety valve" means an ASME-stamped automatic pressure relieving device designed for steam or vapor service which is actuated by the pressure upstream of the valve and characterized by full opening pop-action.
36. "Secondhand" means a boiler, lined hot water heater or pressure vessel that has changed both location and ownership since original installation.
37. "Shelter" means a permanent structure that provides protection from the weather.
38. "Special Inspector" means any authorized inspector who is issued an Arizona Commission but is not employed by the state of Arizona.
39. "State Identification Number" means a unique number assigned by the Division to a boiler, hot water heater or pressure vessel installed in Arizona.
40. "User" means a person or entity that does not have legal title to a boiler, lined hot water heater or pressure vessel, but has control and responsibility for the operation of a boiler, lined hot water heater or pressure vessel.

Historical Note

Former Rules B-2.1 through B-2.6. Former Section R4-13-402 repealed, new Section R4-13-402 adopted effective April 12, 1979 (Supp. 79-2). Amended effective March 31, 1981 (Supp. 81-2). Amended effective May 11, 1981 (Supp. 81-3). Amended effective May 31, 1985 (Supp. 85-3). Section R4-1-402 repealed, new Section adopted effective April 9, 1992 (Supp. 92-2). R20-5-402 recodified from R4-13-402 (Supp. 95-1). Amended effective October 9, 1998 (Supp. 98-4). Amended by final rulemaking at 15 A.A.R. 1496, effective August 18, 2009 (Supp. 09-3).

R20-5-403. Boiler Advisory Board

- A.** Members of the boiler advisory board appointed by the Commission pursuant to A.R.S. § 23-474(2) shall serve for a period of three years. At the end of each three year term, the Commission may extend a member's term an additional three years or replace any member with an individual representing similar interest within the industry. The board shall be composed of persons in the boiler industry and shall be balanced in representation with respect to industry, owner/operators, labor and the public.
- B.** The board shall hold an annual meeting and such other meetings as may be appropriate and shall conduct business at times and places arranged by the Commission.

Historical Note

Former Rules B-3.1 through B-3.3. Former Section R4-13-403 repealed, new Section R4-13-403 adopted effective April 12, 1978 (Supp. 79-2). Section R4-13-403 repealed, new Section adopted effective April 9, 1992 (Supp. 92-2). R20-5-403 recodified from R4-13-403 (Supp. 95-1). Amended by final rulemaking at 15 A.A.R. 1496, effective August 18, 2009 (Supp. 09-3).

R20-5-404. Standards for Boilers, Lined Hot Water Heaters and Pressure Vessels

- A.** The following apply to this Article:

1. An owner or user of a boiler installed, repaired, replaced, or reinstalled in Arizona, six months after the effective date of this Article shall comply with the 2007 ASME Boiler and Pressure Vessel Code, Sections I, II, IV, V, VIII Division 1, 2, 3, IX, and B31.1 Power Piping, and addenda as of July 1, 2007, incorporated by reference. This incorporation does not include any later amendments or editions of the incorporated material. A copy of this referenced material is available for review at the Industrial Commission of Arizona, 800 W. Washington Street, Phoenix, AZ 85007 and may be obtained from ASME International at Three Park Avenue, New York, NY 10016-5990 or at <http://www.asme.org/>.
2. An owner or user of a boiler, lined hot water heater or pressure vessel installed, repaired, replaced, or reinstalled in Arizona, before the effective date of this Article shall comply with subsection (A)(1), or the ASME Boiler and Pressure Vessel Code in effect at the time of the last installation, repair, replacement, or reinstallation of the boiler, lined hot water heater or pressure vessel in Arizona.
3. An owner or user of a gas-fired lined hot water heater installed, operated, repaired, replaced, or reinstalled in Arizona shall comply with the American National Standard for Gas Water Heaters, ANSI Z21.10.3-2004, incorporated by reference. This incorporation does not include any later amendments or editions of the incorporated material. A copy of this referenced material is available for review at the Industrial Commission of Arizona, 800 W. Washington Street, Phoenix, AZ 85007 and may be obtained from ANSI, Attn: Customer Service Department, 25 W. 43rd Street, 4th Floor, New York, NY 10036 or at <http://www.ansi.org/>.
4. An owner or user of a boiler installed, repaired, replaced or reinstalled in Arizona after the effective date of this Article shall comply with the American National Standard for Controls and Safety Devices for Automatically Fired Boilers, ANSI/ASME CSD-1-2006, incorporated by reference. This incorporation does not include any later amendments or editions of the incorporated matter.

A copy of this referenced material is available for review at the Industrial Commission of Arizona, 800 W. Washington Street, Phoenix, AZ 85007 and may be obtained from ASME International, Three Park Avenue, New York, NY 10016-5990 or at <http://www.asme.org/>.

5. An owner or user of a boiler installed, repaired, replaced, or reinstalled in Arizona before the effective date of this Article shall comply with the American National Standard for Controls and Safety Devices for Automatically Fired Boilers in effect at the time of the last installation, repair, replacement or reinstallation of a boiler in Arizona. As an alternative, an owner or user of a boiler described in this subsection may comply with subsection (A)(4).
 6. A permanent source of outside air shall be provided for each boiler and lined hot water heater room to assure complete combustion of the fuel as required by ANSI Z223.1-2006, NFPA 54, National Fuel Gas Code incorporated by reference. This incorporation does not include any later amendments or editions of the incorporated matter. A copy of this referenced material is available for review at the Industrial Commission of Arizona, 800 W. Washington Street, Phoenix, AZ 85007 and may be obtained from ANSI, Attn: Customer Service Department, 25 W. 43rd Street, 4th Floor, New York, NY 10036 or at <http://www.ansi.org/>.
- B.** The following registration requirements apply to this Article:
1. All boilers and lined hot water heaters, including reinstalled and secondhand boilers, shall be registered with the National Board of Boiler and Pressure Vessel Inspectors except for:
 - a. Non-standard boilers installed up to six months after the effective date of this Section,
 - b. Cast iron boilers, and
 - c. Cast aluminum boilers.
 2. All fired and unfired pressure vessels installed or reinstalled on or after July 1, 2009, shall be registered with the National Board of Boiler and Pressure Vessel Inspectors.
- C.** The following installation, maintenance, and repair requirements apply to this Article.
1. An owner or user shall keep a signed copy of the Manufacturer's Data Report for a boiler or lined hot water heater at the location of the boiler or lined hot water heater and make the report available for review upon request from an authorized inspector.
 2. A boiler shall have masonry or structural supports of sufficient strength and rigidity to safely support the boiler and its contents without any vibration in the boiler or its connecting piping.
 3. There shall be at least 36 in. (915 mm) of clearance on each side of the boiler or lined hot water heater. Alternative clearances according to the manufacturer's recommendations are subject to approval by the Division prior to installation of boiler or lined hot water heater.
 4. A boiler with a manhole shall have at least five feet clearance between the boiler manhole and any wall, ceiling, or piping.
 5. A newly constructed boiler room in excess of 500 square feet of floor area and containing one or more boilers with a fuel capacity of 1,000,000 BTU per hour or a heating capacity greater than 285 Kw (electric), shall have at least two exits on each level of the boiler or boilers. The owner or user shall ensure each exit is remotely located from other exits.

6. An owner or user shall keep a boiler or lined hot water heater room clean and with no obstructions to the boiler or lined hot water heater.
7. An owner or user shall not store flammable or explosive materials in a boiler or lined hot water heater room.
8. An owner or user shall not store combustibles less than three feet from any part of a boiler or lined hot water heater.
9. If a boiler or lined hot water heater is moved outside Arizona for temporary use or repairs, the owner or user shall not reinstall the boiler or lined hot water heater in Arizona until the owner or user notifies and receives verbal or written approval from the Division under R20-5-419 to reinstall the boiler or lined hot water heater. If the Division grants approval to reinstall the boiler or lined hot water heater, the owner or user shall not operate the reinstalled boiler or lined hot water heater until the owner or user receives an inspection certificate from the Division under this Article.
10. Before a new power boiler or a used or secondhand boiler or pressure vessel is installed, an inspection shall be made by an authorized inspector of this state, or by a National Board Commission Inspector. This inspection is to assess the integrity of the vessel and evaluate the original design specification. Prior to installation, an application shall be filed by the owner or user of the boiler or pressure vessel with the Division for approval. This application shall contain the following information:
 - a. Name of the owner or user;
 - b. Mailing address of owner or user;
 - c. Business telephone number of owner or user;
 - d. Installation name and address;
 - e. Installation date;
 - f. Start up date;
 - g. Name and address of boiler/pressure vessel insurance company;
 - h. Arizona serial number of the boiler/pressure vessel being replaced, if applicable;
 - i. Description of the new, used or secondhand power boiler/ pressure vessel as to include:
 - i. Manufacture's name,
 - ii. Date manufactured,
 - iii. Maximum allowable pressure or temperature of boiler/pressure vessel, and
 - iv. National Board registration number;
 - j. Name, address, business phone number, cell phone number, fax number and state contractor's license number of company or individual that will be installing the object;
 - k. Name, title and phone number of the contact person on the site of installation; and
 - l. Signature, title and date of the person submitting the application.
11. Before the owner or user installing a used boiler or pressure vessel, the boiler or pressure vessel shall pass a hydrostatic test that is witnessed by an authorized inspector, authorized representative or by any National Board Commissioned inspector in accordance with R20-5-411.
12. An owner or user of a portable boiler shall notify an authorized inspector before installing the portable boiler and shall not operate the portable boiler until the owner or user receives an inspection certificate from the Division.

Historical Note

Former Rules B-4.1 through B-4.3. Former Section R4-13-404 repealed, new Section R4-13-404 adopted effective April 12, 1979 (Supp. 79-2). Amended subsection (P) by

adding paragraph (7) and amended subsection (Q) effective October 3, 1980 (Supp. 80-5). Section R4-13-404 repealed, new Section adopted effective April 9, 1992 (Supp. 92-2).

R20-5-404 recodified from R4-13-404 (Supp. 95-1).

Amended effective October 9, 1998 (Supp. 98-4).

Amended by final rulemaking at 15 A.A.R. 1496, effective August 18, 2009 (Supp. 09-3).

R20-5-405. Repealed

Historical Note

Former Section R4-13-405 repealed effective April 12, 1979 (Supp. 79-2). New Section R4-13-405 adopted effective June 13, 1980 (Supp. 80-3). Section R4-13-405 repealed, new Section adopted effective April 9, 1992

(Supp. 92-2). R20-5-405 recodified from R4-13-405 (Supp. 95-1). Repealed by final rulemaking at 15 A.A.R. 1496, effective August 18, 2009 (Supp. 09-3).

R20-5-406. Repairs and Alterations

- A. If repairs or alterations may affect the working pressure or safety of a boiler, an owner, user, or operator shall consult with an authorized inspector before having the repairs or alterations made. The authorized inspector shall provide the owner, user, or operator information regarding the best method to repair or alter the boiler. The owner, user, or operator shall ensure that an authorized inspector inspects and approves the repairs and alterations after the repairs or alterations are made.
- B. Repairs and alterations to boilers shall conform to the applicable provisions of the National Board Inspection Code, ANSI/NB-23-2007 Edition and 2007 addenda, incorporated by reference. This incorporation does not include any later amendments or editions of the incorporated material. A copy of this referenced material is available for review at the Industrial Commission of Arizona, 800 W. Washington Street, Phoenix, AZ 85007, and may be obtained from the National Board of Boiler and Pressure Vessel Inspectors, 1055 Crupper Avenue, Columbus, OH 43229-1183 or at <http://www.national-board.org/>.
- C. An owner or user shall not permit an individual to remove or repair a safety appliance of a boiler or lined hot water heater in operation. An owner or user shall not permit a person to remove or repair a safety appliance of a boiler or lined hot water heater not in operation except as provided under the ASME Code. If an owner or user permits a person to remove a safety appliance from a boiler or lined hot water heater as provided under the ASME Code, then the owner or user shall ensure that the safety appliance is reinstalled in proper working order before the boiler or lined hot water heater is placed back into operation.
- D. No person shall alter in any manner a safety valve, relief valve, or safety relief valve, except by an organization qualified in accordance with The National Board Inspection Code, ANSI/NB-23 2007 Edition and 2007 addenda incorporated by reference. This incorporation does not include any later amendments or editions of the incorporated material. A copy of this referenced material is available for review at the Industrial Commission of Arizona, 800 W. Washington Street, Phoenix, AZ 85007, and may be obtained from the National Board of Boiler and Pressure Vessel Inspectors at 1055 Crupper Avenue, Columbus, OH 43229-1183 or at <http://www.national-board.org/>.
- E. Repairs of fittings or appliances shall comply with the requirements of the National Board Inspection Code, ANSI/NB-23-2007 Edition and 2007 addenda incorporated by reference. This incorporation does not include any later amendments or editions of the incorporated material. A copy of this referenced material is available for review at the Industrial Commission

of Arizona, 800 W. Washington Street, Phoenix, AZ 85007 and may be obtained from the National Board of Boiler and Pressure Vessel Inspectors, 1055 Crupper Avenue, Columbus, OH 43229-1183 or at <http://www.nationalboard.org/>.

- F.** Beginning six months after the effective date of this Section replacement of fittings or appliances shall comply with the requirements of the 2007 ASME Boiler and Pressure Vessel Code, Sections I, II, IV, V, VIII, Division 1, 2, 3, IX and B31.1 Power Piping, and addenda, incorporated by reference. This incorporation does not include any later amendments or editions of the incorporated material. A copy of this referenced material is available for review at the Industrial Commission of Arizona, 800 W. Washington Street, Phoenix, AZ 85007. A copy of the incorporated material may also be obtained from ASME International, Three Park Avenue, New York, NY 10016-5990 or at <http://www.asme.org>.

Historical Note

Former Section R4-13-406 repealed effective April 12, 1979 (Supp. 79-2). New Section R4-13-406 adopted effective June 13, 1980 (Supp. 80-3). Section R4-13-406 repealed, new Section adopted effective April 9, 1992 (Supp. 92-2). R20-5-406 recodified from R4-13-406 (Supp. 95-1). Amended effective October 9, 1998 (Supp. 98-4). Amended by final rulemaking at 15 A.A.R. 1496, effective August 18, 2009 (Supp. 09-3).

R20-5-407. Inspection of Boilers, Lined Hot Water Heaters, Direct Fired Jacketed Steam Kettles and Issuance of Inspection Certificates

- A.** An authorized inspector shall comply with the guidelines set forth in The National Board Inspection Code, ANSI/NB-23-2007 Edition and 2007 addenda, incorporated by reference. This incorporation does not include any later amendments or editions of the incorporated material. A copy of this referenced material is available for review at the Industrial Commission of Arizona, 800 W. Washington Street, Phoenix, AZ 85007 and may be obtained from the National Board of Boiler and Pressure Vessel Inspectors, 1055 Crupper Avenue, Columbus, OH 43229-1183 or at <http://www.nationalboard.org/>.
- B.** If an owner, user, or operator fails to comply with the requirements for an inspection or pressure test under this Article, the Division shall withhold the inspection certificate until the owner, user, or operator complies with the requirements.
- C.** An authorized inspector shall not engage in the sale of any object or device relating to boilers, lined hot water heaters, direct fired jacketed steam kettles or equipment associated with boilers, or lined hot water heaters or direct fired jacketed steam kettles.
- D.** Under A.R.S. § 23-485(D), the Special Inspector shall file the inspection reports by entering data into the Division's Web-based inspection entry form, by submitting a paper inspection report issued by the Division or by electronic transfer of data between the insurance company's database and the Division's database. The inspection report shall contain the following:
1. Whether it is a Certificate or non-Certificate inspection;
 2. Whether it is an internal or external inspection;
 3. Name of location, address and phone number of the object;
 4. Name, address and phone number of owner or responsible party;
 5. Contact person's name and phone number at the inspection location;
 6. State Identification Number;
 7. Certificate due date;
 8. Certificate duration;
 9. Whether the object is active, inactive or scrapped;
 10. MAWP permitted or allowed;
 11. National Board registration number;
 12. Name of the manufacturer and the year the object was built;
 13. Special location in plant, if applicable;
 14. Boiler type;
 15. Purpose of the boiler;
 16. Specify type of fuel used;
 17. Whether the firing method is automatic, manual or unknown;
 18. Whether the fuel train is in compliance with CSD-1, NFPA 85, Z21.10.3 or other;
 19. Whether the boiler is fully attended as per R20-5-408(C);
 20. Heating Surface/BTU Input/ Kilowatt (Kw) Input, as applicable;
 21. Whether the heating surface type is stamped, computed or unknown;
 22. Minimum safety valve relief capacity required;
 23. Whether the minimum safety valve relief capacity type is BTU/Hr, LBS/Hr or unknown;
 24. Number of temperature/pressure controls, as applicable;
 25. Owner number assigned by the owner to specifically identify object's location;
 26. Inspection date;
 27. Whether the certificate is posted;
 28. Safety Valve Total Capacity;
 29. Safety Valve #1 set pressure;
 30. Safety Valve #2 set pressure;
 31. Safety Valve #3 set pressure;
 32. Whether the object has been hydro tested;
 33. Hydro Test (psi), if applicable;
 34. Whether Pressure/Altitude Gage was tested;
 35. Whether of the condition of the object is okay to issue a certificate;
 36. Inspection comments, condition of boiler;
 37. Violations noted;
 38. Inspector name and Arizona Commission number; and
 39. National Board Commission number.
- E.** The Division shall issue to an owner or user an inspection certificate within 30 calendar days of receipt of an inspection report that documents a boiler, lined hot water heater or direct fired jacketed steam kettle that complies with the Act and this Article. An owner or user of a boiler, lined hot water heater or direct fired jacketed steam kettle shall post the inspection certificate in the establishment where the boiler, lined hot water heater or direct fired jacketed steam kettle is located.
- F.** An owner, user, or operator shall ensure than an authorized inspector tags or stamps a steam boiler with an identification number assigned by the Division immediately after installing, but before operating, a new steam boiler, or when an authorized inspector performs an initial certificate inspection of an existing steam boiler. The identification number shall be at least 5/16" in height and in the following format: AZ-# # # #.
- G.** The Division shall mark with a metal dye stamp a boiler or lined hot water heater identified by the Division as not safe for further service, with the code "XXX AZ8 XXX" which shall designate that the boiler or lined hot water heater is condemned.
- H.** For any conditions not covered by this Article, the applicable provisions of the ASME Code that was in effect in Arizona at the time of the installation of the boiler or lined hot water heater shall apply.

Historical Note

Repealed effective April 12, 1979 (Supp. 79-2). New Section adopted effective April 9, 1992 (Supp. 92-2). R20-5-407 recodified from R4-13-407 (Supp. 95-1).

Amended effective October 9, 1998 (Supp. 98-4).
Amended by final rulemaking at 15 A.A.R. 1496, effective August 18, 2009 (Supp. 09-3).

R20-5-408. Frequency of Inspection

- A. An owner, user, or operator of a power boiler shall ensure that an authorized inspector performs a certificate inspection and external inspection of the power boiler every 12 months. An authorized inspector shall perform the external inspection while the power boiler is in operation to ensure that safety devices of the power boiler are operating properly.
- B. An authorized inspector shall perform an internal inspection and pressure test on a boiler, lined hot water heater or pressure vessel if the inspector determines from an external inspection of the boiler, lined hot water heater or pressure vessel that continued operation of the boiler, lined hot water heater or pressure vessel is a danger to the public or worker safety.
- C. The Division shall issue a 12 month inspection certificate to an owner or user to operate a fully attended power boiler if:
1. An owner or user ensures that an authorized inspector performs an external safety inspection and audit of the operational methods and logs of the fully attended power boiler at least every 12 months and performs an internal inspection of the fully attended power boiler at least every 36 months;
 2. Continuous boiler water treatment is under the direct supervision of persons trained and experienced in water treatment for the purpose of controlling and limiting corrosion and deposits.
 3. Records are available for review, that indicate:
 - a. The date, time, and reason the boiler is out of service; and
 - b. Daily analysis of water samples that adequately show the conditions of the water and elements or characteristics that are capable of producing corrosion or other deterioration to the boiler or its parts; and
 4. Controls, safety devices, instrumentation, and other equipment necessary for safe operation are current, in service, calibrated, and meet the requirements of an appropriate safety code for the size boilers, such as NFPA 85, ASME CSD-1 Controls and Safety Devices for Automatically Fired Boilers, National Board Inspection Code ANSI/NB-23, and state requirements.
 5. Inspection reports of an authorized inspector document that the fully attended power boiler complies with A.R.S. § 23-471 et seq. and this Article.
- D. An owner, user, or operator of a direct-fired jacketed steam kettle shall ensure that an authorized inspector performs a certificate inspection of the direct-fired jacketed steam kettle every 24 months.
- E. An owner, user, or operator of a heating or process boiler, not exceeding 15 p.s.i. maximum allowable working pressure, steam or vapor, shall ensure that an authorized inspector performs a certificate inspection of the heating or process boiler every 24 months.
- F. An owner or user of a hot water heating or hot water supply boiler, or lined hot water heater shall ensure that an authorized inspector performs a certificate and external inspection of the hot water heating or hot water supply boiler or lined hot water heater at the time the hot water heating or hot water supply boiler or lined hot water heater is installed. An inspection certificate issued by the Division following an inspection under this subsection shall not state an expiration date.

Historical Note

Repealed effective April 12, 1979 (Supp. 79-2). New

Section adopted effective April 9, 1992 (Supp. 92-2).
R20-5-408 recodified from R4-13-408 (Supp. 95-1).
Amended effective October 9, 1998 (Supp. 98-4).
Amended by final rulemaking at 15 A.A.R. 1496, effective August 18, 2009 (Supp. 09-3).

R20-5-409. Notification and Preparation for Inspection

- A. An authorized inspector shall perform a certificate inspection at a time mutually agreeable to the inspector and owner, user, or operator.
- B. Before an authorized inspector performs an internal inspection of a boiler, an owner, user, or operator shall:
1. Cool the furnace and combustion chambers;
 2. Drain the water from the boiler;
 3. Remove the manhole and handhole plates, wash-out plugs, and inspection plugs in water column connections;
 4. Remove insulation or brickwork if necessary to determine the condition of the boiler, headers, furnace, supports, and other parts;
 5. Remove the pressure gauge for testing;
 6. Prevent any leakage of steam or hot water into the boiler by disconnecting the involved pipe or valve;
 7. Close, tag, and padlock the non-return and steam stop valves before opening the manhole or handhole covers and entering any part of the steam generating unit that is connected to a common header with other boilers. Open the free blow drain or cock between the non-return and steam stop valves;
 8. Close, tag, and padlock the blowoff valves after draining the boiler; and
 9. Open all drains and vent lines.

Historical Note

Repealed effective April 12, 1979 (Supp. 79-2). New
Section adopted effective April 9, 1992 (Supp. 92-2).
R20-5-409 recodified from R4-13-409 (Supp. 95-1).
Amended effective October 9, 1998 (Supp. 98-4).

R20-5-410. Report of Accident

An owner or user shall notify the Division within 24 hours of an explosion, severe overheating, or personal injury involving a boiler, lined hot water heater or direct fired jacketed steam kettle. A person shall not remove or disturb the involved boiler, lined hot water heater, direct fired jacketed steam kettle or parts of the boiler, lined hot water heater or direct fired jacketed steam kettle before an investigation by an authorized inspector, except for the purpose of preventing personal injury or limiting consequential damage.

Historical Note

Repealed effective April 12, 1979 (Supp. 79-2). New
Section adopted effective April 9, 1992 (Supp. 92-2).
R20-5-410 recodified from R4-13-410 (Supp. 95-1).
Amended effective October 9, 1998 (Supp. 98-4).
Amended by final rulemaking at 15 A.A.R. 1496, effective August 18, 2009 (Supp. 09-3).

R20-5-411. Hydrostatic Tests

The owner or user shall perform a hydrostatic or pneumatic pressure test in accordance with the code incorporated by reference in R20-5-404(A) and R20-5-406(B).

Historical Note

Repealed effective April 12, 1979 (Supp. 79-2). New
Section adopted effective April 9, 1992 (Supp. 92-2).
R20-5-411 recodified from R4-13-411 (Supp. 95-1).
Amended effective October 9, 1998 (Supp. 98-4).
Amended by final rulemaking at 15 A.A.R. 1496, effective August 18, 2009 (Supp. 09-3).

R20-5-412. Automatic Low-water Fuel Cutoff Devices or Combined Water Feeding and Fuel Cutoff Devices

- A. An owner, user, or operator shall ensure that low-water fuel cutoff devices or combined water feeding and fuel cutoff devices do not interfere with an operator's or inspector's ability to safely clean, repair, or inspect a boiler or lined hot water heater.
- B. A low-water fuel cutoff device shall have a pressure rating not less than the set pressure of the safety valve or safety relief valve.
- C. In addition to the requirements of subsections (A) and (B), all low-water fuel cutoffs and flow sensing devices shall be constructed and installed in accordance with applicable ASME Code and standards for boilers and steam jacketed kettles in R20-5-404(A).

Historical Note

Repealed effective April 12, 1979 (Supp. 79-2). New Section adopted effective April 9, 1992 (Supp. 92-2). R20-5-412 recodified from R4-13-412 (Supp. 95-1). Amended effective October 9, 1998 (98-4). Amended by final rulemaking at 15 A.A.R. 1496, effective August 18, 2009 (Supp. 09-3).

R20-5-413. Safety and Safety Relief Valves

- A. A valve shall not be placed between a safety valve or a safety relief valve and installed on a boiler or lined hot water heater, or between a safety valve or a safety relief valve and the discharge pipe attached to the boiler or lined hot water heater.
- B. When a power boiler is supplied with feed-water directly from a water main without the use of a feeding apparatus, safety valves shall not be set at a pressure greater than 94% of the lowest pressure obtained in the water main feeding the boiler;
- C. Safety valves, safety relief valves and relief valves shall conform to the requirements of the 2007 ASME Boiler and Pressure Vessel Code, Section I, IV or VIII, and addenda as of January 1, 2008, incorporated by reference as applicable. This incorporation does not include any later amendments or editions of the incorporated material. A copy of this referenced material is available for review at the Industrial Commission of Arizona, 800 W. Washington Street, Phoenix, AZ and may be obtained from the ASME, Three Park Avenue, New York, NY 10016-5990 or at <http://www.asme.org/>.

Historical Note

Repealed effective April 12, 1979 (Supp. 79-2). New Section adopted effective April 9, 1992 (Supp. 92-2). R20-5-413 recodified from R4-13-413 (Supp. 95-1). Amended effective October 9, 1998 (Supp. 98-4). Amended by final rulemaking at 15 A.A.R. 1496, effective August 18, 2009 (Supp. 09-3).

R20-5-414. Repealed**Historical Note**

Repealed effective April 12, 1979 (Supp. 79-2). New Section adopted effective April 9, 1992 (Supp. 92-2). R20-5-414 recodified from R4-13-414 (Supp. 95-1). Repealed by final rulemaking at 15 A.A.R. 1496, effective August 18, 2009 (Supp. 09-3).

R20-5-415. Boiler Blowdown, Blowoff Equipment and Drains

- A. Except as provided in this Section, an owner or user of blowdown and blowoff equipment shall comply with the National Board Rules and Recommendations for the Design and Construction of Boiler Blowoff Systems, 1991 Edition, incorporated by reference. This incorporation does not include any later amendments or editions of the incorporated material. A

copy of this referenced material is available for review at the Industrial Commission of Arizona, 800 W. Washington Street, Phoenix, AZ 85007 and may be obtained from the National Board of Boiler and Pressure Vessel Inspectors, 1055 Crupper Avenue, Columbus, OH 43229-1183 or at <http://www.nationalboard.org/>.

- B. Blowdown from a boiler is a hazard to life and property.
- C. Blowdown from a boiler shall pass through blowdown equipment that reduces pressure and temperature to levels not exceeding 5 p.s.i.g. and 140° F.
- D. The thickness of a blowdown vessel shall be at least 3/16".
- E. All blowdown equipment shall be fitted with openings that allow cleaning and inspection of the equipment.
- F. Blowdown separators may be used with boilers instead of boiler blowdown tanks, provided that blowdown separators are operated with a temperature gauge and water cooler to prevent drain water temperature from exceeding 140° F.
- G. In addition to the requirements of subsections (A) through (F), the following requirements apply to blowdown piping, valves and drains for power boilers: Each power boiler and high temperature water boiler shall be installed and maintained according to ASME Code, Section I and B31.1, incorporated by reference in R20-5-404, at the time of installation.
- H. In addition to the requirements of subsections (A) through (F), the following requirements apply to bottom blowdown or drain valves for heating boilers and hot water heaters:
 1. A hot water heating boiler or hot water heater shall have a bottom blowdown or drain pipe connection fitted with a valve or cock connected with the lowest available water space with the minimum size of blowdown piping and valves as required by ASME Code, Section IV, incorporated by reference, in R20-5-404(A).
 2. Discharge outlets of blowdown pipes, safety valves and other piping shall be located and structurally supported to prevent injury to individuals.

Historical Note

Repealed effective April 12, 1979 (Supp. 79-2). New Section adopted effective April 9, 1992 (Supp. 92-2). R20-5-415 recodified from R4-13-415 (Supp. 95-1). Amended effective October 9, 1998 (Supp. 98-4). Amended by final rulemaking at 15 A.A.R. 1496, effective August 18, 2009 (Supp. 09-3).

R20-5-416. Maximum Allowable Working Pressure

- A. The ASME Code under which a boiler was constructed and stamped shall determine the maximum allowable working pressure for the ASME-stamped boiler.
- B. If components in the boiler or hot water system such as valves, pumps, expansion tanks, storage tanks or piping have a lesser working pressure rating than the boiler or hot water heater, the pressure setting for the safety or safety relief valve on the boiler or hot water heater shall be based upon the component with the lowest maximum allowable working pressure rating.

Historical Note

Repealed effective April 12, 1979 (Supp. 79-2). New Section adopted effective April 9, 1992 (Supp. 92-2). R20-5-416 recodified from R4-13-416 (Supp. 95-1). Amended effective October 9, 1998 (Supp. 98-4). Amended by final rulemaking at 15 A.A.R. 1496, effective August 18, 2009 (Supp. 09-3).

R20-5-417. Maintenance and Operation of Boilers, Hot Water Heaters and Direct Fired Jacketed Steam Kettles

- A. An owner or user of a boiler, hot water heater or direct fired jacketed steam kettle constructed under the ASME Code, Sections I, IV or VIII Division 1, incorporated by reference in

R20-5-404(A) shall comply with the manufacturer's maintenance and operation instructions for the boiler, hot water heater or direct fired jacketed steam kettle.

- B.** In addition to the requirements of subsection (A), an owner or user of a boiler constructed under the ASME Code, Sections I, IV, shall comply with the following preventive maintenance schedule if the boiler contains the component or system listed.
1. On a daily basis, the owner or user shall:
 - a. Test the low-water fuel cutoff and alarm, and
 - b. Check the burner flame for proper combustion.
 2. On a weekly basis, the owner or user shall:
 - a. Check for proper ignition, and
 - b. Check the flame failure detection system.
 3. On a monthly basis, the owner or user shall:
 - a. Test all fan and air pressure interlocks,
 - b. Check the main burner safety shutoff valve,
 - c. Check the low fire start switch,
 - d. Test fuel pressure and temperature interlocks of oil-fired units, and
 - e. Test the high and low fuel pressure switch of gas-fired units.
 4. Every six months, the owner or user shall:
 - a. Inspect burner components;
 - b. Check flame failure system components, such as vacuum tubes, amplifier and relays;
 - c. Check wiring of all interlocks and shutoff valves;
 - d. Recalibrate all indicating and recording gauges; and
 - e. Check steam and blowdown piping and valves.
 5. Annually, the owner or user shall:
 - a. Replace vacuum tubes, scanners, or flame rods in the flame failure system according to the manufacturer's instructions;
 - b. Check all coils and diaphragms; and
 - c. Test operating parts of all safety shutoff and control valves.
- C.** An owner or user of a power boiler or high temperature boiler shall designate an individual who meets the requirements of subsection (D) to operate the boiler. An owner or user may operate the boiler if the owner or user meets the requirements of subsection (D).
- D.** An operator of a power boiler or high temperature water boiler shall meet the following minimum requirements:
1. Knowledge of and an ability to explain the function and operation of all safety controls of the boiler,
 2. Ability to start the boiler in a safe manner,
 3. Knowledge of all safe methods of feeding water to the boiler,
 4. Knowledge of and the ability to blow down the boiler in a safe manner,
 5. Knowledge of safety procedures to follow if water exceeds or drops below permissible safety levels, and
 6. Knowledge of and the ability to safely shut down the boiler.

Historical Note

Repealed effective April 12, 1979 (Supp. 79-2). New Section adopted effective April 9, 1992 (Supp. 92-2).

R20-5-417 recodified from R4-13-417 (Supp. 95-1).

Amended effective October 9, 1998 (Supp. 98-4).

Amended by final rulemaking at 15 A.A.R. 1496, effective August 18, 2009 (Supp. 09-3).

R20-5-418. Non-standard Boilers

An owner or user shall remove from service a boiler, hot water heater or pressure vessel that does not bear an ASME stamp unless the boiler owner or user request a variance under R20-5-429.

Historical Note

Repealed effective April 12, 1979 (Supp. 79-2). New Section adopted effective April 9, 1992 (Supp. 92-2).

R20-5-418 recodified from R4-13-418 (Supp. 95-1).

Amended effective October 9, 1998 (Supp. 98-4).

Amended by final rulemaking at 15 A.A.R. 1496, effective August 18, 2009 (Supp. 09-3).

R20-5-419. Request to Reinstall Boiler or Lined Hot Water Heater

- A.** The Division shall grant or deny approval to reinstall a boiler or lined hot water heater within three business days after an owner or user requests approval to reinstall the boiler or lined hot water heater. The order of the Division granting or denying approval to reinstall a boiler shall be in writing.
- B.** The Division shall grant approval to reinstall a boiler or lined hot water heater if the boiler or lined hot water heater complies with A.R.S. § 23-471 et seq. and this Article. The Division shall deny approval to reinstall a boiler or lined hot water heater if the boiler or lined hot water heater does not comply with A.R.S. § 23-471 et seq. and this Article.
- C.** An order of the Division denying approval to reinstall a boiler shall be final unless an owner or user requests a hearing under A.R.S. § 23-479 within 15 days after the Division mails the order. The owner or user requesting a hearing shall have the burden to prove that a boiler meets the requirements of A.R.S. § 23-471 et seq. and this Article.

Historical Note

Repealed effective April 12, 1979 (Supp. 79-2). R20-5-419 recodified from R4-13-419 (Supp. 95-1). New Section adopted effective October 9, 1998 (Supp. 98-4).

Amended by final rulemaking at 15 A.A.R. 1496, effective August 18, 2009 (Supp. 09-3).

R20-5-420. Special Inspector Certificate under A.R.S. § 23-485

- A.** Review Time-frames.
1. Administrative Completeness Review.
 - a. The Division shall determine whether an application to take a written examination or request for a special inspector certificate under A.R.S. § 23-485 is complete within three days of receipt of the application or request. The Division shall inform the applicant whether the application or request is complete or incomplete by written notice. If the application or request is incomplete, the Division shall include in its written notice to the applicant a complete list of the missing information.
 - b. The Division shall deem an application or request withdrawn if an applicant fails to file a complete application or request within 10 days of being notified by the Division that the application or request is incomplete, unless the applicant obtains an extension to provide the missing information. An applicant may obtain an extension to submit the missing information by filing a written request with the Division no later than 10 days after the Division mails notice that the application or request is incomplete. The written request for an extension shall state the reasons the applicant is unable to meet the 10-day deadline. If an extension will enable the applicant to assemble and submit the missing information, the Division shall grant an extension of not more than 10 days and provide written notice of the extension to the applicant.
 2. Substantive review.

- a. Application to take written examination under A.R.S. § 23-485(A). Within three days after the Division deems an application complete under subsection (B), the Division shall determine whether the applicant is eligible to take the National Board Examination.
 - b. Request for special inspector certificate under A.R.S. § 23-485. Within three days after the Division deems a request complete under subsection (C), the Division shall determine whether the applicant meets the criteria of A.R.S. § 23-485 and subsection (C).
3. Overall review. The overall review period shall be six days, unless extended under A.R.S. § 41-1072 et seq.
- B.** Application to take Written Examination under A.R.S. § 23-485(A).
 1. An individual requesting to take the written examination under A.R.S. § 23-485(A) shall complete an application to take the National Board Examination and submit the application to the Division at least 45 days before the date of the examination.
 2. The application to take the National Board Examination shall be filed with the Division. An application is considered filed when it is received at the office of the Division and stamped by the Division with the date of filing.
 3. An application to take the National Board Examination shall be on a legible form, paper or electronic, issued to the Division, with the following information:
 - a. Full legal name,
 - b. State or country of residency,
 - c. Mailing address,
 - d. Telephone number,
 - e. E-mail address, and
 - f. Employer's name and address.
- C.** Application for Special Inspector Certificate under A.R.S. § 23-485. An application for a special inspector certificate under A.R.S. § 23-485 is deemed complete under subsection (A)(1) when the following is filed with the Division:
 1. The applicant provides written documentation that the applicant holds a certificate of competency as an inspector of boilers or lined hot water heaters for a state that has a standard of examination equal to that of Arizona or the applicant is a National Board Commissioned Inspector, and
 2. The applicant provides proof of employment as a full time inspector for a company conducting business in Arizona and whose duties as an inspector include making inspections of boilers or lined hot water heaters to be used or insured by the company and not for resale.
- D.** If an applicant meets the criteria of A.R.S. § 23-485 and subsection (C), the Division shall issue a certificate to the applicant under subsection (C). If an applicant fails to meet the criteria of A.R.S. § 23-485 and subsection (C), the Division shall issue a written notice denying eligibility to the applicant. The Commission shall deem the notice denying eligibility final if an applicant does not request a hearing within 15 calendar days after the Division mails the notice.
- E.** Written Examination under A.R.S. § 23-485(A).
 1. The written examination described in A.R.S. § 23-485(A) shall be the National Board Examination of the National Board of Boiler and Pressure Vessel Inspectors.
 2. The Division shall administer the National Board Examination the first Wednesday and Thursday of every March, June, September, and December to eligible applicants. Within two days after the Division administers the National Board Examination, the Division shall return the examinations of eligible applicants to the National Board of Boiler and Pressure Vessel Inspectors. Examinations shall be graded by the National Board of Boiler and Pressure Vessel Inspectors.
3. The Division shall provide written notice to an applicant of the applicant's grade for the National Board Examination within three days after the Division receives notice of the grade from the National Board of Boiler and Pressure Vessel Inspectors.
4. The Division shall issue a certificate of competency to an applicant who passes the National Board Examination.
- F.** Issuance of Special Inspector Certificate. The Division shall issue a special inspector certificate, A.R.S. § 23-485, to an applicant no later than 15 calendar days after the Division determines that an applicant meets the criteria of A.R.S. § 23-485 and subsection (C).
- G.** Hearing on Denial of Eligibility for Special Inspector Certificate.
 1. A request for hearing protesting a notice of eligibility shall be in writing and signed by the applicant or the applicant's legal representative. The applicant shall file the request for hearing with the Division.
 2. The Commission shall hold a hearing under A.R.S. § 41-1065. The hearing shall be stenographically recorded.
 3. The Chair of the Commission or designee shall preside over hearings held under this Section. The Chair shall apply the provisions of A.R.S. § 41-1062 et seq. to hearings held under this Section and shall have the authority and power of a presiding officer as described in A.R.S. § 41-1062.
 4. A decision of the Commission to deny or grant eligibility for a special inspector certificate shall be based upon the criteria set forth in A.R.S. § 23-485 and this Section and shall be made by a majority vote of the quorum of Commission members present when the decision is rendered at a public meeting. After a decision is rendered at a public meeting, the Commission shall issue a written decision upon hearing which shall include findings of fact and conclusions of law, separately stated. An order of the Commission denying a special inspector certificate is final unless an applicant files a request for review within 15 days after the Commission mails its order.
 5. A request for review shall be based upon one or more of the following grounds which have materially affected the rights of an applicant:
 - a. Irregularities in the hearing proceedings or any order or abuse of discretion whereby the applicant seeking review was deprived of a fair hearing;
 - b. Misconduct by the Division;
 - c. Accident or surprise which could not have been prevented by ordinary prudence;
 - d. Newly discovered material evidence that could not have been discovered with reasonable diligence and produced at the hearing;
 - e. Excessive or insufficient sanctions or penalties imposed at hearing;
 - f. Error in the admission or rejection of evidence, or errors of law occurring at, or during the course of, the hearing;
 - g. Bias or prejudice of the Division; and
 - h. The order, decision, or findings of fact are not justified by the evidence or are contrary to law.
 6. The Commission shall issue a decision upon review no later than 30 days after receiving a request for review.

7. The Commission's decision upon review is final unless an applicant seeks judicial review as provided in A.R.S. § 23-483.

Historical Note

Repealed effective April 12, 1979 (Supp. 79-2). R20-5-420 recodified from R4-13-420 (Supp. 95-1). New Section adopted effective October 9, 1998 (Supp. 98-4). Amended by final rulemaking at 15 A.A.R. 1496, effective August 18, 2009 (Supp. 09-3).

R20-5-421. Repealed

Historical Note

Repealed effective April 12, 1979 (Supp. 79-2). R20-5-421 recodified from R4-13-421 (Supp. 95-1).

R20-5-422. Repealed

Historical Note

Repealed effective April 12, 1979 (Supp. 79-2). R20-5-422 recodified from R4-13-422 (Supp. 95-1).

R20-5-423. Repealed

Historical Note

Repealed effective April 12, 1979 (Supp. 79-2). R20-5-423 recodified from R4-13-423 (Supp. 95-1).

R20-5-424. Repealed

Historical Note

Repealed effective April 12, 1979 (Supp. 79-2). R20-5-424 recodified from R4-13-424 (Supp. 95-1).

R20-5-425. Repealed

Historical Note

Repealed effective April 12, 1979 (Supp. 79-2). R20-5-425 recodified from R4-13-425 (Supp. 95-1).

R20-5-426. Repealed

Historical Note

Repealed effective April 12, 1979 (Supp. 79-2). R20-5-426 recodified from R4-13-426 (Supp. 95-1).

R20-5-427. Repealed

Historical Note

Repealed effective April 12, 1979 (Supp. 79-2). R20-5-427 recodified from R4-13-427 (Supp. 95-1).

R20-5-428. Repealed

Historical Note

Repealed effective April 12, 1979 (Supp. 79-2). R20-5-428 recodified from R4-13-428 (Supp. 95-1).

R20-5-429. Variance

- A. Any owner or user may apply to the Director for a variance from the requirements of this Article, upon demonstrating the construction, installation, and operation of the boiler or pressure vessel will maintain the same level of safety as prescribed by this Chapter. The Director shall issue a variance if the Director determines that the proponent of the variance has demonstrated the construction, installation, and operation of the boiler or pressure vessel will maintain the same level of safety as prescribed by this Chapter. The variance issued shall prescribe the construction, installation, operation, maintenance, and repair conditions that the owner or user shall maintain.
- B. A variance may be modified or revoked upon application by an owner, user or the Director, on the Director's own motion at any time after six months from issuance if the owner or user

has not complied with the variance or if the variance does not protect the health and safety of employees or general public.

- C. The application for a variance shall be made on the form issued by the Division and contains the following information:
1. Owner or user's name and company name;
 2. Mailing address;
 3. Telephone number;
 4. Fax number;
 5. Contact person;
 6. Contact person's telephone number;
 7. Address or location of proposed variance;
 8. Type of facility to include;
 - a. Variance description;
 - b. Justification for variance;
 - c. Component or system involved;
 - d. Supporting documentation for variance;
 - e. Identify the statute, rule, code or standard to justify the variance; and
 9. Printed name and title of owner or user, signature of owner or user and date.
- D. If an owner or user does not agree with the variance issued or revoked by the Director, a request for a hearing under A.R.S. § 23-479 can be made with the Commission.

Historical Note

New Section made by final rulemaking at 15 A.A.R. 1496, effective August 18, 2009 (Supp. 09-3).

R20-5-430. Forced Circulation Hot Water Heaters

- A. All water tube or coil-type hot water heaters that require forced circulation to prevent overheating and failure of the tubes or coils shall have a safety control, to prevent burner operation at a flow rate inadequate to protect the hot water heater unit against overheating, at all allowable firing rates. The safety control shall shut down the burner and prevent restarting until an adequate flow is restored.
- B. All water tube or coil-type hot water heaters that require forced circulation to prevent overheating and failure of the tubes or coils, shall have a manually operated remote shut-down switch or circuit breaker and shall be located just outside the hot water heater room door and marked for easy identification. The shutdown switch shall be installed in a manner to safeguard against tampering. If a hot water heater room door is on the building exterior, the switch shall be located just inside the door. If there is more than one door to the hot water heater room there shall be a switch located at each door. The remote shutdown switch or circuit breaker shall disconnect all power to the burner controls.

Historical Note

New Section made by final rulemaking at 15 A.A.R. 1496, effective August 18, 2009 (Supp. 09-3).

R20-5-431. Code Cases

Code cases approved for use by the ASME Code Committee are allowed to be used in the design, fabrication and testing of boilers and pressure vessels provided approval from the Chief Boiler Inspector is obtained prior to use.

Historical Note

New Section made by final rulemaking at 15 A.A.R. 1496, effective August 18, 2009 (Supp. 09-3).

R20-5-432. Historical Boilers

Historical boilers shall require an initial Certificate inspection by an authorized inspector, followed by a Certificate inspection every three years thereafter if stored inside a shelter, or annually if stored outdoors. The initial Certificate inspection shall include ultrasonic thickness testing of all pressure boundaries. Thinning of the pres-

sure retaining boundary shall be monitored and recorded on the inspection report, in accordance with R20-5-407(D), to the owner and the Division's electronic copy.

Historical Note

New Section made by final rulemaking at 15 A.A.R. 1496, effective August 18, 2009 (Supp. 09-3).

ARTICLE 5. ELEVATOR SAFETY

R20-5-501. Repealed

Historical Note

Former Rule E-1. Amended effective November 9, 1979 (Supp. 79-6). R20-5-501 recodified from R4-13-501 (Supp. 95-1). Section repealed by final rulemaking at 9 A.A.R. 381, effective March 15, 2003 (Supp. 03-1).

R20-5-502. Definitions

The following definitions apply to this Article unless otherwise specified:

1. "ASME" means American Society of Mechanical Engineers.
2. "AZFS Key" means Arizona Firefighters Service Key, a universal key used by a firefighter to operate a conveyance during an emergency.
3. "Chief" means the head inspector of the Elevator Safety Section of the Division of Occupational Safety and Health.
4. "Elevator Safety Section" means the Elevator Safety Section of the Division of Occupational Safety and Health of the Industrial Commission of Arizona.
5. "Inspection" means the official determination by an inspector of the condition of all parts of the equipment on which the safe operation of an elevator depends.
6. "Major Alteration" means work performed to any conveyance that is not routine maintenance or repair.
7. "State Serial Number" is a unique number assigned by the Chief Elevator Inspector to each individual elevator, dumbwaiter, escalator, and moving walks.

Historical Note

Former Rule E-2. R20-5-502 recodified from R4-13-502 (Supp. 95-1). Amended by final rulemaking at 9 A.A.R. 381, effective March 15, 2003 (Supp. 03-1). Amended by final rulemaking at 15 A.A.R. 872, effective May 5, 2009 (Supp. 09-2).

R20-5-503. Repealed

Historical Note

Former Rule E-3. R20-5-503 recodified from R4-13-503 (Supp. 95-1). Section repealed by final rulemaking at 9 A.A.R. 381, effective March 15, 2003 (Supp. 03-1).

R20-5-504. Safety Standards for Platform Lifts and Stairway Chairlifts

Every owner or operator under A.R.S. § 23-491.02 shall comply with the American Society of Mechanical Engineers Safety Standard for Platform Lifts and Stairway Chairlifts ASME A18.1-2005, with amendments as of November 29, 2005, which are incorporated by reference. This incorporation by reference does not include any later amendments or editions of the incorporated matter. A copy of this referenced material is available for review at the Industrial Commission of Arizona, 800 West Washington Street, Phoenix, Arizona 85007, and ASME at Three Park Avenue, New York, New York 10016-5990 or at <http://www.asme.org>.

Historical Note

Former Rule E-4. R20-5-504 recodified from R4-13-504 (Supp. 95-1). Section repealed; new Section made by

final rulemaking at 9 A.A.R. 381, effective March 15, 2003 (Supp. 03-1). Amended by final rulemaking at 15 A.A.R. 872, effective May 5, 2009 (Supp. 09-2).

R20-5-505. Certificate of Inspection

The owner or operator under A.R.S. § 23-491.02 shall keep the Industrial Commission's Certificate of Inspection at the same location as the elevator, dumbwaiter, escalator, moving walk, or related equipment and make the certificate available for inspection and copying upon request. The State Serial Number shall be posted or displayed in the elevator cab, and on the escalators, the State Serial Number shall be affixed to the right, at the lower end of the unit.

Historical Note

Former Rule E-5. R20-5-505 recodified from R4-13-505 (Supp. 95-1). Amended by final rulemaking at 9 A.A.R. 381, effective March 15, 2003 (Supp. 03-1). Amended by final rulemaking at 15 A.A.R. 872, effective May 5, 2009 (Supp. 09-2).

R20-5-506. Recordkeeping

- A. The Elevator Safety Section shall assign a State Serial Number to every elevator, dumbwaiter, escalator, and moving walk for recordkeeping purposes. The State Serial Number shall be on a tag that is affixed to the controller or mainline disconnect in the elevator machine room.
- B. The owner or operator shall notify the Elevator Safety Section at least 90 days before installation, relocation, or major alteration of a dumbwaiter with automatic transfer device within the state, elevator, escalator, dumbwaiter, moving walk, material lift, wheelchair lift, stairway chairlift, or platform lift.
- C. The building owner or operator shall notify the Elevator Safety Section within 24 hours of every accident involving personal injury or disabling damage to a dumbwaiter with automatic transfer device, an elevator, escalator, dumbwaiter, moving walk, material lift, wheelchair lift, stairway chairlift, or platform lift.

Historical Note

Former Rule E-6. Amended effective November 9, 1979 (Supp. 79-6). R20-5-506 recodified from R4-13-506 (Supp. 95-1). Amended by final rulemaking at 9 A.A.R. 381, effective March 15, 2003 (Supp. 03-1). Amended by final rulemaking at 15 A.A.R. 872, effective May 5, 2009 (Supp. 09-2).

R20-5-507. Safety Code for Elevators, Escalators, Dumbwaiters, Moving Walks, Material Lifts, and Dumbwaiters with Automatic Transfer Devices

Every owner or operator of an elevator, escalator, dumbwaiter, moving walk, material lift, or dumbwaiter with automatic transfer device, installed on or after the effective date of this Section shall comply with the ASME A17.1-2007 Safety Code for Elevators and Escalators, which is incorporated by reference. This incorporation by reference does not include any later amendments or editions of the incorporated matter. A copy of this referenced material is available for review at the Industrial Commission of Arizona, 800 West Washington Street, Phoenix, Arizona 85007, and may be obtained from ASME at Three Park Avenue, New York, New York 10016-5990 or at <http://www.asme.org>. Every owner or operator of an elevator, escalator, dumbwaiter, moving walk, material lift, or dumbwaiter with an automatic transfer device, installed before the effective date of this Section shall comply with the ASME A17.1 Safety Code for Elevators and Escalators in effect at the time of installation or, as an alternative, may comply with ASME A17.1-2007.

Historical Note

Former Rule R4-13-507 repealed, new Section R4-13-

507 adopted effective November 9, 1979 (Supp. 79-6).
Amended effective March 30, 1981 (Supp. 81-2).
Amended effective June 23, 1983 (Supp. 83-3). Amended effective July 24, 1985 (Supp. 85-4). Amended effective September 5, 1989 (Supp. 89-3). Amended effective March 20, 1992 (Supp. 91-2). R20-5-507 recodified from R4-13-507 (Supp. 95-1). Amended effective October 8, 1996 (Supp. 96-4). Amended by final rulemaking at 5 A.A.R. 2935, effective August 4, 1999 (Supp. 99-3). Amended by final rulemaking at 9 A.A.R. 381, effective March 15, 2003 (Supp. 03-1). Amended by final rulemaking at 15 A.A.R. 872, effective May 5, 2009 (Supp. 09-2).

R20-5-508. Safety Standards for Belt Manlifts

Every owner or operator under A.R.S. § 23-491.02 shall comply with the standards of the American National Standard Institute Safety Standard for Belt Manlifts, ASME A90.1-2003, which is incorporated by reference. This incorporation by reference does not include any later amendments or editions of the incorporated matter. A copy of this referenced material is available for review at the Industrial Commission of Arizona, 800 West Washington Street, Phoenix, Arizona 85007, and ASME at Three Park Avenue, New York, New York 10016-5990 or at <http://www.asme.org/>.

Historical Note

Adopted effective November 9, 1979 (Supp. 79-6). R20-5-508 recodified from R4-13-508 (Supp. 95-1). Amended by final rulemaking at 9 A.A.R. 381, effective March 15, 2003 (Supp. 03-1). Amended by final rulemaking at 15 A.A.R. 872, effective May 5, 2009 (Supp. 09-2).

R20-5-509. Safety Requirements for Personnel Hoists and Employee Elevators for Construction and Demolition Operations

Every owner or operator under A.R.S. § 23-491.02 shall comply with the standards of the American National Standard Institute Safety Requirements for Personnel Hoists and Employee Elevators for Construction and Demolition Operations, ANSI, A10.4-2007, which is incorporated by reference. This incorporation by reference does not include any later amendments or editions of the incorporated matter. A copy of this referenced material is available for review at the Industrial Commission of Arizona, 800 West Washington Street, Phoenix, Arizona 85007, and ASME at Three Park Avenue, New York, New York 10016-5990 or at <http://www.asme.org/>.

Historical Note

Adopted effective November 9, 1979 (Supp. 79-6). Amended effective June 23, 1983 (Supp. 83-3). R20-5-509 recodified from R4-13-509 (Supp. 95-1). Amended by final rulemaking at 9 A.A.R. 381, effective March 15, 2003 (Supp. 03-1). Amended by final rulemaking at 15 A.A.R. 872, effective May 5, 2009 (Supp. 09-2).

R20-5-510. Safety Requirements for Material Hoists

Every owner or operator under A.R.S. § 23-491.02 shall comply with the standards of the American National Standard Institute Safety Requirements for Material Hoists, ANSI, A10.5-2006, which is incorporated by reference. This incorporation by reference does not include any later amendments or editions of the incorporated matter. A copy of this referenced material is also available for review at the Industrial Commission of Arizona, 800 West Washington Street, Phoenix, Arizona 85007, and ASME at Three Park Avenue, New York, New York 10016-5990 or at <http://www.asme.org/>.

Historical Note

Adopted effective November 9, 1979 (Supp. 79-6).

Amended effective June 23, 1983 (Supp. 83-3). R20-5-510 recodified from R4-13-510 (Supp. 95-1). Amended by final rulemaking at 9 A.A.R. 381, effective March 15, 2003 (Supp. 03-1). Amended by final rulemaking at 15 A.A.R. 872, effective May 5, 2009 (Supp. 09-2).

R20-5-511. Guide for Inspection of Elevators, Escalators, and Moving Walks

Every Elevator Inspector under A.R.S. § 23-491.05 shall use the American National Standard Institute, Guide for Inspection of Elevators, Escalators, and Moving Walks, ASME, A17.2-2004, which is incorporated by reference. This incorporation by reference does not include any later amendments or editions of the incorporated matter. A copy of this referenced material is also available for review at the Industrial Commission of Arizona, 800 West Washington Street, Phoenix, Arizona 85007, and ASME at Three Park Avenue, New York, New York 10016-5990 or at <http://www.asme.org/>.

Historical Note

Adopted effective March 30, 1981 (Supp. 81-2). R20-5-511 recodified from R4-13-511 (Supp. 95-1). Amended by final rulemaking at 9 A.A.R. 381, effective March 15, 2003 (Supp. 03-1). Amended by final rulemaking at 15 A.A.R. 872, effective May 5, 2009 (Supp. 09-2).

R20-5-512. Expired

Historical Note

Adopted effective March 30, 1981 (Supp. 81-2). R20-5-512 recodified from R4-13-512 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 11 A.A.R. 2320, effective May 19, 2005 (Supp. 05-2).

R20-5-513. Firefighters' Emergency Operation

All conveyances provided with firefighters' emergency operation installed per ASME, A17.1-2007, incorporated by reference, shall utilize the AZFS Key.

Historical Note

New Section made by final rulemaking at 15 A.A.R. 872, effective May 5, 2009 (Supp. 09-2).

ARTICLE 6. OCCUPATIONAL SAFETY AND HEALTH STANDARDS

R20-5-601. The Federal Occupational Safety and Health Standards for Construction, 29 CFR 1926

Each employer shall comply with the standards in the Federal Occupational Safety and Health Standards for Construction, as published in 29 CFR 1926, with amendments as of March 26, 2012, incorporated by reference. Copies of these referenced materials are available for review at the Industrial Commission of Arizona and may be obtained from the United States Government Printing Office, Superintendent of Documents, Washington, D.C. 20402. These standards shall apply to all conditions and practices related to construction activity by all employers, both public and private, in the state of Arizona. This incorporation by reference does not include amendments or editions to 29 CFR 1926 published after March 26, 2012.

Historical Note

Editorial correction (Supp. 75-1). Amended as an emergency effective November 16, 1977 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 77-6). Amended as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-601 repealed, former emergency adoption effective October 29, 1980, adopted effective March 2, 1981 (Supp. 81-2). Amended effective June 17, 1981 (Supp. 81-3). Amended effective November 14,

1984 (Supp. 84-6). Amended effective March 3, 1987 (Supp. 87-1). Amended effective April 22, 1988; amended effective May 26, 1988 (Supp. 88-2). Amended effective October 14, 1988 (Supp. 88-4). Amended effective September 14, 1989 (Supp. 89-3). Amended effective April 2, 1990 (Supp. 90-2). Amended effective August 6, 1990 (Supp. 90-3). Amended effective February 8, 1991 (Supp. 91-1). Amended effective November 21, 1991 (Supp. 91-4). Amended effective February 28, 1992 (Supp. 91-2). Amended effective October 22, 1992; amended effective December 23, 1992 (Supp. 92-4). Amended effective September 13, 1993 (Supp. 93-3). Amended effective October 21, 1993; amended effective December 17, 1993 (Supp. 93-4). Amended effective May 11, 1994 (Supp. 94-2). Amended effective November 18, 1994 (Supp. 94-4). Amended effective January 12, 1995; R20-5-601 recodified from R4-13-601 (Supp. 95-1). Amended effective August 28, 1996 (Supp. 96-3). Amended effective April 1, 1997 (Supp. 97-2). Amended effective December 12, 1997 (Supp. 97-4). Amended effective August 27, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 592, effective January 14, 2000 (Supp. 00-1). Amended by final rulemaking at 8 A.A.R. 851, effective February 5, 2002 (Supp. 02-1). Amended by final rulemaking at 9 A.A.R. 2108, effective June 2, 2003 (Supp. 03-2). Amended by final rulemaking at 12 A.A.R. 4102, effective December 4, 2006 (Supp. 06-4). Amended by final rulemaking at 13 A.A.R. 1417, effective March 30, 2007 (Supp. 07-1). Amended by final rulemaking at 14 A.A.R. 2711, effective June 17, 2008 (Supp. 08-2). Amended by final rulemaking at 16 A.A.R. 1469, effective September 11, 2010 (Supp. 10-3). Amended by final rulemaking at 17 A.A.R. 1264, effective June 13, 2011 (Supp. 11-2). Amended by final rulemaking at 18 A.A.R. 1492, effective August 5, 2012 by Notice of Public Information at 18 A.A.R. 1653 (Supp. 12-2). Amended by final rulemaking at 18 A.A.R. 3007, effective October 24, 2012 (Supp. 12-4).

R20-5-601.01. Fall Protection for Residential Construction

Each employer shall comply with the requirements in A.R.S. Title 23, Chapter 2, Article 13. These requirements shall apply to all conditions and practices related to residential construction activity by all employers, both public and private, in the state of Arizona.

Historical Note

New Section made by exempt rulemaking at 18 A.A.R. 1144, effective May 25, 2012 (Supp. 12-2).

R20-5-602. The Federal Occupational Safety and Health Standards for General Industry, 29 CFR 1910

Each employer shall comply with the standards in Subparts B through Z inclusive of the Federal Occupational Safety and Health Standards for General Industry, as published in 29 CFR 1910, with amendments as of March 26, 2012, incorporated by reference. Copies of these reference materials are available for review at the Industrial Commission of Arizona and may be obtained from the United States Government Printing Office, Superintendent of Documents, Washington, D.C. 20402. These standards shall apply to all conditions and practices related to general industry activity by all employers, both public and private, in the state of Arizona; provided that this Section shall not apply to those conditions and practices which are the subject of R20-5-601. This incorporation by reference does not include amendments or editions to 29 CFR 1910 published after March 26, 2012.

Historical Note

Editorial correction (Supp. 75-1). Amended as an emer-

gency effective November 16, 1977 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 77-6). New Section R4-13-602 adopted effective July 30, 1980 (Supp. 80-4). Amended as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-602 repealed, former emergency adoption effective October 29, 1980, adopted effective March 2, 1981 (Supp. 81-2). Amended effective June 17, 1981 (Supp. 81-3). Amended subsection (A) effective October 1, 1981 (Supp. 81-5). Amended subsection (A) effective March 5, 1982 (Supp. 82-2). Amended subsection (A) effective May 6, 1983 (Supp. 83-3). Amended subsection (A) effective April 6, 1984 (Supp. 84-2). Amended subsection (A) effective July 3, 1984 (Supp. 84-4). Amended subsection (A) effective October 18, 1984 (Supp. 84-5). Editorial correction, amendment October 18, 1984, withdrawn for subsequent certification. Amended effective November 14, 1984, and December 14, 1984 (Supp. 84-6). Amended subsection (A) effective June 9, 1986 (Supp. 86-3). Amended subsection (A) effective March 3, 1987 (Supp. 87-1). Amended subsection (A) effective June 26, 1987 (Supp. 87-2). Amended subsection (A) effective April 22, 1988; amended subsection (A) effective May 26, 1988 (Supp. 88-2). Amended subsection (A) effective October 14, 1988 (Supp. 88-4). Amended effective September 14, 1989 (Supp. 89-3). Amended effective April 2, 1990 (Supp. 90-2). Amended effective August 6, 1990 (Supp. 90-3). Amended effective February 8, 1991 (Supp. 91-1). Amended effective November 21, 1991 (Supp. 91-4). Amended effective February 28, 1992 (Supp. 91-2). Amended effective March 20, 1992 (Supp. 91-2). Amended effective June 16, 1992 (Supp. 92-2). Amended effective October 22, 1992; amended effective December 23, 1992 (Supp. 92-4). Amended effective May 14, 1993 (Supp. 93-2). Amended effective September 13, 1993 (Supp. 93-3). Amended effective October 21, 1993; amended effective December 17, 1993 (Supp. 93-4). Amended effective May 11, 1994 (Supp. 94-2). Amended effective July 19, 1994 (Supp. 94-3). Amended effective November 18, 1994 (Supp. 94-4). Amended effective January 12, 1995; Amended effective February 10, 1995; R20-5-602 recodified from R4-13-602 (Supp. 95-1). Amended effective August 28, 1996 (Supp. 96-3). Amended effective April 1, 1997 (Supp. 97-2). Amended effective December 12, 1997 (Supp. 97-4). Amended effective August 27, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 592, effective January 14, 2000 (Supp. 00-1). Amended by final rulemaking at 7 A.A.R. 5137, effective October 19, 2001 (Supp. 01-4). Amended by final rulemaking at 9 A.A.R. 2108, effective June 2, 2003 (Supp. 03-2). Amended by final rulemaking at 11 A.A.R. 576, effective January 4, 2005 (Supp. 05-1). Amended by final rulemaking at 12 A.A.R. 4102, effective December 4, 2006 (Supp. 06-4). Amended by final rulemaking at 13 A.A.R. 1417, effective March 30, 2007 (Supp. 07-1). Amended by final rulemaking at 13 A.A.R. 2927, effective July 31, 2007 (07-3). Amended by final rulemaking at 14 A.A.R. 193, effective January 8, 2008 (Supp. 08-1). Amended by final rulemaking at 14 A.A.R. 2711, effective June 17, 2008 (Supp. 08-2). Amended by final rulemaking at 14 A.A.R. 4337, effective December 30, 2008 (Supp. 08-4). Amended by final rulemaking at 15 A.A.R. 1564, effective August 31, 2009 (Supp. 09-3). Amended by final rulemaking at 16 A.A.R. 1469, effective September 11, 2010 (Supp. 10-3). Amended by final

rulemaking at 17 A.A.R. 109, effective January 12, 2011 (Supp. 11-1). Amended by final rulemaking at 17 A.A.R. 1264, effective June 13, 2011 (Supp. 11-2). Amended by final rulemaking at 18 A.A.R. 1492, effective August 5, 2012 by Notice of Public Information at 18 A.A.R. 1653 (Supp. 12-2). Amended by final rulemaking at 18 A.A.R. 3007, effective October 24, 2012 (Supp. 12-4).

R20-5-602.01. Subpart T, Commercial Diving Operations

Each employer shall comply with the standards in Subpart T of the Federal Occupational Safety and Health Standards for the General Industry as published in 29 CFR 1910, with amendments as specified in R20-5-602, except that the exemption set forth in 29 CFR 1910.401(a)(2)(ii) shall not apply. Subpart T shall apply to any diving operation performed solely for search, rescue, or related public safety purposes by or under the control of a governmental agency.

Historical Note

New Section made by final rulemaking at 14 A.A.R. 193, effective January 8, 2008 (Supp. 08-1).

R20-5-603. The Federal Occupational Safety and Health Standards for Agriculture, 29 CFR 1928

Each employer shall comply with the standards in Subparts A through D inclusive of the Federal Occupational Safety and Health Standards for Agriculture, as published in 29 CFR 1928, with amendments as of March 7, 1996, incorporated by reference and on file with the Office of the Secretary of State. Copies of these referenced materials are available for review at the Industrial Commission of Arizona and may be obtained from the United States Government Printing Office, Superintendent of Documents, Washington, D.C. 20402. This incorporation by reference does not include amendments or editions to 29 CFR 1928 published after March 7, 1996.

Historical Note

Adopted effective February 28, 1975 (Supp. 75-1). Former Section R4-13-603 repealed, new Section R4-13-603 adopted as an emergency effective November 16, 1977, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 77-6). Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-603 repealed, former emergency adoption effective October 29, 1980, adopted effective March 2, 1981 (Supp. 81-2). Amended effective April 22, 1988 (Supp. 88-2). Amended effective December 17, 1993 (Supp. 93-4). Amended effective May 11, 1994 (Supp. 94-2). Amended effective November 18, 1994 (Supp. 94-4). Amended effective February 10, 1995. R20-5-603 recodified from R4-13-603 (Supp. 95-1). Amended effective April 1, 1997 (Supp. 97-2).

R20-5-604. Rules of Agency Practice and Procedure concerning OSHA Access to Employee Medical Records, 29 CFR 1913

Each employer pursuant to A.R.S. § 23-403(B) shall comply with Federal Regulations, Title 29, Part 1913, with amendments as of May 23, 1980 (amendments of May 23, 1980 on file with the Secretary of State), which are hereby adopted and incorporated by reference as if set forth fully herein. This regulation applies to OSHA Access to Employee Medical Records.

Historical Note

Adopted effective February 28, 1975 (Supp. 75-1). Repealed as an emergency effective November 16, 1977, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 77-6). Repealed as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Repealed effective March 2, 1981 (Supp. 81-2). New rule adopted effective November 14,

1984 (Supp. 84-6). R20-5-604 recodified from R4-13-604 (Supp. 95-1).

R20-5-605. Hoes for Weeding or Thinning Crops

- A. The use of a hoe with a handle less than four feet in length for weeding or thinning crops is prohibited. This prohibition is based upon the existence of other practical and adequate alternatives to the use of these short-handle hoes.
- B. This rule does not apply to greenhouse or nursery operations.

Historical Note

Adopted effective February 28, 1975 (Supp. 75-1). Repealed as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Repealed effective March 2, 1981 (Supp. 81-2). New Section R4-13-605 adopted effective September 7, 1984 (Supp. 84-5). R20-5-605 recodified from R4-13-605 (Supp. 95-1).

R20-5-606. State Definition of Terms Used in Adopting Federal Standards Pursuant to R20-5-601, R20-5-602, R20-5-603 and R20-5-604

For the purposes of the standards enumerated in the federal occupational safety and health standards incorporated into R20-5-601, R20-5-602, R20-5-603, and R20-5-604:

1. "Agency" means the Industrial Commission of Arizona.
2. "Assistant Secretary" means the Director of the Arizona Division of Occupational Safety and Health of the Industrial Commission of Arizona.
3. "Assistant Secretary of Labor for Occupational Safety and Health" means the Director of the Arizona Division of Occupational Safety and Health of the Industrial Commission of Arizona.
4. "Office of the Solicitor of Labor" means Legal Counsel for the Industrial Commission of Arizona.
5. "OSHA" means Arizona Division of Occupational Safety and Health.

Historical Note

Adopted effective February 28, 1975 (Supp. 75-1). Repealed as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Repealed effective March 2, 1981 (Supp. 81-2). New Section R4-13-606 adopted effective May 31, 1985 (Supp. 85-3). R20-5-606 recodified from R4-13-606 (Supp. 95-1).

R20-5-607. Expired

Historical Note

Adopted effective February 28, 1975 (Supp. 75-1). Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-607 repealed, former emergency adoption effective October 29, 1980, adopted and amended effective March 2, 1981 (Supp. 81-2). R20-5-607 recodified from R4-13-607 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 9 A.A.R. 5062, effective September 30, 2003 (Supp. 03-4).

R20-5-608. Definitions

- A. "Act" means the Arizona Occupational Safety and Health Act of 1972, with amendments effective August 27, 1977 (Arizona Revised Statutes, Title 23, Chapter 2, Article 10).
- B. The definitions and interpretations contained in A.R.S. § 23-401 of the Act shall be applicable to such terms when used in these rules.
- C. "Working days" means Mondays through Fridays but shall not include Saturdays, Sundays, or state holidays. In computing fifteen working days, the day of the receipt of any notice shall

not be included, and the last day of the fifteen working days shall be included.

- D. "Compliance Safety and Health Officer" means a person authorized by the Occupational Safety and Health Division, Industrial Commission of Arizona, to conduct inspections.
- E. "Establishment" means a single physical location where business is conducted or where services or industrial operations are performed. (For example: a factory, mill, stores, hotel, restaurant, movie theatre, farm, ranch, bank, sales office, warehouse, or central administrative office.) Where distinctly separate activities are performed at a single physical location (such as contract construction activities from the same physical location as a lumber yard), each activity shall be treated as a separate physical establishment, and a separate notice or notices shall be posted in each such establishment, to the extent that such notices have been furnished by the Industrial Commission of Arizona, Division of Occupational Safety and Health. Where employers are engaged in activities which are physically dispersed, such as agriculture, construction, transportation, communications, and electric, gas and sanitary services, the notice or notices required by this Section shall be posted at the location to which employees report each day. Where employees do not usually work at, or report to, a single establishment, such as traveling salesmen, technicians, engineers, etc., such notice or notices shall be posted at the location from which the employees operate to carry out their activities. In all cases, such notice or notices shall be posted in accordance with requirements of subsection (A) of this Section.

Historical Note

Adopted effective February 28, 1975 (Supp. 75-1). Repealed as an emergency effective November 16, 1977, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 77-6). Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-608 repealed, new Section R4-13-608 adopted effective March 2, 1981 (Supp. 81-2). R20-5-608 recodified from R4-13-608 (Supp. 95-1).

R20-5-609. Posting of Notice: Availability of the Act, Regulations and Applicable Standards

- A. Each employer shall post and keep posted a notice or notices, to be furnished by the Industrial Commission of Arizona, Division of Occupational Safety and Health, informing employees of the protections and obligations provided for in the Act, and that for assistance and information, including copies of the Act and of specific safety and health standards, employees should contact the employer or the nearest office of the Industrial Commission. Such notice or notices shall be posted by the employer in each establishment in a conspicuous place or places where notices to employees are customarily posted. Each employer shall take steps to ensure that such notices are not altered, defaced, or covered by other material.
- B. Copies of the Act, all regulations published in this Chapter and applicable standards will be available at all offices of the Arizona Division of Occupational Safety and Health. If an employer has obtained copies of these materials, he shall make them available upon request to any employee or his authorized representative for review in the establishment where the employee is employed on the same day the request is made or at the earliest time mutually convenient to the employee or his authorized representative and the employer.
- C. Any employer failing to comply with the provisions of this Section shall be subject to citation and penalty in accordance with the provisions of A.R.S. § 23-418 of the Act.

Historical Note

Adopted effective February 28, 1975 (Supp. 75-1). Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-609 repealed, former Section R4-13-608 adopted as an emergency effective October 29, 1980, renumbered and amended as Section R4-13-609 effective March 2, 1981 (Supp. 81-2). R20-5-609 recodified from R4-13-609 (Supp. 95-1).

R20-5-610. Authority for Inspection

- A. The Director of the Division of Occupational Safety and Health or his authorized representative upon presentation of credentials shall be permitted to enter without delay and at reasonable times any factory, plant, establishment, construction site, or other area, or place of environment where work is performed by an employee of an employer; to inspect and investigate during regular working hours and in a reasonable manner, any such place of employment, and all pertinent conditions, structures, machines, apparatus, devices, equipment and materials therein; to question privately any employer, owner, operator, agent or employee and to review records required by the Act and regulations published in this Article and other records which are directly related to the purpose of the inspection.
- B. Representatives of the Secretary of Health, Education, and Welfare are authorized to make inspections and to question employers and employees in order to carry out the functions of the Secretary of Health, Education, and Welfare under the Williams-Steiger Occupational Safety and Health Act. Inspections conducted by Department of Labor Compliance Safety and Health Officers and representatives of the Secretary of Health, Education and Welfare under Section 8 of the Williams-Steiger Occupational Safety and Health Act and pursuant to 29 CFR Part 1903 shall not affect the authority of any state to conduct inspections in accordance with agreements and plans under Section 18 of the Williams-Steiger Occupational Safety and Health Act.
- C. Prior to inspecting areas containing information which is classified by an agency of the United States government in the interests of national security, Compliance Safety and Health Officers shall have obtained the appropriate security clearance.

Historical Note

Adopted effective February 28, 1975 (Supp. 75-1). Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-610 repealed, former Section R4-13-609 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-610 effective March 2, 1981 (Supp. 81-2). R20-5-610 recodified from R4-13-610 (Supp. 95-1).

R20-5-611. Objection to Inspection

- A. Upon a refusal to permit a Compliance Safety and Health Officer, in the exercise of his official duties, to enter without delay and at reasonable times any place of employment or any place therein, to inspect, to review records, or to privately question any employer, owner, operator, agent, or employee, in accordance with rule R20-5-610, or to permit a representative of employees to accompany the Compliance Safety and Health Officer during the physical inspection of any workplace in accordance with rule R20-5-615, the Compliance Safety and Health Officer shall terminate the inspection or confine the inspection to other areas, conditions, structures, machines, apparatus, devices, equipment, materials, records, or interviews concerning which no objection is raised. The Compliance Safety and Health Officer shall endeavor to ascertain the reason for such refusal and shall immediately report the refusal

and the reason therefore to the Director of the Division. The Director shall immediately consult with the Industrial Commission and its legal counsel, who shall promptly take appropriate action, including compulsory process if necessary.

- B. Compulsory process may be sought in advance of an inspection or reinvestigation if, in the judgment of the Director of the Division and the Industrial Commission Chief Legal Counsel, circumstances exist including but not limited to specific evidence of an existing violation or reasonable legislative or administrative standards for conducting an inspection which make pre-inspection process desirable or necessary.
- C. With the approval of the Industrial Commission, and the Industrial Commission Chief Legal Counsel, compulsory process may also be obtained by the Director of the Division or his designee.
- D. For purposes of this Section, the term compulsory process shall mean the institution of any appropriate action, including ex parte application for an inspection warrant or its equivalent.

Historical Note

Adopted effective June 19, 1975 (Supp. 75-1). Repealed as an emergency effective November 16, 1977, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 77-6).

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-611 repealed, former Section R4-13-610 adopted as an emergency effective October 29, 1980, renumbered and amended as Section R4-13-611 effective March 2, 1981 (Supp. 81-2). R20-5-611 recodified from R4-13-611 (Supp. 95-1).

R20-5-612. Entry Not a Waiver

Any permission to enter, inspect, review records, or question any person shall not imply or be conditioned upon a waiver of any cause of action, citation, or penalty under the Act. Compliance Safety and Health Officers are not authorized to grant any such waiver.

Historical Note

Adopted effective June 19, 1975 (Supp. 75-1). Repealed as an emergency effective November 16, 1977, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 77-6).

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-612 repealed, former Section R4-13-611 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-612 effective March 2, 1981 (Supp. 81-2). R20-5-612 recodified from R4-13-612 (Supp. 95-1).

R20-5-613. Advance Notice of Inspections

- A. Advance notice of inspections may not be given except in the following situations:
 1. In cases of apparent imminent danger, to enable the employer to abate the danger as quickly as possible;
 2. In circumstances where the inspection can most effectively be conducted after regular business hours or where special preparations are necessary for an inspection;
 3. Where necessary to ensure the presence of representatives of the employer and employees or the appropriate personnel needed to aid in an inspection; and
 4. In other circumstances where the Division Director determines that the giving of advance notice would enhance the probability of an effective and thorough inspection.
- B. In the situations described in subsection (A) of this Section, advance notice of inspections may be given only if authorized by the Division Director. When advance notice is given, it shall be the employer's responsibility promptly to notify the

authorized representative of employees of the inspection, if the identity of such representative is known to the employer. (See rule R20-5-615(B) as to situations where there is no authorized representative of employees.) Upon the request of the employer, the Compliance Safety and Health Officer will inform the authorized representative of employees of the inspection, provided that the employer furnishes the Compliance Safety and Health Officer with the identity of such representative and with such other information as is necessary to enable him promptly to inform such representative of the inspection. An employer who fails to comply with his obligation under this subsection promptly to inform the authorized representative of the employees of the inspection or to furnish such information as is necessary to enable the Compliance Safety and Health Officer to promptly inform such representative of the inspection may be subject to citation and penalty under A.R.S. § 23-408 of the Act. Advance notice in any of the situations described in subsection (A) of this Section shall not be given more than 24 hours before the inspection is scheduled to be conducted, except in apparent imminent danger situations and other unusual circumstances.

Historical Note

Adopted effective July 28, 1975 (Supp. 75-1). Repealed as an emergency effective November 16, 1977, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 77-6).

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-613 repealed, former Section R4-13-612 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-613 effective March 2, 1981 (Supp. 81-2). R20-5-613 recodified from R4-13-613 (Supp. 95-1).

R20-5-614. Conduct of Inspections

- A. At the beginning of an inspection, Compliance Safety and Health Officers shall present their credentials to the owner, operator, or agent in charge at the establishment; explain the nature and purpose of the inspection; and indicate generally the scope of the inspection and the records specified in rule R20-5-610 which they wish to review.
- B. Compliance Safety and Health Officers shall have authority to take environmental samples and to take or obtain photographs related to the purpose of the inspection, employ other reasonable investigative techniques, and question privately any employer, owner, operator, agent or employee of an establishment.
- C. In taking photographs and samples, Compliance Safety and Health Officers shall take reasonable precautions to ensure that such actions with flash, spark producing, or other equipment would not be hazardous. Compliance Safety and Health Officers shall comply with all employer safety and health rules and practices at the establishment being inspected, and they shall wear and use appropriate protective clothing and equipment.
- D. The conduct of inspections shall be such as to preclude unreasonable disruption to the operations of the employer's establishment.
- E. At the conclusion of an inspection, a Compliance Safety and Health Officer shall confer with the employer or his representative and informally advise him of any apparent safety or health violations disclosed by the inspection. During such conference, the employer shall be afforded an opportunity to bring to the attention of the Compliance Safety and Health Officer any pertinent information regarding conditions in the workplace.

Historical Note

Adopted effective March 2, 1976 (Supp. 76-2). Repealed as an emergency effective November 16, 1977, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 77-6).

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-614 repealed, former Section R4-13-613 adopted as an emergency effective October 29, 1980, renumbered and amended as Section R4-13-614 effective March 2, 1981 (Supp. 81-2).

R20-5-614 recodified from R4-13-614 (Supp. 95-1).

R20-5-615. Representatives of Employers and Employees

- A.** Compliance Safety and Health Officers shall be in charge of inspections and questioning of persons. A Compliance Safety and Health Officer may permit additional employer representatives and additional representatives authorized by employees to accompany him where he determines that such additional representatives will further aid the inspection. A different employer and employee representative may accompany the Compliance Officer during each different phase of an inspection if this will not interfere with the conduct of the inspection.
- B.** Compliance Safety and Health Officers shall have authority to resolve all disputes as to who is the representative authorized by the employer and employees for the purpose of this rule. If there is no authorized representative of employees, or if the Compliance Safety and Health Officer is unable to determine with reasonable certainty who is such representative, he shall consult with a reasonable number of employees concerning matters of safety and health in the workplace.
- C.** The representative(s) authorized by employees shall be an employee(s) of the employer. However, if in the judgment of the Compliance Safety and Health Officer, good cause has been shown why accompaniment by a third party who is not an employee is reasonably necessary to the conduct of an effective and thorough physical inspection of the workplace, such third party may accompany the Compliance Safety and Health Officer during the inspection.
- D.** Compliance Safety and Health Officers are authorized to deny the right of accompaniment under this Section to any person whose conduct interferes with a fair and orderly inspection. The right of accompaniment in areas containing trade secrets shall be subject to the provisions of rule R20-5-616(B). With regard to information classified by an agency of the United States government in the interest of national security, only persons authorized to have access to such information may accompany a Compliance Safety and Health Officer in areas containing such information.

Historical Note

Adopted effective March 2, 1976 (Supp. 76-2). Repealed as an emergency effective November 16, 1977, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 77-6).

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-615 repealed, former Section R4-13-614 adopted as an emergency effective October 29, 1980, renumbered and amended as Section R4-13-615 effective March 2, 1981 (Supp. 81-2).

R20-5-615 recodified from R4-13-615 (Supp. 95-1).

R20-5-616. Trade Secrets

- A.** At the commencement of an inspection, the employer may identify areas in the establishment which contain or which might reveal a trade secret. If the Compliance Safety and Health Officer has no clear reason to question such identification, information obtained in such areas, including all negatives and prints of photographs, environmental samples, shall

be labeled "confidential-trade secret" and shall not be disclosed except in accordance with provisions of A.R.S. § 23-426.

- B.** Upon the request of an employer, any authorized representative of employees under rule R20-5-615 in an area containing trade secrets shall be an employee in that area or an employee authorized by the employer to enter that area. Where there is no such representative or employee, a Compliance Safety and Health officer shall consult with a reasonable number of employees who work in that area concerning matters of safety and health.

Historical Note

Adopted effective March 2, 1976 (Supp. 76-2). Repealed as an emergency effective November 16, 1977, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 77-6).

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-616 repealed, former Section R4-13-615 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-616 effective March 2, 1981 (Supp. 81-2).

R20-5-616 recodified from R4-13-616 (Supp. 95-1).

R20-5-617. Consultation with Employees

Compliance Safety and Health Officers may privately consult with employees concerning matters of occupational safety and health to the extent they deem necessary for the conduct of an effective and thorough inspection. During the course of an inspection, any employee shall be afforded an opportunity to bring any violation of the Act, which he has reason to believe exists in the workplace, to the attention of the Compliance Safety and Health Officer.

Historical Note

Adopted effective January 21, 1976 (Supp. 76-1).

Repealed as an emergency effective November 16, 1977, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 77-6). Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-617 repealed,

former Section R4-13-616 adopted as an emergency effective October 29, 1980, renumbered and amended as Section R4-13-617 effective March 2, 1981 (Supp. 81-2).

R20-5-617 recodified from R4-13-617 (Supp. 95-1).

R20-5-618. Complaints by Employees

- A.** A copy of a complaint submitted pursuant to A.R.S. § 23-408(E) shall be provided to the employer or his agent by the Director of the Division of Occupational Safety and Health or his representative no later than the time of inspection, except that, upon the request of the person giving such notice, his name shall not appear in such copy or in any record published, released, or made available by the Arizona Division of Occupational Safety and Health.
- B.** If upon receipt of such notification the Division Director determines that the complaint meets the requirements set forth in subsection (A) of this rule, and that there are reasonable grounds to believe that the alleged violation exists, he shall cause an inspection to be made as soon as practicable, to determine if such alleged violation exists. Inspections under this rule shall not be limited to matters referred to in the complaint.

Historical Note

Adopted effective January 21, 1976 (Supp. 76-1).

Repealed as an emergency effective November 16, 1977, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 77-6). Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-618 repealed,

former Section R4-13-617 adopted as an emergency effective October 29, 1980, renumbered and amended as Section R4-13-618 effective March 2, 1981 (Supp. 81-2).

R20-5-618 recodified from R4-13-618 (Supp. 95-1).

R20-5-619. Inspection Not Warranted; Informal Review

If the Division Director determines that an inspection is not warranted because there are no reasonable grounds to believe that a violation or danger exists with respect to a complaint in accordance with A.R.S. § 23-408(E), he shall notify the complaining party in writing of such determination. The complaining party may obtain review of such determination by submitting a written statement of position with the Industrial Commission and, at the same time, providing the employer with a copy of such statement by certified mail. The employer may submit an opposing written statement of position with the Industrial Commission and, at the same time, provide the complaining party with a copy of such statement by certified mail. Upon the request of the complaining party or the employer, the Industrial Commission, at their discretion, may hold an informal conference in which the complaining party and the employer may orally present their views. After considering all written and oral views presented, the Industrial Commission shall affirm, modify, or reverse the determination of the Division Director and furnish the complaining party and the employer a written notification of their decision and the reasons therefore. The decision of the Industrial Commission shall be final and not subject to further review. Such determination shall be without prejudice to the filing of a new complaint meeting the requirements of A.R.S. § 23-408(E).

Historical Note

Adopted effective May 25, 1977 (Supp. 77-3). Repealed as an emergency effective November 16, 1977, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 77-6).

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-619 repealed, former Section R4-13-618 adopted as an emergency effective October 29, 1980, renumbered and amended as Section R4-13-619 effective March 2, 1981 (Supp. 81-2).

R20-5-619 recodified from R4-13-619 (Supp. 95-1).

R20-5-620. Expired

Historical Note

Adopted effective May 25, 1977 (Supp. 77-3). Repealed as an emergency effective November 16, 1977, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 77-6).

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-620 repealed, former Section R4-13-619 adopted as an emergency effective October 29, 1980, renumbered and amended as Section R4-13-620 effective March 2, 1981 (Supp. 81-2). R20-5-620 recodified from R4-13-620 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 9 A.A.R. 5062, effective September 30, 2003 (Supp. 03-4).

R20-5-621. Citations: Notices of De Minimis Violations

A. The Division Director shall review the inspection reports of the Compliance Safety and Health Officer. If, on the basis of the report, the Division Director believes that the employer has violated a requirement of A.R.S. § 23-403 of the Act, of any standard, rule or order promulgated pursuant to A.R.S. § 23-410 of the Act, or of any substantive rule published in these rules, he shall, if appropriate, consult with the Industrial Commission's counsel and shall issue to the employer either a citation or notice of de minimis violations. An appropriate citation or notice of de minimis violation shall be issued even though

after being informed of an alleged violation by the Compliance Safety and Health Officer, the employer immediately abates, or initiates steps to abate, such alleged violation. Any citation or notice of de minimis violations shall be issued with reasonable promptness after termination of the inspection. No citation may be issued under this rule after the expiration of six months following the occurrence of any alleged violation.

- B. If a citation or notice of de minimis violation issued for a violation alleged in a request for inspection under A.R.S. § 23-408(E), a copy of the citation or notice of de minimis violation shall also be sent to the employee or representative of employees who made such request or notification.
- C. After an inspection, if the Division Director determines that a citation is not warranted with respect to a danger or violation alleged to exist in a request for inspection under A.R.S. § 23-408(E), the informal review procedures prescribed in rule R20-5-619(A) shall be applicable. After considering all views presented, the Industrial Commission shall affirm the determination of the Division Director, order a reinspection, or issue a citation if the Industrial Commission believes that the inspection disclosed a violation. The Industrial Commission shall furnish the complaining party and the employer with a written notification of their determination and the reasons therefore. The determination of the Industrial Commission shall be final and not subject to review.
- D. Every citation shall state that the issuance of a citation does not constitute a finding that a violation of the Act has occurred unless there is a failure to contest as provided for in the Act or, if contested, unless a citation is affirmed by the Hearing Division or the Review Commission.

Historical Note

Adopted as an emergency effective May 24, 1977, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 77-3). Repealed as an emergency effective November 16, 1977, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 77-6). Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-620 adopted as an emergency effective October 29, 1980, renumbered and amended as Section R4-13-621 effective March 2, 1981 (Supp. 81-2). R20-5-621 recodified from R4-13-621 (Supp. 95-1).

R20-5-622. Proposed Penalties

- A. All employers shall be notified of any proposed penalties, issued pursuant to A.R.S. § 23-418, by certified mail or by a signed verification in person.
- B. The Division Director shall determine the amount of any proposed penalty, giving due consideration to the appropriateness of penalty with respect to the size of the business of the employer being charged, the gravity of the violation, the good faith of the employer, and the history of previous violations in accordance with the provisions of A.R.S. § 23-418 of the Act.
- C. Appropriate penalties may be proposed with respect to an alleged violation even though after being informed of such alleged violation by the Compliance Safety and Health Officer, the employer immediately abates, or initiates steps to abate, such alleged violation. Penalties shall not be proposed for de minimis violations which have no direct or immediate relationship to safety or health.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-621 adopted as an emergency effective October 29, 1980, renumbered and amended as Section R4-13-622 effective March 2, 1981

(Supp.81-2). R20-5-622 recodified from R4-13-622 (Supp. 95-1).

R20-5-623. Posting of Citations

- A.** Upon receipt of any citation under the Act, the employer shall immediately post such citation, or a copy thereof, unedited, at or near each place an alleged violation referred to in the citation occurred, except as provided below. Where, because of the nature of the employer's operations, it is not practicable to post the citation at or near each place of alleged violation, such citation shall be posted, unedited, in a prominent place where it will be readily observable by all affected employees. For example, where employers are engaged in activities which are physically dispersed, the citation may be posted at the location to which the employees report each day. Where employees do not primarily work at or report to a single location, the citation may be posted at the location from which the employees operate to carry out their activities. The employer shall take steps to ensure that the citation is not altered, defaced, or covered by other material. Notices of de minimis violations need not be posted.
- B.** Each citation, or a copy thereof, shall remain posted until the violation has been abated, or for three working days, whichever is later. The filing by the employer of a notice of intention to contest under A.R.S. § 23-471(A) shall not affect his posting responsibility under this rule unless and until the Hearing Division and/or Review Commission issues a final order vacating the citation.
- C.** An employer to whom a citation has been issued may post a notice in the same location where such citation is posted indicating that the citation is being contested before the Hearing Division and/or Review Commission, and such notice may explain the reasons for such contest. The employer may also indicate that specified steps have been taken to abate the violation.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-622 adopted as an emergency effective October 29, 1980, renumbered and amended as Section R4-13-623 effective March 2, 1981 (Supp. 81-2). R20-5-623 recodified from R4-13-623 (Supp. 95-1).

R20-5-624. Employer and Employee Contests before the Hearing Division

- A.** All notices to contest citations and/or penalties shall be submitted to the Division Director and immediately transmitted to the Hearing Division in accordance with the Rules of Procedure prescribed by the Industrial Commission.
- B.** Any affected employee or employee representative appealing the period allowed an employer to abate a particular violation shall submit the notice of contest to the Division Director who shall immediately transmit such notice to the Hearing Division in accordance with the Rules of Procedure prescribed by the Industrial Commission.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-623 adopted as an emergency effective October 29, 1980, renumbered and amended as Section R4-13-624 effective March 2, 1981 (Supp. 81-2). R20-5-624 recodified from R4-13-624 (Supp. 95-1).

R20-5-625. Failure to Correct a Violation for Which a Citation Has Been Issued

- A.** All employers failing to correct an alleged violation for which a citation has been issued, within the period permitted for its correction, shall be notified of such failure and any proposed penalties issued pursuant to A.R.S. § 23-418 by certified mail or by signed verification in person.
- B.** All notices to contest a notification of failure to correct a violation and of proposed additional penalty shall be submitted to the Division Director and immediately transmitted to the Hearing Division in accordance with the Rules of Procedure prescribed by the Industrial Commission.
- C.** Each notification of failure to correct a violation and of proposed additional penalty shall state that it shall be deemed to be the final order of the Industrial Commission and not subject to review by any court or agency unless within fifteen working days from the receipt of such notification, the employer notifies the Division Director in writing that he intends to contest the notification or the proposed additional penalty before the Hearing Division.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-624 adopted as an emergency effective October 29, 1980, renumbered and amended as Section R4-13-625 effective March 2, 1981 (Supp. 81-2). R20-5-625 recodified from R4-13-625 (Supp. 95-1).

R20-5-626. Informal Conferences

At the request of an affected employer, employee, or representative of employees, the Industrial Commission, or their designee, may hold an informal conference for the purpose of discussing any issues raised by an inspection, citation, notice of proposed penalty, or notice of intention to contest. The settlement of any issue at such conference shall be subject to rules and procedures prescribed by the Industrial Commission. If the conference is requested by the employer, an affected employee or his representative shall be afforded an opportunity to participate, at the discretion of the Industrial Commission or their designee. If the conference is requested by an employee or representative of employees, the employer shall be afforded an opportunity to participate, at the discretion of the Industrial Commission or their designee. Any party may be represented by counsel in such conference. No such conference or request for such conference shall operate as a stay of any fifteen working day period for filing a notice of intention to contest as prescribed in rule R20-5-624.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-625 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-626 effective March 2, 1981 (Supp. 81-2). R20-5-626 recodified from R4-13-626 (Supp. 95-1).

R20-5-627. Abatement Verification

- A.** Scope and application. This Section applies to employers, as defined in A.R.S. § 23-401, who receive a citation for a violation of the Arizona Occupational Safety and Health Act.
- B.** Definitions:
 1. Abatement means action by an employer to comply with a cited standard or rule or to eliminate a recognized hazard, as defined in A.R.S. § 23-401, identified by the Division during an inspection.
 2. Abatement date means:

- a. For an uncontested citation item, the later of:
 - i. The date in the citation for abatement of the violation;
 - ii. The date approved by the Division as a result of a petition for modification of the abatement date (PMA); or
 - iii. The date for abatement completion as established in a citation by an informal conference agreement.
 - b. For a contested citation item for which an administrative law judge has issued a final decision affirming the violation, the later of:
 - i. The date identified in the final decision for completion of abatement;
 - ii. The date computed by adding the original period allowed for abatement in the citation to begin 15 days from the final decision date of an administrative law judge; or
 - iii. The date established by a formal settlement agreement.
 3. Affected employee means an employee who is exposed to the hazard identified as a violation in a citation.
 4. Final order date means:
 - a. The date on which an uncontested citation is deemed final under A.R.S. § 23-417 (A); or
 - b. For a contested citation item: The date on which a decision or order of an administrative law judge becomes final under A.R.S. § 23-421 or § 23-423.
 5. Movable equipment means a hand-held or non-hand-held machine or device, powered or unpowered, that is used to do work and is moved within or between workplaces.
- C. Abatement certification.**
 1. Within 10 calendar days after the abatement date, an employer shall certify to the Division that the employer has abated each cited violation except as provided in subsection (C)(2). An employer may use Appendix A to certify abatement.
 2. An employer is not required to certify abatement if a Compliance Safety and Health Officer, during an onsite inspection:
 - a. Observes, within 24 hours after a violation is identified, that abatement has occurred; and
 - b. Notes the abatement action on the citation.
 3. An employer's certification that abatement is complete shall include, for each cited violation, in addition to the information required by subsection (H), the completion date and method of abatement and a statement that affected employees and their representatives have been informed of the completed abatement.
- D. Abatement documentation.**
 1. Within 10 days after the abatement date, an employer shall submit to the Division, documents which evidence that abatement is complete for each willful or repeat violation and for any serious violation for which abatement documentation is required.
 2. Documents which evidence that abatement is complete may include documents for purchase or repair of equipment, photographs or videos of the abatement, or other written records.
- E. Abatement plans.**
 1. The Division may require an employer to submit an abatement plan, except for a nonserious violation, when the time permitted for abatement is more than 90 days. The citation shall state that an abatement plan is required. An employer may use Appendix B for an abatement plan.
2. An employer shall submit an abatement plan for each cited violation within 25 days from the date of a final order when the citation states that a plan is required. In the abatement plan, the employer shall identify:
 - a. The violation,
 - b. The steps necessary to achieve abatement,
 - c. A schedule for completing abatement, and
 - d. How the employer will protect employees from the violative condition until abatement is complete.
 - F. Progress reports.**
 1. The Division may require an employer who submits an abatement plan under subsection (E), to submit periodic progress reports for each cited violation. If the Division requires a periodic progress report, the citation shall include the following information:
 - a. Periodic progress reports are required and the cited violations for which periodic progress reports are required;
 - b. The date on which an initial progress report must be submitted. The date of the initial progress report shall be no sooner than 30 days after the submission date required for abatement;
 - c. Whether additional progress reports are required; and
 - d. The date on which additional progress reports shall be submitted.
 2. For each violation, the employer shall summarize in the progress report, the action taken to achieve abatement and the date the action was taken.
 - G. Employee notification.**
 1. An employer shall inform affected employees and the employees' representative of abatement activities covered by this Section by posting a copy of each document submitted to the Division or a summary of the document at the location of the cited violation.
 2. For employers who have mobile work operations, the employer shall:
 - a. Post each document or a summary of the document submitted to the Division in a conspicuous place where it can be readily seen by employees and the employee representative; or
 - b. Take other steps to communicate fully to affected employees and the employees' representative about abatement actions.
 3. The employer shall inform employees and the employees' representative of the right to examine and copy all abatement documents submitted by the employer to the Division.
 - a. An employee or an employee representative shall submit a written request to examine and copy abatement documents within three working days of receiving notice that the documents have been submitted to the Division.
 - b. An employer shall comply with an employee's or employee representative's written request to examine and copy abatement documents within five working days of receiving the request.
 4. An employer shall ensure that notice in subsection (G)(1) to employees and a employee representative is provided at the same time or before the information is provided to the Division and that abatement documents are:
 - a. Not altered, defaced, or physically covered by other material; and
 - b. Remain posted for at least three working days after submission to the Division.
 - H. Transmitting abatement documents.**

1. An employer shall include, in each submission required by this Section, the following information:
 - a. The employer's name and address;
 - b. The inspection number to which the submission relates;
 - c. The citation, item number, and location to which the submission relates;
 - d. A statement that the information submitted is accurate; and
 - e. The signature of the employer or the employer's authorized representative.
2. The date of postmark is the date of submission for mailed documents. For documents transmitted by other means, the date the Division receives the document is the date of submission.

I. Movable equipment.

1. For serious, repeat, and willful violations involving movable equipment, an employer shall attach a warning tag or a copy of the citation to the operating controls or to the cited component of equipment that is moved within or between workplaces. The Division shall deem attaching a copy of the citation to the equipment to meet the tagging requirement of subsection (I)(3) and the posting requirement of R20-5-623.
2. The employer shall use a warning tag to warn employees about the nature of the violation involving the movable equipment and identifies the location of the violation. An employer may use the tag in Appendix C to meet this requirement.
3. If a violation has not been abated, an employer shall attach a warning tag or a copy of the citation to the equipment as follows:
 - a. For hand-held equipment, the employer shall attach a warning tag or copy of the citation within eight hours after the employer receives the citation; and
 - b. For non-hand-held equipment, the employer shall attach a warning tag or copy of the citation before moving the equipment within or between workplaces.
4. For the construction industry, a tag that is designed and used in accordance with 29 CFR 1926.20(b)(3) and 29 CFR 1926.200(h) is deemed by the Division to meet the requirements of this Section when the information required by subsection (I)(2) is included on the tag.
5. An employer shall ensure that the tag or copy of the citation attached to movable equipment is not altered, defaced, or physically covered by other material.
6. An employer shall ensure that the tag or copy of the citation attached to movable equipment remains attached until:
 - a. The employer has abated the violation and all abatement verification documents required by this Section have been submitted to the Division;
 - b. The employer has permanently removed the cited equipment from service or the cited equipment is no longer within the employer's control; or
 - c. The Division, administrative law judge, or Review Board vacates the citation.

Historical Note

Adopted effective June 26, 1998 (Supp. 98-2).

Appendix A. Sample Abatement - Certification Letter (Non-mandatory)

[Name], Director
The Industrial Commission of Arizona
Division of Occupational Safety and Health

P. O. Box 19070
Phoenix, Arizona 85005

[Company's Name]
[Company's Address]

The hazard referenced in Inspection Number [Insert 9-digit #] for violation identified as:

Citation [insert #] and item [insert #] was corrected on [insert date] by:

Citation [insert #] and item [insert #] was corrected on [insert date] by:

Citation [insert #] and item [insert #] was corrected on [insert date] by:

Citation [insert #] and item [insert #] was corrected on [insert date] by:

Citation [insert #] and item [insert #] was corrected on [insert date] by:

I attest that the information contained in this document is accurate.

Signature

Typed or Printed Name

Historical Note

Appendix A adopted effective June 26, 1998 (Supp. 98-2).

Appendix B. Sample Abatement Plan or Progress Report (Nonmandatory)

(Name), Director
The Industrial Commission of Arizona
Division of Occupational Safety and Health
P. O. Box 19070
Phoenix, Arizona 85005

[Company's Name]
[Company's Address]

Check one:

Abatement Plan []

Progress Report []

Inspection Number _____

Page _____ of _____

Citation Number(s)* _____

Item Number(s)* _____

Action	Proposed Completion Date (for abatement plans only)	Completion Date (for progress reports only)
1.
2.
3.

-

 4.

 5.

Date required for final abatement: _____

I attest that the information contained in this document is accurate.

 Signature

 Typed or Printed Name

Name of primary point of contact for questions: (optional)

Telephone number: _____

*Abatement plans or progress reports for more than one citation item may be combined in a single abatement plan or progress report if the abatement actions, proposed completion dates, and actual completion dates (for progress reports only) are the same for each of the citation items.

Historical Note

Appendix B adopted effective June 26, 1998 (Supp. 98-2).

Appendix C. Sample Warning Tag (Nonmandatory)

O

WARNING:

**EQUIPMENT HAZARD
BY ADOSH**

EQUIPMENT CITED:

HAZARD CITED:

**FOR DETAILED INFORMATION:
SEE ADOSH CITATION POSTED AT:**

BACKGROUND COLOR--ORANGE
 MESSAGE COLOR--BLACK

Historical Note

Appendix C adopted effective June 26, 1998 (Supp. 98-2).

R20-5-628. Safe Transportation of Compressed Air or Other Gases

An employer shall not use Polyvinyl Chloride (PVC) piping in a place of employment for the transportation and distribution of compressed air or other compressed gases in an above-ground installation.

Historical Note

New Section made by final rulemaking at 9 A.A.R. 1161, effective March 11, 2003 (Supp. 03-1).

R20-5-629. The Occupational Injury and Illness Recording and Reporting Requirements, 29 CFR 1904

All employers, both public and private shall comply with the Occupational Injury and Illness Recording and Reporting Requirements, published in 29 CFR 1904, as amended June 30, 2003, incorporated by reference. This incorporation by reference contains no future editions or amendments. Copies of the incorporated materials are available for review at the Industrial Commission of Arizona and may be obtained from the United States Government Printing Office, Superintendent of Documents, Washington, D.C. 20402.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 364, effective December 31, 2001 (Supp. 01-4). Amended by final rulemaking at 9 A.A.R. 874, effective February 19, 2003 (Supp. 03-1). Amended by final rulemaking at 10 A.A.R. 318, effective January 1, 2004 (Supp. 03-4).

R20-5-630. Repealed

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-640 adopted as an emergency effective October 29, 1980, renumbered and amended as Section R4-13-630 effective March 2, 1981 (Supp. 81-2). R20-5-630 recodified from R4-13-631 (Supp. 95-1). Section repealed by final rulemaking at 8 A.A.R. 364, effective December 31, 2001 (Supp. 01-4).

R20-5-631. Repealed

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former emergency adoption effective October 29, 1980, adopted effective March 2, 1981 (Supp. 81-2). R20-5-631 recodified from R4-13-631 (Supp. 95-1). Section repealed by final rulemaking at 8 A.A.R. 364, effective December 31, 2001 (Supp. 01-4).

R20-5-632. Repealed

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former emergency adoption effective October 29, 1980, adopted effective March 2, 1981 (Supp. 81-2). R20-5-632 recodified from R4-13-632 (Supp. 95-1). Section repealed by final rulemaking at 8 A.A.R. 364, effective December 31, 2001 (Supp. 01-4).

R20-5-633. Repealed

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former emergency adoption effective Octo-

ber 29, 1980, adopted effective March 2, 1981 (Supp. 81-2). R20-5-633 recodified from R4-13-633 (Supp. 95-1). Section repealed by final rulemaking at 8 A.A.R. 364, effective December 31, 2001 (Supp. 01-4).

R20-5-634. Repealed**Historical Note**

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former emergency adoption effective October 29, 1980, adopted effective March 2, 1981 (Supp. 81-2). R20-5-634 recodified from R4-13-634 (Supp. 95-1). Section repealed by final rulemaking at 8 A.A.R. 364, effective December 31, 2001 (Supp. 01-4).

R20-5-635. Repealed**Historical Note**

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former emergency adoption effective October 29, 1980, adopted effective March 2, 1981 (Supp. 81-2). R20-5-635 recodified from R4-13-635 (Supp. 95-1). Section repealed by final rulemaking at 8 A.A.R. 364, effective December 31, 2001 (Supp. 01-4).

R20-5-636. Repealed**Historical Note**

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former emergency adoption effective October 29, 1980, adopted and amended effective March 2, 1981 (Supp. 81-2). R20-5-636 recodified from R4-13-636 (Supp. 95-1). Section repealed by final rulemaking at 8 A.A.R. 364, effective December 31, 2001 (Supp. 01-4).

R20-5-637. Repealed**Historical Note**

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former emergency adoption effective October 29, 1980, adopted effective March 2, 1981 (Supp. 81-2). Amended effective December 14, 1994 (Supp. 94-4). R20-5-637 recodified from R4-13-637 (Supp. 95-1). Section repealed by final rulemaking at 8 A.A.R. 364, effective December 31, 2001 (Supp. 01-4).

R20-5-638. Repealed**Historical Note**

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former emergency adoption effective October 29, 1980, adopted effective March 2, 1981 (Supp. 81-2). R20-5-638 recodified from R4-13-638 (Supp. 95-1). Section repealed by final rulemaking at 8 A.A.R. 364, effective December 31, 2001 (Supp. 01-4).

R20-5-639. Repealed**Historical Note**

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former emergency adoption effective October 29, 1980, adopted effective March 2, 1981 (Supp. 81-2). R20-5-639 recodified from R4-13-639 (Supp. 95-1). Section repealed by final rulemaking at 8 A.A.R. 364, effective December 31, 2001 (Supp. 01-4).

R20-5-640. Repealed**Historical Note**

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-641 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-640 effective March 2, 1981 (Supp. 81-2). R20-5-640 recodified from R4-13-640 (Supp. 95-1). Section repealed by final rulemaking at 8 A.A.R. 364, effective December 31, 2001 (Supp. 01-4).

R20-5-641. Repealed**Historical Note**

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-642 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-641 effective March 2, 1981 (Supp. 81-2). R20-5-641 recodified from R4-13-641 (Supp. 95-1). Section repealed by final rulemaking at 8 A.A.R. 364, effective December 31, 2001 (Supp. 01-4).

R20-5-642. Repealed**Historical Note**

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-643 adopted as an emergency effective October 29, 1980, renumbered and amended as Section R4-13-642 effective March 2, 1981 (Supp. 81-2). R20-5-642 recodified from R4-13-642 (Supp. 95-1). Section repealed by final rulemaking at 8 A.A.R. 364, effective December 31, 2001 (Supp. 01-4).

R20-5-643. Repealed**Historical Note**

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-644 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-643 effective March 2, 1981 (Supp. 81-2). R20-5-643 recodified from R4-13-643 (Supp. 95-1). Section repealed by final rulemaking at 8 A.A.R. 364, effective December 31, 2001 (Supp. 01-4).

R20-5-644. Repealed**Historical Note**

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-645 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-644 effective March 2, 1981 (Supp. 81-2). R20-5-644 recodified from R4-13-644 (Supp. 95-1). Section repealed by final rulemaking at 8 A.A.R. 364, effective December 31, 2001 (Supp. 01-4).

R20-5-645. Repealed**Historical Note**

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-646 adopted as an emergency effective October 29, 1980, renumbered and amended as Section R4-13-645 effective March 2, 1981 (Supp. 81-2). R20-5-645 recodified from R4-13-645 (Supp. 95-1). Section repealed by final rulemaking at 8 A.A.R. 364, effective December 31, 2001 (Supp. 01-4).

R20-5-646. Emergency Expired

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Emergency expired. R20-5-646 recodified from R4-13-646 (Supp. 95-1).

R20-5-647. Reserved

R20-5-648. Reserved

R20-5-649. Reserved

R20-5-650. Definitions

As used in rules R20-5-650 through R20-5-669 inclusive, unless the context clearly requires otherwise:

1. "Act" means the Arizona Occupational Safety and Health Act of 1972 (Arizona Revised Statutes, Title 23, Chapter 2, Article 10).
2. "Commission" means the Industrial Commission of Arizona.
3. "Person" means an individual, partnership, association, corporation, business trust, legal representative, an organized group of individuals, or political subdivision.
4. "Party" means a person admitted to participate in a hearing conducted in accordance with subsection (3). An applicant for relief and any affected employee shall be entitled to be named as parties.
5. "Affected employee" means an employee or any one of his authorized representatives, such as his collective bargaining agent, who would be affected by the granting or denial of a variance.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-651 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-650 effective March 2, 1981 (Supp. 81-2). R20-5-650 recodified from R4-13-650 (Supp. 95-1).

R20-5-651. Petitions for Amendments

Any person may at any time petition the Commission in writing to revise, amend, or revoke any provisions of rules R20-5-650 through R20-5-669 inclusive. The petition should set forth either the terms or the substance of the rule desired, with a concise statement of the reasons therefor and the effects thereof.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-652 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-651 effective March 2, 1981 (Supp. 81-2). R20-5-651 recodified from R4-13-651 (Supp. 95-1).

R20-5-652. Effects of Variances

All variances granted hereunder shall have only future effect. In their discretion, the Commission may decline to entertain an application for variance on the subject or issue concerning which a citation has been issued to the employer involved and a proceeding on the citation or a related issue concerning a proposed penalty or period of abatement is pending before the Federal Occupational Safety and Health Review Commission, State of Arizona Hearing Division or the Arizona Review Board until the completion of such proceeding.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-654 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-652 effective March 2, 1981 (Supp. 81-2). R20-5-652 recodified from R4-13-652 (Supp. 95-1).

R20-5-653. Public Notice of a Granted Variance

Every final action granting a variance, shall be published in state-wide newspapers. Every such final action shall specify the alternative to the standard involved which the particular variance permits.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-655 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-653 effective March 2, 1981 (Supp. 81-2). R20-5-653 recodified from R4-13-653 (Supp. 95-1).

R20-5-654. Form of Documents; Subscription; Copies

- A. No particular form is prescribed for applications and other papers which may be filed in proceedings hereunder. However, any applications and other papers shall be clearly legible. An original and six copies of any application and other papers shall be filed. The original shall be typewritten. Clear carbon copies or printed or processed copies are acceptable copies.
- B. Each application or other paper which is filed in proceedings hereunder shall be signed by the person filing the same or by his attorney or other authorized representative and where required by these regulations shall be verified by the applicant.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-646 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-654 effective March 2, 1981 (Supp. 81-2). R20-5-654 recodified from R4-13-654 (Supp. 95-1).

R20-5-655. Variances

- A. Application for variance. Any employer, or class of employers, desiring a variance from a standard or regulation or any portion thereof, authorized by A.R.S. § 23-411 of the Act may file a written application containing the information specified in subsection (B) of this Section with the Industrial Commission of Arizona, 1601 West Jefferson, Phoenix, Arizona 85005.
- B. Contents. An application filed pursuant to subsection (A) of this Section shall contain the information specified in A.R.S. § 23-411(B) and (C) of the Act.
- C. Interim order.
 1. Application. In accordance with A.R.S. § 23-411(B)(3) of the Act, an application may also be made for an interim order to be effective until a decision is rendered on the application for the variance filed previously or concurrently. An application for an interim order shall include a verified statement of facts and arguments supporting such application. The Commission may rule ex parte upon the application.
 2. Notice of denial of application. If an application filed pursuant to subsection (C)(1) is denied, the applicant shall be given prompt notice of the denial, which shall include, or be accompanied by, a brief statement of the grounds therefore.

3. Notice of the grant of an interim order. If an interim order is granted, a copy of the order shall be served upon the applicant for the order and other parties and the terms of the order shall be published in statewide newspapers. It shall be a condition of the order that the affected employer shall give notice thereof to affected employees by the same means to be used to inform them of an application for variance.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-657 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-655 effective March 2, 1981 (Supp. 81-2). R20-5-655 recodified from R4-13-655 (Supp. 95-1).

R20-5-656. Variances under A.R.S. § 23-412

- A. Application for variance. Any employer, or class of employers, desiring a variance authorized by A.R.S. § 23-412 of the Act may file a written application containing the information specified in subsection (B) of this Section, with the Industrial Commission of Arizona, 1601 W. Jefferson, Phoenix, Arizona 85005.
- B. Contents. An application filed pursuant to subsection (A) of this Section shall contain the information specified in A.R.S. § 23-412 of the Act.
- C. Interim order
 1. Application. An application may also be made for an interim order to be effective until a decision is rendered on the application for the variance filed previously or concurrently. An application for an interim order shall include a verified statement of facts and arguments supporting such application. The Commission may rule ex parte upon the application.
 2. Notice of denial of application. If an application filed pursuant to subsection (C)(1) is denied, the applicant shall be given prompt notice of the denial, which shall include, or be accompanied by, a brief statement of the grounds therefore.
 3. Notice of the grant of an interim order. If an interim order is granted, a copy of the order shall be served upon the applicant and other parties, and the terms of the order shall be published in statewide newspapers. It shall be a condition of the order that the affected employer shall give notice thereof to affected employees by the same means to be used to inform them of an application for a variance.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-658 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-656 effective March 2, 1981 (Supp. 81-2). R20-5-656 recodified from R4-13-656 (Supp. 95-1).

R20-5-657. Renewal of Rules or Orders: Federal Multi-state Variances

- A. Renewal or rules or orders. Any final rule or order issued under A.R.S. § 23-411 of the Act may be renewed or extended as permitted by the applicable Section and in the manner prescribed for its issuance.
- B. Multi-state variances. Where a federal variance has been granted with multi-state applicability, including applicability in this state operating under a state plan approved under Sec-

tion 18 of the Act, from a standard or portion thereof identical to this state's standard or regulation or portion thereof such variance shall likewise be deemed an authoritative interpretation of the employer(s)' compliance obligation with regard to the state standard or portion thereof provided no objections of substance are found to be interposed by the Commission.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-659 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-657 effective March 2, 1981 (Supp. 81-2). R20-5-657 recodified from R4-13-657 (Supp. 95-1).

R20-5-658. Action on Applications

- A. Defective applications
 1. If an application filed pursuant to rule R20-5-655, R20-5-656, R20-5-657 and R20-5-658 does not conform to the applicable Section, the Commission may deny the application.
 2. Prompt notice of the denial of an application shall be given to the applicant.
 3. A notice of denial shall include, or be accompanied by, a brief statement of the grounds for denial.
 4. A denial of an application pursuant to this subsection shall be without prejudice to the filing of another application.
- B. Adequate applications
 1. If an application has not been denied pursuant to subsection (A) of this Section, the Commission shall cause to be published in statewide newspapers a notice of the filing of the application.
 2. A notice of the filing of an application shall include:
 - a. The terms, or an accurate summary, of the application;
 - b. A reference to the Section of the Act under which the application has been filed;
 - c. An invitation to interested persons to submit within a stated period of time written data, views, or arguments regarding the application; and
 - d. Information to affected employers, employees, of any right to request a hearing on the application.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-660 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-658 effective March 2, 1981 (Supp. 81-2). R20-5-658 recodified from R4-13-658 (Supp. 95-1).

R20-5-659. Request for Hearings on Petition

- A. Request for hearing. Any employer, employee, authorized employee representative, representative, or other person interested in or affected by an order of the Commission may petition for a hearing on the reasonableness and lawfulness of an order issued under A.R.S. §§ 23-411 or 23-412, by a verified petition filed with the Commission.
- B. Contents of a petition. A request for a hearing filed pursuant to subsection (A) of this Section shall include:
 1. The name and address of the applicant;
 2. A concise statement of facts showing how the employer, employee, authorized employee representative, representative, or other person would be affected by the relief applied for;

3. A petition shall set forth specifically and in detail the order upon which a hearing is desired;
4. The reasons why the order is unreasonable or unlawful;
5. The issue to be considered by the Commission on the hearing. Objections other than those set forth in the petition are deemed finally waived.
6. If the applicant is an employer, a certification that the applicant has informed his affected employees of the application by:
 - a. Giving a copy thereof to their authorized representative;
 - b. Posting at the place or places where notices to employees are normally posted, a statement giving a summary of the petition specifying where a copy of the full petition may be examined (or, in lieu of the summary, posting the application itself); and
 - c. Other appropriate means.
7. If the applicant is an affected employee, a certification that a copy of the petition has been furnished to the employer.

- C. The Commission may on its own motion proceed to modify or revoke a rule or order issued under A.R.S. §§ 23-411 or 23-412 of the Act. In such event, the Commission shall cause to be published in statewide newspapers a notice of its intention, affording interested persons an opportunity to submit written data, views, or arguments regarding the proposal and informing the affected employer and employees of their right to request a hearing and shall take such other action as may be appropriate to give actual notice to the affected employees. Any request for a hearing shall include a short and plain statement of:
1. How the proposed modification or revocation would affect the requesting party; and
 2. What the requesting party would seek to show on the subjects or issues involved.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-661 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-659 effective March 2, 1981 (Supp. 81-2). R20-5-659 recodified from R4-13-659 (Supp. 95-1).

R20-5-660. Consolidation of Proceedings

The Commission on its own motion or that of any party may consolidate or contemporaneously consider two or more proceedings which involve the same or closely related issues.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-662 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-660 effective March 2, 1981 (Supp. 81-2). R20-5-660 recodified from R4-13-660 (Supp. 95-1).

R20-5-661. Notice of Hearing

- A. Service. Upon request for a hearing as provided in this Section, or upon its own initiative, the Commission shall serve, or cause to be served, a reasonable notice of hearing.
- B. Contents. A notice of hearing served under subsection (A) of this Section shall include:
1. The time, place, and nature of the hearing;
 2. The legal authority under which the hearing is to be held;
 3. A specification of issues of fact and law.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-663 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-661 effective March 2, 1981 (Supp. 81-2). R20-5-661 recodified from R4-13-661 (Supp. 95-1).

R20-5-662. Manner of Service

Service of any document upon any party may be made by personal delivery of, or by mailing, a copy of the document to the last known address of the party. The person serving the document shall certify to the manner and the date of the service.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-664 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-662 effective March 2, 1981 (Supp. 81-2). R20-5-662 recodified from R4-13-662 (Supp. 95-1).

R20-5-663. Industrial Commission; Powers and Duties

- A. Powers. The Commissioners shall have all powers necessary or appropriate to conduct a fair, full, and impartial hearing, including the following:
1. To administer oaths and affirmations;
 2. To rule upon offers of proof and receive relevant evidence;
 3. To provide for discovery and to determine its scope;
 4. To regulate the course of the hearing and the conduct of the parties and their counsel therein;
 5. To consider and rule upon procedural requests;
 6. To hold conferences for the settlement or simplification of the issues by consent of the parties;
 7. To make, or to cause to be made, an inspection of the employment or place of employment involved;
 8. To make decisions in accordance with A.R.S. §§ 23-405.5, 23-411, 23-412, and 23-945; and
 9. To take any other appropriate action authorized by the Act, this Section, or A.R.S. § 23-945.
- B. Contumacious conduct; failure or refusal to appear or obey the rulings of the Commission.
1. Contumacious conduct at any hearing before the Commission shall be grounds for exclusion from the hearing.
 2. If a witness or a party refuses to answer a question after being directed to do so, or refuses to obey an order to provide or permit discovery, the Commission may make such orders with regard to the refusal as are just and appropriate, including an order denying an application of an applicant or regulating the contents of the record of the hearing.
- C. Referral to Rules of Procedure for Occupational Safety and Health hearings. On any procedural question not regulated by this Section, the Act, or A.R.S. § 23-945, Commission shall be guided to the extent practicable by any pertinent provisions of the Rules of Procedure for Occupational Safety and Health hearings before the Industrial Commission of Arizona.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-665 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-663 effective March 2, 1981

(Supp. 81-2). R20-5-663 recodified from R4-13-663 (Supp. 95-1).

R20-5-664. Prehearing Conferences

- A.** Convening a conference. Upon its own motion or the motion of a party, the Commission may direct the parties or their counsel to meet with them for a conference to consider:
1. Simplification of the issues;
 2. Necessity or desirability of amendments to documents for purposes of clarification, simplification, or limitation;
 3. Stipulations, admissions of fact, and of contents and authenticity of documents;
 4. Limitation of the number of parties and of expert witnesses; and
 5. Such other matters as may tend to expedite the disposition of the proceeding and to assure a just conclusion thereof.
- B.** Record of conference. The Commission shall make an order which recites the action taken at the conference, the amendments allowed to any documents which have been filed, and the agreements made between the parties as to any of the matters considered, and which limits the issues for hearings to those not disposed of by admission or agreements; and such order when entered controls the subsequent course of the hearing, unless modified at the hearing, to prevent manifest injustice.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-666 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-664 effective March 2, 1981 (Supp. 81-2). R20-5-664 recodified from R4-13-664 (Supp. 95-1).

R20-5-665. Consent Findings and Rules or Orders

- A.** General. At any time before the reception of evidence in any hearing, or during any hearing, a reasonable opportunity may be afforded to permit the negotiation by the parties of an agreement containing consent findings and a rule or order disposing of the whole or any part of the proceeding. The allowance of such opportunity and the duration thereof shall be in the discretion of the Commission. After consideration of the nature of the proceeding, the requirements of the public interest, the representations of the parties, and the probability of an agreement which will result in a just disposition of the issues involved.
- B.** Contents. Any agreement containing consent findings in rule or other disposing of a proceeding shall also provide:
1. That the rule or order shall have the same force and effect as if made after a full hearing;
 2. That the entire record on which any rule or order may be based shall consist solely of the application and the agreement;
 3. A waiver of any further procedural steps before the Commission; and
 4. A waiver of any right to challenge or contest the validity of the findings and of the rule or order made in accordance with the agreement.
- C.** Submission. On or before the expiration of the time granted for negotiations, the parties or their counsel may:
1. Submit the proposed agreement to the Commission for its consideration; or
 2. Inform the Commission that agreement cannot be reached.
- D.** In the event an agreement containing consent findings and rule or order is submitted within the time allowed therefor, the

Commission may accept such agreement by issuing its decision based upon the agreed findings.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-667 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-665 effective March 2, 1981 (Supp. 81-2). R20-5-665 recodified from R4-13-665 (Supp. 95-1).

R20-5-666. Discovery

- A.** Depositions
1. For reasons of unavailability or for other good cause shown, the testimony of any witness may be taken by deposition. Depositions may be taken orally or upon written interrogatories before any person designated by the Commission and having power to administer oaths.
 2. Application. Any party desiring to take the deposition of a witness may make application in writing to the Commission, setting forth:
 - a. The reasons why such deposition should be taken;
 - b. The time when, the place where, and the name and post office address of the person before whom the deposition is to be taken;
 - c. The name and address of each witness; and
 - d. The subject matter concerning which each witness is expected to testify.
 3. Notice. Such notice as the Commission may order shall be given by the party taking the deposition to every other party.
 4. Taking and receiving in evidence. Each witness testifying upon deposition shall be sworn, and the parties not calling him shall have the right to cross-examine him. The questions propounded and the answers thereto, together with all objections made, shall be reduced to writing, read to the witness, subscribed by him, and certified by the officer before whom the deposition is taken. Thereafter, the officer shall seal the deposition, with two copies thereof, in an envelope and mail the same by registered mail to the presiding hearing examiner. Subject to such objections to the questions and answers as were noted at the time of taking the deposition and would be valid were the witness personally present and testifying, such deposition may be read and offered in evidence by the party taking it as against any party who was present, represented at the taking of the deposition, or who had due notice thereof. No part of a deposition shall be admitted in evidence unless there is a showing that the reasons for the taking of the deposition in the first instance exist at the time of the hearing.
- B.** Other discovery. Whenever appropriate to a just disposition of any issue in a hearing, the Commission may allow discovery by any other appropriate procedure, such as by written interrogatories upon a party, production of documents by a party, or by entry for inspection of the employment or place of employment involved.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-668 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-666 effective March 2, 1981 (Supp. 81-2). R20-5-666 recodified from R4-13-666 (Supp. 95-1).

R20-5-667. Hearings

- A. Order of proceeding. Except as may be ordered otherwise by the Commission, the party applicant for relief shall proceed first at a hearing.
- B. Burden of proof. The party applicant shall have the burden of proof.
- C. Evidence
 - 1. Admissibility. A party shall be entitled to present its case or defense by oral or documentary evidence, to submit rebuttal evidence, and to conduct such cross-examination as may be required for a full and true disclosure of the facts. Any oral or documentary evidence may be received, but the Commission shall exclude evidence which is irrelevant, immaterial, or unduly repetitious.
 - 2. Testimony of witnesses. The testimony of a witness shall be upon oath or affirmation administered by the Commission.
- D. Official notice. Official notice may be taken of any material fact not appearing in evidence in the record, which is among the traditional matters of judicial notice: provided that the parties shall be given adequate notice, at the hearing or by reference in the Commission's decision, of the matters so noticed and shall be given adequate opportunity to show the contrary.
- E. Record. Minutes shall be taken of the Commission hearings. Copies of the minutes may be obtained by the parties upon written application filed with the secretary of the Commission and upon the payment of fees at the rate provided in the agreement with the Commission.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-669 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-667 effective March 2, 1981 (Supp. 81-2). R20-5-667 recodified from R4-13-667 (Supp. 95-1).

R20-5-668. Decisions of the Commission

- A. Proposed findings of fact, conclusions, and rules or orders. Within 10 days after completion of the hearing or such additional time as the Commission may allow, each party may file with the Commission proposed findings of fact, conclusions of law, and rule or order, together with a supporting brief expressing the reasons for such proposals. Such proposals and brief shall be served on all other parties and shall refer to all portions of the record and to all authorities relied upon in support of each proposal.
- B. Decisions of the Commission. Within a reasonable time after the time allowed for the filing of proposed findings of fact, conclusions of law, and rule or order, the Commission shall make and serve upon each party its decision, which shall become final upon the 30th day after service thereof, unless exceptions are filed thereto, as provided in rule R20-5-669. The decision of the Commission shall include:
 - 1. A statement of findings and conclusions, with reasons and basis therefor, upon each material issue of fact, law, or discretion presented on the record, and
 - 2. The appropriate rule, order, relief, or denial thereof. The decision of the hearing examiner shall be based upon a consideration of the whole record and shall state all facts officially notice and relied upon. It shall be made on the basis of a preponderance of reliable and probative evidence.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days

(Supp. 80-5). Former Section R4-13-670 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-668 effective March 2, 1981 (Supp. 81-2). R20-5-668 recodified from R4-13-668 (Supp. 95-1).

R20-5-669. Judicial Review

Any employer, employee, authorized employee representative, representative, or any person in interest is dissatisfied with an order of the Commission may appeal in accordance with A.R.S. § 23-413 of the Act.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-674 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-670 effective March 2, 1980 (Supp. 81-2). R20-5-669 recodified from R4-13-669 (Supp. 95-1).

R20-5-670. Field Sanitation

- A. This Section applies to any agricultural establishment where a crew of five or more employees are engaged on any given day in hand-labor operations in one location.
- B. As used in this Section:
 - 1. "Agricultural establishment" means a business operation that uses paid employees in the production of food, fiber or other material such as seed, seedlings, plants or parts of plants.
 - 2. "Crew of employees" means a group of persons who are employed to perform hand-labor operations as a unit at an agricultural establishment. "Crew of employees" does not include the employer and the employer's immediate family members.
 - 3. "Hand-labor operations" means agricultural activities or operations performed in the field by hand or with hand tools. Hand-labor operations include the hand-harvest of vegetables, nuts and fruits, hand-weeding of crops and hand-planting of seedlings. Hand-labor operations do not include such activities as logging operations, irrigation operations, the care or feeding of livestock or hand-labor operations in permanent structure, such as canning facilities or packing houses. Hand-labor operations do not include activities in which persons are acting as equipment operators.
 - 4. "Handwashing facility" means a facility providing either a basin, container or outlet with an adequate supply of potable water, soap and single-use towels.
 - 5. "Potable water" means water that meets the standards for drinking purposes prescribed by the state or local authority having jurisdiction or water that meets the quality standards prescribed by the United States Environmental Protection Agency's National Interim Primary Drinking Water Regulations, published in 40 CFR Part 141 (July 1983), incorporated by reference and on file in the Office of the Secretary of State.
 - 6. "Toilet facility" means a facility designed for the purpose of both defecation and urination, including biological or chemical toilets, combustion toilets or sanitary privies, which is supplied with toilet paper adequate for employee needs. Toilet facilities may be either fixed or portable.
- C. Employers shall provide the following for employees engaged in hand-labor operations at an agricultural establishment without cost to the employee:
 - 1. Potable drinking water as follows:
 - a. Potable water shall be provided and shall be placed in locations readily accessible to all employees.

- b. The water shall be suitably cool, no more than 80°F, and in sufficient amounts, a minimum of two gallons per employee, taking into account the air temperature, humidity and the nature of the work performed, to meet employees' need.
 - c. The water shall be dispensed in single-use drinking cups or by fountains. The use of common drinking cups or dippers is prohibited.
- 2. Toilet and handwashing facilities as follows:
 - a. One toilet facility and one handwashing facility shall be provided for each 40 employees or fraction thereof, except as provided in subsection (D) of this Section.
 - b. Toilet facilities shall have doors that can be closed and latched from the inside and shall be constructed to ensure privacy.
 - c. Toilet and handwashing facilities shall be accessibly located, in close proximity to each other and within 1/4 mile of each employee's place of work in the field. If it is not feasible to locate facilities accessibly and within the required distance due to the terrain, facilities shall be located at the point of closest vehicular access.
- D. Toilet and handwashing facilities are not required for employees who perform field work for a period of three hours or less (including transportation time to and from the field) during the day.
- E. Potable drinking water and toilet and handwashing facilities shall be maintained in accordance with appropriate public health sanitation practices, including all of the following:
 - 1. Drinking water containers shall be covered, cleaned and refilled daily.
 - 2. Toilet facilities shall be operational and maintained in clean and sanitary condition and shall be supplied with toilet paper adequate for employee needs.
 - 3. Handwashing facilities shall be maintained in clean and sanitary condition.
 - 4. Disposal of wastes from facilities shall not cause unsanitary conditions.
- F. Employees shall be allowed reasonable opportunities during the workday to use the facilities.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Adopted effective May 2, 1986 (Supp. 86-3). R20-5-670 recodified from R4-13-670 (Supp. 95-1).

R20-5-671. Reserved

R20-5-672. Reserved

R20-5-673. Reserved

R20-5-674. Emergency expired

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Emergency expired. R20-5-674 recodified from R4-13-674 (Supp. 95-1).

R20-5-675. Reserved

R20-5-676. Reserved

R20-5-677. Reserved

R20-5-678. Reserved

R20-5-679. Reserved

R20-5-680. Protected Activity

- A. All complaints pursuant to A.R.S. § 23-425 shall relate to conditions at the workplace. The filing of complaints need not be in writing for purposes of this subsection except that those complaints filed pursuant to R20-5-682 shall comply with R20-5-682. The term "filed any complaint" as used in A.R.S. § 23-425(A) includes:
 - 1. Employee requests for inspection pursuant to A.R.S. § 23-408(F);
 - 2. Complaints registered with other state, local or federal governmental agencies which have the authority to regulate or investigate occupational safety and health conditions;
 - 3. Complaints lodged with employers; or
 - 4. Complaints filed as specified in R20-5-682.
- B. The term "instituted or caused to be instituted any proceeding" as used in A.R.S. § 23-425(A) includes:
 - 1. Inspections of worksites under A.R.S. § 23-408(A);
 - 2. Employee contest of abatement date under A.R.S. § 23-417(D);
 - 3. Employee initiation of proceedings for promulgation of an occupational safety and health standard under A.R.S. § 23-410(A);
 - 4. Employee application for modification or revocation of a variance under A.R.S. § 23-413;
 - 5. Employee judicial challenge to a standard under A.R.S. § 23-410(E);
 - 6. Employee appeal of an Administrative Law Judge Division order under A.R.S. § 23-421(C);
 - 7. Exercise of rights by any employee pursuant to A.R.S. § 23-418.01;
 - 8. Any other employee action authorized by the Arizona Occupational Safety and Health Act of 1972; or
 - 9. Setting into motion the activities of others which result in the proceedings specified in subsections (B)(1) through (8).
- C. The term "testified or is about to testify in any such proceeding" as used in A.R.S. § 23-425(A) includes:
 - 1. Testimony in proceedings instituted or caused to be instituted by the employee; or
 - 2. Any statements given in the course of judicial, quasi-judicial or administrative proceedings. For this purpose, administrative proceedings include inspections, investigations and administrative rulemaking or adjudicative functions.
- D. The term "the exercise by such employee on behalf of himself or others of any right afforded by this Article" as used in A.R.S. § 23-425(A) includes:
 - 1. The right to participate as a party in enforcement proceedings pursuant to A.R.S. § 23-408(D);
 - 2. The right to request information from the Industrial Commission; or
 - 3. To cooperate with inspections or investigations by the Industrial Commission.
- E. If the employee, with no reasonable alternative, refuses in good faith to expose himself to a dangerous condition, the employee is engaged in protected activity. The condition causing the employee's apprehension of death or injury must be of such a nature that a reasonable person, under the circumstances then confronting the employee, would conclude there is a real danger of death or serious injury and that there is insufficient time, due to the urgency of the situation, to eliminate the dangers through resort to regular statutory enforcement channels. In addition, in such circumstances, the employee, where possible, must also have sought from his

employer and been unable to obtain a correction of the dangerous condition.

- F. Employees who refuse to comply with valid occupational safety and health standards or valid safety rules implemented by the employer are not protected by A.R.S. § 23-425.

Historical Note

Adopted effective May 3, 1989 (Supp. 89-2). R20-5-680
recodified from R4-13-680 (Supp. 95-1).

R20-5-681. Elements of a Violation of A.R.S. § 23-425

To establish a violation of A.R.S. § 23-425(A), the employee shall prove all of the following:

1. The employee was engaged in protected activities as defined in R20-5-680.
2. The employer had knowledge of the employee's protected activities prior to the adverse action which the employee claims to be a discharge or discrimination.
3. The action claimed to be discharge or discrimination was adverse to the employee.
4. The protected activity was a substantial reason for the alleged discharge or discrimination or the alleged discharge or discrimination would not have taken place but for the employee's engagement in the protected activity.

Historical Note

Adopted effective May 3, 1989 (Supp. 89-2). R20-5-681
recodified from R4-13-681 (Supp. 95-1).

R20-5-682. Procedure

- A. A complaint of A.R.S. § 23-425(A) discharge or discrimination shall be filed with the Division of Occupational Safety and Health by the employee or by a representative authorized by A.R.S. § 23-408(F) to do so on the employee's behalf. The complaint shall be written and shall be signed by the person filing the complaint.
- B. The date of filing a complaint under A.R.S. § 23-425(B) is the date of receipt of the complaint by the Division.
- C. The Division may accept or deny an employee's withdrawal of a complaint. The Industrial Commission's investigatory jurisdiction shall not be foreclosed by unilateral action of the employee.
- D. The Industrial Commission may resolve an A.R.S. § 23-425 complaint with the employer without the consent of the employee.
- E. The Industrial Commission's jurisdiction to investigate and determine A.R.S. § 23-425 complaints is independent of the jurisdiction of other agencies or bodies. The Industrial Commission may defer to the results of other such proceedings where:
1. The rights asserted in those other proceedings are substantially the same as the rights pursuant to A.R.S. § 23-425;
 2. The factual issues in such proceedings are substantially the same as the factual issues before the Industrial Commission;
 3. The proceedings were fair and regular; and
 4. The outcome of the proceedings was not inconsistent with the purposes of this Chapter and the Act.
- F. A determination pursuant to A.R.S. § 23-425(C) includes:
1. A decision to not proceed with the case;
 2. To defer the case to another forum; or
 3. To proceed to litigation in Superior Court.

Historical Note

Adopted effective May 3, 1989 (Supp. 89-2). R20-5-682
recodified from R4-13-682 (Supp. 95-1).

ARTICLE 7. SELF-INSURANCE REQUIREMENTS FOR WORKERS' COMPENSATION POOLS ORGANIZED UNDER A.R.S. § 23-961.01

R20-5-701. Definitions

In addition to the definitions provided in A.R.S. § 23-901, the following definitions apply to this Article:

"Administrator" means an individual or organization chosen by a board to manage the daily operations of a pool.

"Applicant" means a worker compensation pool organized under A.R.S. § 23-961.01 that has filed an initial application for authority to self-insure.

"Board of trustees" or "board" means a body of individuals that manage all operations of a worker compensation pool.

"Cash flow ratio" means a numerical relationship that reflects an ability to meet current financial obligations out of cash flow and is calculated by dividing funds received from operations of a business by current liabilities.

"Certificate of authority" means a document issued by the Commission granting a pool authority to be self-insured for purposes of workers' compensation.

"Claim" means a worker compensation claim.

"Code classification" means a number assigned by an approved rating organization that classifies employees.

"Current ratio" means a numerical relationship that reflects an ability to pay current obligations and is calculated by dividing current assets by current liabilities.

"Debt status ratio" means a numerical relationship that reflects the proportion of funds supplied internally relative to the funds supplied by creditors and is calculated by dividing net worth by total liabilities.

"Division" means the Administration Division of the Industrial Commission of Arizona.

"Excess insurance carrier" means an insurance carrier authorized by the Arizona Department of Insurance to issue policies of excess insurance coverage and casualty insurance coverage to a self-insured.

"Experience modification rate" means a ratio comparing actual losses to expected losses based on a formula determined by an approved rating organization and which includes three years of loss information.

"Financial rating organization" means a nationally recognized organization such as Standard & Poor's or Moody's that evaluates and rates securities.

"Fiscal year" means a 12 month cycle that begins from the effective date of authority to self-insure.

"Loss fund" means an account from which money is used to pay all workers' compensation expenses including current and contingent liabilities of a worker's compensation claim of a pool.

"Member" means an employer described in A.R.S. § 23-961.01 that has joined with other employers to form a pool.

"Pool" means a workers' compensation group organized under A.R.S. § 23-961.01.

"Profitability ratio" means a numerical relationship that represents the return on assets and the efficiency of assets and is calculated by dividing profit before taxes by total assets, multiplied by 100.

“Quick ratio” means a numerical relationship that represents the degree to which liabilities are covered by the most liquid current assets and is calculated by dividing cash and equivalents, plus trade receivables, by current liabilities.

“Rate” means an assignment of a code classification based on risk as established by a rating organization and approved by the Arizona Department of Insurance.

“Rating organization” means an entity that meets the requirements of A.R.S. § 20-363(F) and is approved by the Arizona Department of Insurance to establish rates, codes, and formulas used to calculate worker compensation premiums.

“Service company” means an entity or organization that is contracted by a pool to receive, process, and pay workers’ compensation claims for a pool.

“Trustee fund” means an account into which premiums, investment proceeds, and other revenues are deposited and are used to cover all administrative or operational expenses of a pool.

“Working capital ratio” means a numerical relationship that measures the sufficiency of working capital to support sales and is calculated by dividing working capital by sales.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

R20-5-702. Computation of Time

- A. In computing any period of time prescribed or allowed by this Article, the Commission shall not include the day of the act or event from which the period of time begins to run. The Commission shall include the last day of the period computed unless it is a Saturday, Sunday, or legal holiday in which event the period shall run until the end of the next day that is not a Saturday, Sunday, or legal holiday. When the period of time prescribed or allowed is less than 11 days, the Commission shall exclude intermediate Saturdays, Sundays, and legal holidays in the computation of time.
- B. Except as otherwise provided by law, the Commission may extend time limits prescribed by this Article for good cause.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

R20-5-703. Forms Prescribed by the Commission

The following forms are available upon request from the Commission and contain requests for the information listed in each subsection.

1. Initial Application for Authority to Self-insure:
 - a. Name of the pool;
 - b. Address and telephone number of the pool’s principal office;
 - c. Effective date of formation of the pool;
 - d. Name and address of each member of the pool;
 - e. Two digit standard industrial classification code for each member of the pool;
 - f. Name and address of the industry or trade association, or professional organization to which members of the pool belong;
 - g. Effective date of formation of the industry or trade association, or professional organization to which members of the pool belong;
 - h. Type of business in which members are engaged and length of time in business for each member;
 - i. Explanation of how businesses of members are the same or similar;
 - j. Amount of workers’ compensation insurance premiums paid by each member in the preceding year;
2. Renewal Application:
 - a. Name of the pool;
 - b. Address and telephone number of the pool’s principal office;
 - c. Name and address of each member of the pool and the effective date of membership;
 - d. Renewal date of the pool;
 - e. Effective date of initial authority to self-insure;
 - f. Total number of member employees covered by the pool;
 - g. Total payroll of the pool for the last fiscal year;
 - h. Name, address, and telephone number of the administrator;
 - i. Name, address, and telephone number of the service company, if applicable;
 - j. Name, address, and telephone number of the excess insurance carrier;
 - k. Name and address of the companies providing guaranty bond and fidelity policy;
 - l. Name and address of individuals serving on the board of trustees;
 - m. Names, titles, addresses, and telephone numbers of persons in charge of loss control and underwriting programs;
 - n. Authorized signature and title of person signing renewal application;
 - o. Statement that all information and assertions contained in the renewal application and the documents accompanying the renewal application are factually correct and true; and
 - p. Date of execution of the renewal application.
3. Self-Insurance Guaranty Bond Form:
 - a. Pool identification;
 - b. Names of fidelity and surety insurance companies;
 - c. Description of the bond, including the amount and conditions of the bond obligations and liability of surety;
 - d. Statement regarding the responsibility for fees and costs associated with the collection of the bond and the responsibility for payment of any award or judgment against the surety;
 - e. Authorized signatures and titles by pool, surety, and agent; and
 - f. Date of execution of the guaranty bond form.
4. Option Election Form:
 - a. Calculation and selection of type of guaranty bond and securities;
 - b. Description of incurred liability and anticipated future liability (compensation and medical) on all

- k. Names and addresses of the board of trustees;
- l. Name, address, and telephone number of the administrator appointed by the board of trustees;
- m. Name, address, and telephone number of the service company, if applicable;
- n. Names, titles, addresses, and telephone numbers of the persons in charge of the loss control and underwriting programs;
- o. Premium tax plan selection;
- p. Authorized signature and title of person signing initial application;
- q. Statement that all information and assertions contained in the application and the documents accompanying the application are factually correct and true; and
- r. Date of execution of the initial application.

- open cases for the preceding four years and the current year;
 - c. Authorized signature and title of person signing option election form;
 - d. Statement that all information and assertions contained in the form are factually correct and true; and
 - e. Date of execution of the option election form.
5. Self-insured Payroll Report:
- a. Description of the cumulative payroll for all members of the pool (classification codes, methods and types of pay);
 - b. Amount paid in the preceding calendar year;
 - c. Authorized signature and title of person signing self-insured payroll report;
 - d. Statement that all information and assertions contained in the report are factually correct and true; and
 - e. Date of execution of self-insured payroll report.
6. Self-insured Medical Report:
- a. Description of costs relating to industrial injuries;
 - b. Reinsurance premiums paid;
 - c. Total expenditures for workers' compensation and occupational disease claims;
 - d. Authorized signature and title of person signing self-insured medical report;
 - e. Statement that all information and assertions contained in the report are factually correct and true; and
 - f. Date of execution of the self-insured medical report.
7. Self-insured Injury Report:
- a. Description of specific information for the current year and three preceding years for each injury requiring payment in excess of \$5000 which includes accumulated amount paid and reserved for each claim in excess of \$5,000;
 - b. Description of all injuries for the current year and three preceding years if individual injury required payment of less than \$5,000;
 - c. Authorized signature, title, and telephone number of person signing self-insured injury report;
 - d. Statement that all information and assertions contained in the report are factually correct and true; and
 - e. Date of execution of the self-insured injury report.
8. Quarterly Tax Payment Form:
- a. Name and address of the pool;
 - b. Description and calculation of the quarterly tax and designation of the applicable quarter;
 - c. Amount of annual tax paid in the previous calendar year; amount of the quarterly tax paid adjusted for change in the tax rate;
 - d. Description and calculation of any penalty due;
 - e. Authorized signature, title and telephone number of person signing the quarterly tax payment form;
 - f. Statement that all information and assertions contained in the form are factually correct and true; and
 - g. Date of execution of the quarterly tax payment form.
9. Application to Add a Member to Self-insured Pool:
- a. Name of the pool and name of the member to be added to the pool, including if applicable, addresses, corporation, subsidiary, partnership, and trust information;
 - b. Nature and years in business of the member to be added;
 - c. History of business in Arizona and elsewhere for the member to be added;
 - d. Payroll data for each member to be added;
 - e. Work force data for each member to be added;
 - f. Financial data for each member to be added;
 - g. Insurance data for each member to be added;
 - h. Two digit standard industrial classification code for each member of the pool;
 - i. Workers' compensation claims, loss and performance history for the member to be added;
 - j. Authorization by board resolution approving addition of each new member;
 - k. Authorized signature and title of person signing application;
 - l. Statement that all information and assertions contained in the application are factually correct and true; and
 - m. Date of execution of the application.
10. Notice Confirming Addition of Member to Pool:
- a. Name of the pool;
 - b. Name and address of the new member;
 - c. Effective date of membership;
 - d. Rate and code classification to be applied to new member;
 - e. Standard industrial classification code for new member;
 - f. Authorized signature and title of person signing notice;
 - g. Statement that all information and assertions contained in the notice are factually correct and true; and
 - h. Date of execution of the notice.
11. Notice of Termination of Membership:
- a. Name and address of pool;
 - b. Effective date of termination;
 - c. Name and address of the member to be terminated, identified as follows:
 - i. All names and addresses of every location used by the member;
 - ii. If the member is a partnership, the names and addresses of all the partners;
 - iii. If the member is a corporation doing business under a number of divisions, the notice shall state the names of all the divisions of the corporation; and
 - iv. If a member changes names, both the new and former names.
 - d. Authorized signature, title and telephone number of person signing notice;
 - e. Statement that all information and assertions contained in the notice are factually correct and true; and
 - f. Date of execution of the notice.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

R20-5-704. Requirement for Commission Approval to Act as Self-insurer

A pool does not have authority to act as a self-insurer under A.R.S. §§ 23-961 and 23-961.01 unless the pool receives and maintains a certificate of authority from the Commission.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

R20-5-705. Duration of Certificate of Authority

Except as provided in this subsection, a certificate of authority is valid for one fiscal year. The Commission may renew the certificate on an annual basis upon application by a pool. If a pool timely files a complete renewal application under this Article, the Commission

shall consider the existing certificate of authority valid, subject to compliance with A.R.S. § 23-901 et seq. and this Article, until a new certificate of authority is issued or an order of the Commission denying a renewal application becomes final.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

R20-5-706. Time-frames for Processing Initial and Renewal Application for Authority to Self-insure

A. Administrative completeness review.

1. Initial application. The Division shall review an initial application for authority to self-insure within 20 days of receipt of the application to determine if the application contains the information required by A.R.S. § 23-961.01 and this Article. The Division shall inform an applicant by written notice whether the application is complete or is deficient within the time-frame provided in this subsection. If the application is incomplete, the Division shall include in its written notice to the applicant a complete list of the missing information. The Division shall deem the application withdrawn if an applicant fails to file a complete application within 45 days of being notified by the Division that its application is incomplete or deficient.
2. Renewal application. The Division shall review a renewal application for authority to self-insure within 20 days of receipt of the application to determine if the application contains the information required by A.R.S. § 23-961.01 and this Article. The Division shall inform a pool by written notice whether the application is complete or is deficient within the time-frame provided in this subsection. If the renewal application is incomplete, the Division shall include in its written notice to the pool a complete list of the missing information. The Division shall deem the application withdrawn if a pool fails to file a complete application within 45 days of being notified by the Division that its application is incomplete or deficient, except that failure to file the financial and actuarial reports required under R20-5-708(C) shall not cause the Division to deem the application withdrawn if a pool files the financial and actuarial reports with the Division within 120 days after the end of the pool's fiscal year.

B. Substantive review.

1. Initial application. Within 70 days after the Division deems an initial application complete, the Commission shall determine whether an initial application for authority to self-insure meets the substantive criteria of A.R.S. § 23-961.01 and this Article and shall issue an order granting or denying authority to self-insure.
2. Renewal application. Within 40 days after the Division deems a renewal application complete, the Commission shall determine whether a renewal application for authority to self-insure meets the substantive criteria of A.R.S. § 23-961.01 and this Article and shall issue an order granting or denying authority to self-insure.

C. Overall review.

1. Initial application. The overall review period shall be 90 days, unless extended under A.R.S. § 41-1072 et seq.
2. Renewal application. The overall review period shall be 60 days, unless extended under A.R.S. § 41-1072 et seq.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

R20-5-707. Filing Requirements for Initial Application for Self-Insurance License

A. Initial application for authorization to self-insure.

1. An application for authority to self-insure shall be completed on forms approved by the Commission.
 2. An application for authority to self-insure shall be filed with the Division. An application is considered filed when it is received at the office of the Division.
 3. An application shall be typewritten or written in ink in legible text.
 4. The administrator of a pool shall sign the application. The signature of the administrator shall be notarized.
 5. The administrator shall verify, in writing, that the information contained in and submitted with the application is true and correct.
- B. The Commission shall deem an initial application for authority to self-insure complete if an applicant provides the following information with the initial application:**
1. A copy of the contract required under A.R.S. § 23-961.01 establishing the pool;
 2. A copy of the articles of incorporation establishing the pool, if applicable;
 3. A copy of the trust agreement establishing the pool, if applicable;
 4. A copy of the by-laws governing the operations of the pool;
 5. An original, signed application to join the pool from every employer receiving approval from the board to join the pool;
 6. A resolution from the board approving employers for membership in the pool;
 7. A certified copy of an audited financial statement or an internally reviewed and signed financial statement for each employer applying for membership in the pool for the most current and prior two years that, considered collectively, demonstrate that the combined net worth of the employers applying for membership at the time of the initial application is not less than \$1,000,000;
 8. A copy of the following financial ratios for each employer applying for membership in the pool:
 - a. Cash flow ratio;
 - b. Current ratio;
 - c. Debt status ratio;
 - d. Profitability ratio;
 - e. Quick ratio; and
 - f. Working capital ratio.
 9. A detailed description of the loss control program required under R20-5-727, including a description of training programs and safety requirements implemented or to be implemented;
 10. A written statement from each member with an experience modification rate greater than 1.10 describing the causes of the member's experience modification rate and outlining remedial measures the member has taken and will take to lower the member's experience modification rate;
 11. An original, signed fidelity policy, or a certified copy, that meets the requirements of R20-5-712, or written confirmation from an authorized insurance company that it will provide fidelity coverage to the applicant as required under R20-5-712 which coverage is effective on the date the applicant is approved by the Industrial Commission to begin self-insurance;
 12. An original, signed guaranty bond, securities, or letter of credit that meets the requirements of R20-5-713 or any of the following:
 - a. Written confirmation from an authorized insurance company that it will provide a guaranty bond to the applicant as required under R20-5-713 which shall

- be deposited with the Industrial Commission before approval for self-insurance is effective,
 - b. Written confirmation from a financial institution that it will provide a letter of credit to the applicant as required under R20-5-713 which is effective when approval for self-insurance is effective, or
 - c. Written confirmation from a pool that it will obtain securities as required under R20-5-713 which shall be deposited with the Arizona State Treasurer before approval for self-insurance is effective.
13. A completed and signed Option Election Form and Self-Insurance Bond Form;
 14. A copy of excess insurance policies issued by an authorized carrier that meet the requirements of R20-5-715 or written confirmation from an authorized insurance company that it will provide excess insurance coverage to the applicant as required under R20-5-715. The excess coverage shall be effective on the date the applicant is approved by the Industrial Commission to begin self-insurance;
 15. A copy of the signed agreement or contract of hire between a board and the administrator of the pool;
 16. A designation of a service company and a copy of the signed agreement between the service company and pool that meet the requirements of R20-5-725 or a written statement with supporting documentation required under R20-5-726 requesting authorization to process claims in-house;
 17. A list of all rates by code classification to be used by the pool to calculate premiums;
 18. A statement showing how premiums shall be calculated for members;
 19. A detailed description of the underwriting program required under R20-5-727;
 20. A feasibility study by a member of the American Academy of Actuaries (MAAA) or a Fellow of the Casualty Actuarial Society (FCAS) that documents the rate structure needed to set premium levels to cover potential losses and expenses of the pool; and
 21. A schedule showing net workers' compensation premiums paid, total losses incurred, and experience modification rates for the three preceding years for each employer applying for membership in the pool.
3. An application shall be typewritten or written in ink in legible text;
 4. The administrator of a pool shall sign the application. The signature of the administrator shall be notarized; and
 5. The administrator shall verify, in writing, that the information contained in and submitted with the application is true and correct.
- C. A self-insured pool shall provide the following information at the time the pool files a renewal application:
 1. An updated, completed and signed Option Election Form;
 2. A continuation certificate for the guaranty bond or letter of credit signed by an authorized representative of the surety or bank in an amount equal to the amount set forth in the updated Option Election Form and that meets the requirements of R20-5-713;
 3. A confirmation of excess insurance policies issued by an authorized carrier that meet the requirements of R20-5-715;
 4. A copy of a signed service contract that meets the requirements of R20-5-725 designating an approved service company or a written statement with supporting documentation required under R20-5-726 requesting authorization to process claims in-house;
 5. A continuation certificate for the fidelity policy that meets the requirements of R20-5-712;
 6. A statement of any change made in the rates and code classifications utilized by the pool to calculate workers' compensation premiums;
 7. A statement of any change in the calculation method of a premium for each member;
 8. A statement describing the expenses paid from the trustee fund and the loss fund expressed in a dollar amount and as a percentage of the total premiums collected by the pool in the preceding fiscal year;
 9. A copy of the current contract or agreement of hire between the pool and administrator; and
 10. A copy of the current delegation agreement between the board of trustees and administrator, if applicable, under R20-5-719(C).
 - D. No later than 120 days after the end of a pool's fiscal year, the pool shall file with the Division a copy of the pool's most recent audited annual financial statements and a copy of the pool's most recent actuarial review of:
 1. Losses and reserves for all known claims, and
 2. Reserves for incurred but not reported claims.
 - E. The Commission shall deem a renewal application complete when a pool provides the information required under subsections (C) and (D).
 - F. If a pool does not file a renewal application, each member of the pool shall provide the Commission proof of compliance with A.R.S. § 23-961(A) no later than 10 days after the pool's certificate of authority expires.
 - G. If a pool's renewal application is deemed withdrawn under this Section, each member of the pool shall provide proof of compliance with A.R.S. § 23-961(A) no later than 10 days after the date the Commission deems the application withdrawn.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

R20-5-708. Filing Requirements for Renewal Application for Self-Insurance License

- A. A self-insured pool seeking renewal of an authority to self-insure for workers' compensation insurance shall file a renewal application 30 days before the existing certificate of authority expires. A pool shall maintain all bonds, policies, and contracts required under this Article while a renewal application is pending before the Commission. The Commission shall deem a renewal application withdrawn if a pool fails to maintain all bonds, policies, and contracts required under this Article.
- B. A renewal application shall meet the following requirements:
 1. An application for renewal of authority to self-insure shall be completed on a form approved by the Commission;
 2. An application for renewal of authority to self-insure shall be filed with the Division. An application is considered filed when it is received at the office of the Division;

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

R20-5-709. Combined Net Worth

A pool shall ensure that the combined net worth of its members is at least \$1 million at the time the pool files an initial application for authority to self-insure.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

R20-5-710. Similar Industry Requirement

The Commission shall consider the following in determining whether two or more employers meet the similar industry requirement of A.R.S. § 23-961.01:

1. Two digit standard industrial classification code established by the 1987 Standard Industrial Classification Manual assigned to an employer applying for membership in the pool; and
2. Other information describing or concerning the business of an employer applying for membership in the pool. The Commission may solicit additional written or oral information from a pool or others to assist the Commission in determining whether two or more employers are engaged in a similar industry.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

R20-5-711. Joint and Several Liability of Members

A. The joint and several liability provision described under A.R.S. § 23-961.01(E) shall include the following meaning:

1. Liability of members. Each member is liable for its own workers' compensation claims or losses incurred during the member's period of membership in the pool to the extent that the pool does not pay the claims or losses. A member's liability for its own claims or losses continues for the life of the claims and continues notwithstanding the pool's inability to process or pay the member's claims or losses. Failure of the pool to comply with the provisions of the Arizona Workers' Compensation Act relating to payment and processing of claims shall result in the assignment of the claims to the State Compensation Fund under A.R.S. § 23-966 and shall not relieve a member of liability for its own losses or claims. In the event that claims are assigned to the State Compensation Fund under A.R.S. § 23-966, the Industrial Commission shall have a right of reimbursement against the member for the amount paid by the State Compensation Fund for the member's own claims and losses, including costs, necessary expenses and reasonable attorney's fees, to the extent that such claims and losses are not covered by the pool's bonds or assets.
2. Liability of a pool. The pool shall pay all claims for which each member incurs liability during each member's period of membership. The pool shall defend, in the name of and on behalf of any member, any action or other proceeding which may arise or be instituted against a member as a result of injury or death covered by the Arizona Workers' Compensation Act and accompanying rules. The pool shall pay all legal costs and all expenses incurred for investigation, negotiation or defense related to such action or proceeding. The pool shall also pay all judgments or awards, and all interest due and accruing after a judgment.

- B. The joint and several liability clause required under A.R.S. § 23-961.01 to be included in each agreement or contract to establish a pool shall include the language in subsection (A)(1) and (2).
- C. The joint and several liability clause required under A.R.S. § 23-961.01(E) applies to any agreement used to form a pool on a cooperative or contract basis, through a joint formation of a nonprofit corporation, or by the execution of a trust agreement.
- D. A pool shall ensure that all members read and agree, in writing, to the joint and several clause required under A.R.S. § 23-961.01 and described in subsection (A).

- E. Failure to comply with the requirements of A.R.S. § 23-961.01(E) and this Section is cause for revocation of authority to self-insure.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

R20-5-712. Fidelity Policy

- A. A pool shall obtain and maintain during all periods of self-insurance a fidelity policy to protect the pool from unlawful actions of the following:
 1. Individuals appointed to the pool's board of trustees (individual and collective liability),
 2. Administrator of the pool, and
 3. Employees of the pool.
- B. The amount of the fidelity policy in subsection (A) shall be at least \$1 million. A pool may purchase a fidelity policy in excess of \$1 million if the pool determines that a policy in excess of \$1 million is necessary to protect members of the pool from damages resulting from misrepresentation or misuse of any monies or securities owned, controlled, or managed by the board, administrator, or employees of the pool.
- C. The pool shall provide the Commission proof of the fidelity policy as required under R20-5-707 and R20-5-708.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

R20-5-713. Guaranty Bond

- A. A pool shall obtain and maintain during all periods of self-insurance a guaranty bond equal to the greater of either:
 1. 125% of the total outstanding accrued liability as reflected in the option election form described in subsection (B); or
 2. \$200,000.
- B. A pool shall complete and sign an option election form when an initial or renewal application is filed to determine the amount of the bond or securities required to cover the pool's losses. A pool shall ensure that the information contained in the option election form is in agreement with the data provided in the actuarial report. A guaranty bond or continuation certificate for the guaranty bond shall be in the amount established in the option election form.
- C. A guaranty bond or continuation certificate for the guaranty bond filed with the Commission shall bear the effective date of the certificate of authority under which the pool is authorized to self-insure. The guaranty bond or continuation certificate shall be valid for a period of one year, subject to annual renewal in the amount established in the Option Election Form filed with a renewal application.
- D. A guaranty bond or continuation certificate for the guaranty bond shall be issued by an insurance carrier authorized by the Arizona Department of Insurance to transact fidelity and surety insurance in Arizona. The guaranty bond and continuation certificate shall be executed by an authorized agent of a surety, as evidenced by a certified power of attorney, and countersigned by a licensed resident agent.
- E. Instead of posting a guaranty bond, a pool may either deposit with the Commission for transmittal to the Arizona State Treasurer, bonds of the United States or other securities. The amount of the bond or securities shall bear a face value equal to the requirements of subsections (A) and (B).
- F. Instead of posting a guaranty bond, a pool may obtain a letter of credit. The amount of the letter of credit shall be equal to the requirements of subsections (A) and (B).
- G. The Commission shall not accept certificates of deposit instead of a guaranty bond, securities, or letter of credit.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

R20-5-714. Securities Deposited with the Arizona State Treasurer

- A. Any securities deposited with Arizona State Treasurer under R20-5-713(E) shall be registered as follows: "The Industrial Commission of Arizona, in trust for the fulfillment by (name of pool), of (name of pool's) obligations under the Arizona Workers' Compensation Act."
- B. The securities shall be held by the State Treasurer, as custodian, subject to the order of and in trust for, the Industrial Commission of Arizona.
- C. The Commission shall have the following powers with regard to securities held by the State Treasurer:
 - 1. To collect or order the collection of the securities as they become due;
 - 2. To sell or order the sale of the securities, or any part of the securities; and
 - 3. To apply or order the application of the proceeds of the sale of securities, to the payment of any award rendered against the pool in the event of a default in the payment of a pool's obligations under the Arizona Workers' Compensation Act.
- D. The Commission shall remit, upon request from a pool that has deposited securities for transmittal to the State Treasurer, interest coupons on securities as they mature.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

R20-5-715. Aggregate and Specific Excess Insurance Policies

- A. A pool shall maintain aggregate and specific excess insurance policies during all periods of self-insurance.
- B. The Commission shall not consider policies of aggregate and specific excess insurance when determining a pool's ability to fulfill its financial obligations under the Arizona Workers' Compensation Act, unless the policies are issued by a casualty insurance company authorized by the Arizona Department of Insurance to transact business in Arizona.
- C. A pool or insurance company seeking to cancel or refuse renewal of aggregate and specific excess insurance policies shall provide 90 days written notice of the proposed cancellation or non-renewal to the other party to the policies and to the Commission. The written notice shall be by registered or certified mail. Failure to provide notice as required by this Section precludes cancellation or non-renewal of the policies.
- D. Policy and Retention Amounts.
 - 1. Policy and retention amounts for specific and aggregate excess insurance for a pool shall be as follows:
 - a. Maximum retention for specific excess insurance shall not exceed \$250,000. Specific excess insurance shall be provided to the statutory limit; and
 - b. Maximum retention of aggregate excess insurance shall not exceed 110% of collected premiums. Total aggregate insurance coverage shall not be less than \$5,000,000.
 - 2. Aggregate and specific excess insurance policies shall state that payments of workers' compensation benefits on a claim made by a member employer, pool, or surety under a bond or through the use of other approved securities shall be applied toward reaching the retention level in the policy.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

R20-5-716. Rates and Code Classifications; Penalty Rate

- A. A pool shall only use rates and code classifications obtained from a rating organization licensed by the Arizona Department of Insurance.
- B. A pool may apply a penalty rate in excess of an annual premium to any member with an unfavorable loss experience, provided the pool provides written notice to the member 30 days before the effective date of the change in rate.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

R20-5-717. Gross Annual Premium of Pool; Calculation and Payment of Workers' Compensation Premiums; Discounts; Refunds

- A. The gross annual workers' compensation premium for a pool shall be sufficient to fund the administrative expenses and total incurred losses of the pool.
- B. A pool shall calculate a member's workers' compensation premium and experience modification rate using formulas described in a rating plan that meets the following:
 - 1. The rating plan is filed by an Arizona licensed rating organization, and
 - 2. The rating plan has not been disapproved by the Arizona Department of Insurance.
- C. Each member shall pay to a pool the premium due in equal monthly or quarterly payments for the premium year, except that upon admission into a pool, a new member shall pay no later than five days after the effective date of membership not less than 25% of the annual premium calculated for the new member. The remaining premium due after a new member has advanced 25% of the annual premium shall be paid in equal monthly or quarterly payments for the premium year. A pool shall permit a member to pay a premium in advance of the monthly or quarterly schedule.
- D. Deviations from rates.
 - 1. A pool shall not deviate from established workers' compensation rates unless the pool complies with the following:
 - a. The deviation is based upon the expense and loss experience of the pool,
 - b. The deviation is supported and justified by an actuary's feasibility study, and
 - c. The pool provides the information required under this subsection to the Division and receives approval from the Division.
 - 2. The Division shall approve the deviation if the deviation is based upon the expense and loss experience of a pool and is justified in an actuary's feasibility study.
- E. Refunds. A pool may declare a refund of surplus money, including excess investment income, to its members under the following conditions:
 - 1. Surplus money exists, including excess investment money, for a fiscal year in excess of the amount necessary to meet all financial obligations for the fiscal year, including financial obligations arising from incurred but not reported claims;
 - 2. Total assets of a pool are greater than total liabilities for each fiscal year;
 - 3. An actuary approves the amount of the refund;
 - 4. The amount of refund is a fixed liability of the pool at the time the refund is declared; and
 - 5. The board sets a date for the refund that shall not be less than 12 months after the end of the fiscal year in which the excess is reported.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

R20-5-718. Financial Statements

- A.** A pool shall ensure that a financial statement is prepared annually at the end of its fiscal year by a certified public accountant who has experience in auditing insurance carriers or self-insured pools. The financial statement shall be accompanied by an actuarial report regarding reserves for claims and associated expenses, and claims incurred, but not reported.
- B.** A pool shall ensure that reported reserves in a financial statement are established based on 110% of an actuary's best estimate.
- C.** A pool shall ensure that an actuarial opinion is rendered by an actuary who is a member of the Academy of Actuaries (MAAA) or a fellow of the Casualty Actuarial Society (FCAS).
- D.** A pool shall ensure that the pool's annual financial statement described in subsection (A) is audited by a certified public accountant. The audit shall include:
 - 1. An evaluation and statement from the certified public accountant whether invested surplus money was invested in compliance with R20-5-724;
 - 2. A description of how the pool operates; and
 - 3. A statement whether the pool complied with statutes and rules governing self-insured workers' compensation pools as it relates to financial matters.
- E.** Upon request by the Commission or within 120 days after a pool's fiscal year ends, a pool shall file its annual financial statement with the Commission. If a pool stops providing coverage on an ongoing basis or fails to file a renewal application for authorization to self-insure, then the pool shall provide its annual financial statement within 120 days after the pool's fiscal year ends.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

R20-5-719. Board of Trustees

- A.** A pool shall be managed by a board of trustees consisting of at least five individuals elected for a stated term of office. At least 2/3 of a board shall be from the membership of the pool.
- B.** Minimum duties and responsibilities of a board. In addition to those duties and responsibilities provided by law, the duties of a board shall include:
 - 1. Responsibility for all operations of a pool;
 - 2. Ensuring compliance with this Article and the applicable provisions of the Arizona Workers' Compensation Act;
 - 3. Hiring of an administrator to manage the daily operations of a pool;
 - 4. Reviewing and taking action on applications for membership in a pool;
 - 5. Contracting with a service company or seeking authorization from the Commission to process workers' compensation claims in-house;
 - 6. Determining the premium to be charged to a member;
 - 7. Investing surplus monies in compliance with this Article and other applicable law;
 - 8. Enacting procedures that limit disbursement of money to payment and expenses associated with claims processing and administrative expenses necessary to conduct the operations of the pool;
 - 9. Ensuring that the pool complies with statutory accounting principles (SAP) and provides accurate financial information to enable complete and accurate preparation of financial reports;
 - 10. Maintaining all records and documents relating to the formation and ongoing operations of the pool; and
 - 11. Ensuring that accounts and records of the pool are audited as required under this Article.

- C.** Delegation of board duties to administrator.
 - 1. Except as prohibited by law, a board may delegate to an administrator the duties the board determines proper.
 - 2. Delegation of duties from a board to an administrator shall be in writing. A copy of the delegation agreement shall be provided to the Commission with each renewal application.
- D.** Board prohibitions. A board or board trustee shall not commit or perform the following acts:
 - 1. Extend credit to members for payment of a premium;
 - 2. Utilize money collected as premiums for a purpose unauthorized by this Article;
 - 3. Borrow money from a pool or in the name of a pool without providing written notice to the Commission of the nature and purpose of the loan; and
 - 4. Approve admission into a pool an employer who has a negative net worth and whose admission would impair the ability of the pool to meet its financial obligations under the Arizona Workers' Compensation Act.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

R20-5-720. Administrator; Prohibitions; Disclosure of Interest

- A.** An administrator of a pool shall not be a member of a board of trustees of a workers' compensation pool.
- B.** An administrator shall not commit any of the acts described in R20-5-719(D).
- C.** An administrator shall disclose to a board any actual or perceived employment or financial interest that the administrator or administrator's family has in any potential provider of services or insurance coverage to the pool. The administrator shall disclose the interest before a contract or agreement is reached with the company or business providing the service or coverage. If a pool has an existing contract or agreement in which a prospective administrator or administrator's family has an actual or perceived employment or financial interest, the administrator shall disclose the interest before accepting a position as administrator for the pool. It is the responsibility of a board to identify for a prospective administrator current providers of services and coverage to the pool.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

R20-5-721. Admission of Employers into an Existing Workers' Compensation Pool

- A.** An employer that meets the requirements of A.R.S. § 23-961.01 and this Article that seeks to join an existing pool shall submit an application for membership to the board of trustees of the pool, or the board's designee, on a form approved by the Commission.
- B.** Consideration of application by a board.
 - 1. A board shall approve or deny admission in the pool according to the bylaws of the pool and other applicable statutes and rules.
 - 2. Upon approval of admission of an employer by a board, the board shall transmit the original application of the employer and board resolution approving membership to the Commission for consideration and approval.
- C.** Commission Approval.
 - 1. Except as provided in subsection (C)(2), within seven days after receiving an employer application described in subsection (B)(2), the Division shall advise the pool whether the employer application is complete. Within 45 days after receiving a complete employer application described in subsection (B)(2), the Commission shall

consider the application and shall approve the admission of an employer into a pool if each of the following requirements are met:

- a. The employer meets the requirements of A.R.S. § 23-961.01 and this Article;
- b. Admission of the employer into the pool does not impair the ability of the pool to meet the requirements of A.R.S. § 23-961.01 and this Article;
- c. Admission of the employer into the pool does not impair the ability of the pool to meet its financial obligations under the Arizona Workers' Compensation Act.

2. After a pool has completed one year of operation, the pool may request Commission authorization to admit new members without Commission approval. Within 30 days after receiving such a request, the Commission shall consider and approve the request to add members to a pool without Commission approval if the pool meets the following:

- a. The pool uses the similar industry requirement set forth in R20-5-710 and provides a list or description of businesses that the pool will consider as being similar; and
- b. The pool adopts as its own criteria for admission of new employers the criteria set forth in subsection (C)(1) and provides financial standards that the pool shall apply to employers seeking admission into the pool.

3. The Commission shall issue written findings and an order either approving or denying admission of an employer into a pool under subsection (C)(1) or approving or denying authorization to add members without Commission approval under subsection (C)(2). The Commission shall mail the findings and order upon the interested parties. The written findings and order is final unless a party files a request for hearing with the Administration Division within 10 days after the findings and order is issued. Hearing rights and procedure are governed by R20-5-736, R20-5-737, and R20-5-738.

D. Admission of an employer under subsection (C)(2).

1. A pool shall require an employer applying for membership in the pool to provide a financial report that is either a certified audited financial statement or an internally reviewed and signed financial statement certified by an officer or representative of the employer applying for membership.
2. If a pool approves admission of a new employer into the pool, the pool shall send written notice to the Commission, on a form approved by the Commission, within 10 days and prior to the effective date of membership, confirming that the pool has admitted a new member.
3. In addition to the notice required under subsection (D)(2), the pool shall also provide to the Commission, the board resolution approving membership and a copy of the employer's application for admission into the pool.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

R20-5-722. Termination by a Member in a Pool; Cancellation of Membership by a Pool; Final Accounting

- A.** A member of a pool may terminate its participation in the pool or submit to cancellation by a pool under the bylaws of the pool and other applicable statutes and rules.
- B.** A pool shall provide the Commission written notice of a member's intent to terminate membership or a pool's intent to cancel a member's participation in the pool at least 30 days before

the termination or cancellation is effective on a form approved by the Commission.

- C.** A pool shall provide a final accounting and settlement of the obligations of or refunds to a terminated or canceled member when all incurred claims are concluded, settled, or paid.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

R20-5-723. Trustee Fund; Loss Fund

- A.** A pool shall maintain a trustee fund and a loss fund.

B. Trustee fund.

1. All premiums and assessments charged to members of a pool shall be paid to the trustee fund which fund shall be placed in a designated federally insured depository in Arizona.
2. A pool shall create a loss fund from the trustee fund.
3. A pool shall pay administrative expenses of the pool from the trustee fund.
4. Money from the trustee fund shall be transferred to the loss fund as needed to enable a pool to pay from the loss fund cash needs related to liabilities imposed or arising under the Arizona Workers' Compensation Act.

C. Loss fund.

1. A pool shall place its loss fund in a designated federally insured depository in Arizona.
2. A pool shall pay all workers' compensation expenses from the loss fund.
3. A loss fund shall be maintained at all times by an authorized service company or administrator charged with processing and paying workers' compensation claims.
4. A pool shall ensure that its loss fund is financially able to cover current cash needs related to liabilities imposed or arising under the Arizona Workers' Compensation Act.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

R20-5-724. Investment Activity of a Pool

A pool may invest surplus money not needed for immediate cash needs under the following conditions:

1. Investments are limited to:
 - a. United States Government bonds;
 - b. United States Treasury notes;
 - c. Municipal and corporate bonds described under subsections (A)(2), (3), and (4);
 - d. Certificates of deposit;
 - e. Savings accounts in banks located in Arizona that are federally insured; and
 - f. Common or preferred stock.
2. Corporate and municipal bonds are restricted to the top three major investment grades as determined by two financial rating services;
3. Not more than 5% of a corporate municipal bond portfolio is invested in any one corporation or municipality;
4. Not more than 30% of the market value of a portfolio is in corporate and municipal bonds;
5. Not more than 20% of the market value of an investment portfolio is in common and preferred stocks; and
6. Not more than 5% of a common and preferred stock portfolio is invested in any one corporation.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

R20-5-725. Service Companies; Qualifications; Contracts; Transfer of Claims

- A.** A pool shall obtain the services of a service company to process the pool's workers' compensation claims unless the pool

obtains permission to process its own workers' compensation claims from the Commission under R20-5-726.

B. Qualifications of a service company.

1. A service company shall have facilities and equipment to manage, process, and store workers' compensation claims;
2. If required by law, a service company shall ensure that a licensed claims adjuster processes all workers' compensation claims. If a licensed claims adjuster is not required by law to process claims, then the service company shall ensure that workers' compensation claims are processed by persons with experience, training, and knowledge of the following:
 - a. Processing of Arizona workers' compensation claims; and
 - b. Arizona Worker's Compensation Act;
3. Service company personnel processing workers' compensation claims shall attend and complete training provided by the Commission Claims Division.

C. A service company shall process and pay each worker's compensation claim in compliance with the Arizona Workers' Compensation Act and the rules. A contract between a pool and service company shall include this requirement.

D. Transfer of claims from one service company to another service company.

1. The transfer of claims from one service company to another service company shall be handled in a way that does not interfere with or interrupt the processing of a worker's compensation claim.
2. A service company transferring a worker's compensation claim shall communicate to the new service company the historical claims processing activity associated with the worker's compensation claim, and shall provide an original or copy of every document required for continued processing of the worker's compensation claim.
3. A pool shall immediately provide written notice to the Industrial Commission Claims Division of any transfer of a worker's compensation claim from one service company to another.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

R20-5-726. Processing of Workers' Compensation Claims by a Pool

- A.** The Commission shall permit a pool to process its own workers' compensation claims if the pool provides information and supporting documentation establishing the following:
1. The pool has facilities and equipment to manage, process, and store its own workers' compensation claims;
 2. If required by law, a pool shall ensure that a licensed claims adjuster processes all workers' compensation claims. If a licensed claims adjuster is not required by law to process claims, then the pool shall ensure that workers' compensation claims are processed by persons with experience, training, and knowledge of the following:
 - a. Processing of Arizona workers' compensation claims; and
 - b. Arizona Workers' Compensation Act;
 3. Pool personnel processing workers' compensation claims shall attend and complete training provided by the Commission Claims Division.
- B.** A pool shall pay and process workers' compensation claims in compliance with the Arizona Workers' Compensation Act and the rules.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

R20-5-727. Loss Control and Underwriting Programs

- A.** A pool shall maintain during all periods of self-insurance a loss control program that includes, at a minimum, written safety requirements and training programs for all employees of members.
- B.** A pool shall maintain during all periods of self-insurance an underwriting program that enables the pool to calculate and determine workers' compensation premiums due and to discharge the pool's responsibilities under the Arizona Workers' Compensation Act and this Article.
- C.** A pool shall ensure those persons with education, experience, or training in loss control administer the loss control program.
- D.** A pool shall ensure those persons with education, experience, or training in underwriting administer the underwriting program.
- E.** A pool shall maintain facilities and equipment to implement the loss control and underwriting programs.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

R20-5-728. Insufficient Assets or Funds of a Pool; Plans of Abatement; Notice of Bankruptcy

- A.** A pool shall immediately provide written notice to the Commission if collected premiums and earned investment income for a fiscal year are insufficient to pay benefits under the Arizona Workers' Compensation Act for all reported workers' compensation claims and expenses for the year. When a pool provides notice to the Commission of the deficiency, the pool shall also provide a written proposal to achieve 100% funding. The proposal may include the following:
1. Use of premiums collected in other fiscal years, but not necessary for payment of claims or expenses in the year collected;
 2. Use of investment earnings associated with other fiscal years, but not necessary for payment of claims or expenses in the year in which associated; or
 3. Assessment of members.
- B.** The Commission shall review the proposal submitted under subsection (A) and approve the proposal within 10 days if the Commission determines that the proposal will abate the deficiency. A pool shall implement the plan no later than 30 days after the date the Commission approves the plan and shall achieve 100% funding within one year after the date the Commission approves the plan. Failure to implement the plan is cause for revocation of the pool's certificate of authority under R20-5-739.
- C.** If, as a result of an audit or examination by either a pool or the Commission, it appears that the assets of a pool are insufficient to enable the pool to discharge the pool's responsibilities under the Arizona Workers' Compensation Act and this Article, the Commission shall notify the administrator and the board of the deficiency and issue an order to abate the deficiency.
- D.** The Commission has authority to include in its order of abatement issued under subsection (C) a provision that a pool shall not add new members to the pool until the deficiency is abated.
- E.** Failure to comply with an order of abatement within 60 days after the order is issued constitutes cause for revocation of a pool's certificate of authority under R20-5-739.
- F.** A pool shall provide immediate written notice to the Commission of any bankruptcy filing by the pool.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

R20-5-729. Arizona Office; Recordkeeping; Records Available for Review

- A. A pool shall maintain an office in Arizona.
- B. A pool shall ensure that all financial reports and minutes are signed by an authorized representative of the pool.
- C. A pool shall make board meeting minutes, reports or other documents concerning payroll, audits, investments, experience rating, or other information concerning the pool available to the Commission upon request.
- D. A pool shall retain records relating to the formation and operation of the pool. The pool's current board shall know the current location of the records.
- E. Records of a pool are the property of the pool. If records of a pool are in the control or custody of a third party, the third party shall immediately surrender the records to a pool, upon request by the pool.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

R20-5-730. Order for Additional Financial Information; Examination of Accounts and Records by Commission

If the Commission questions a pool's financial ability to pay workers' compensation claims under the Arizona Workers' Compensation Act, the Commission may order the pool to provide additional financial information from the pool's auditor or may order an independent financial examination of the pool.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

R20-5-731. Assignment of Claims Under A.R.S. § 23-966; Obligation of Member to Reimburse the Commission

The Commission shall assign all workers' compensation claims of a pool to the State Compensation Fund under A.R.S. § 23-966 in the event that a pool files for bankruptcy or a pool is unable to process or pay benefits as required under the Arizona Workers' Compensation Act. In the event that the Commission assigns workers' compensation claims to the State Compensation Fund under A.R.S. § 23-966, the Commission shall have a right of reimbursement against any member of a pool for the amount paid by the State Compensation Fund for the member's claims and losses, including reasonable administrative costs, to the extent that such claims and losses are not covered by the pool's bonds or assets.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

R20-5-732. Calculation and Payment of Taxes under A.R.S. § 23-961 and A.R.S. § 23-1065

- A. Subject to subsection (B), the Commission shall determine the taxes to be paid under A.R.S. § 23-961(G) and A.R.S. § 23-1065(A) by calculating a pool's premiums using one of the following insurance plans selected by a pool:
 - 1. Fixed premium plan:
 - a. A plan in which neither losses nor incurred loss reserves are used to calculate a premium;
 - b. A discount is allowed for premium size; and
 - c. The taxable premium is calculated as follows: Payroll x applicable rate - premium discount.
 - 2. Guaranteed cost plan:
 - a. A plan that provides for a direct relationship, on an annual basis, of the premium for tax purposes and the experience modification rate developed to reflect the loss payments and incurred loss experience of an insured;
 - b. The taxable premium is calculated as follows: (Payroll x applicable rate x experience modification rate) - premium discount.

- 3. Retrospective plan:
 - a. A plan that provides for a relationship between the premium for tax purposes, the experience modification rate developed to reflect the loss payment and incurred loss experience of an insured, and the actual incurred losses for the tax year;
 - b. Plan is calculated annually and premium is not subject to further adjustment during the tax year;
 - c. The net taxable premium is calculated as follows: (payroll x applicable rate x experience modification rate x basic premium factor) + (losses for current year + adjusted losses for premium year x conversion factor) x tax multiplier; and
 - d. The net taxable premium is subject to a maximum and minimum premium level depending on which one of the four rating insurance option plans specified in the rating system filed by the rating organization is used by the State Compensation Fund under A.R.S. Title 20, Chapter 2, Article 4;
- B. A pool shall not select a retrospective plan unless the pool meets the following criteria:
 - 1. The pool has an annual net taxable premium exceeding \$100,000; and
 - 2. The pool submits and calculates four years of data concerning paid loss determinations and incurred loss reserved for each workers' compensation claim which information shall be used to calculate an experience modification factor for the pool. The oldest three years of data is used to calculate the rate and the current year data is used to calculate the tax.
- C. A pool shall submit to the Commission information required on the following forms no later than February 15 of each year:
 - 1. Self-insured Payroll Report, and
 - 2. Self-insured Injury Report.
- D. Payment of quarterly tax.
 - 1. The Commission shall calculate quarterly taxes owed under A.R.S. § 23-961(H) or A.R.S. § 23-1065(A) in one of the following ways:
 - a. 25% of the tax calculated for the previous year and adjusted for changes in the tax rate; or
 - b. Calculation based on actual payroll and premiums collected for each quarter.
 - 2. A pool shall file a completed and signed Self-insurers' Quarterly Tax Payment Form with each quarterly tax payment.
 - 3. Quarterly payments are due April 30, July 31, October 31, and January 31, for the periods ending March 31, June 31, September 30, and December 31, respectively.
 - 4. Quarterly tax payments may be adjusted because of changes in the annual tax rate.
- E. After receipt of the information required under A.R.S. § 23-961 and this Article, the Commission shall determine the annual taxes owed by a pool. The Commission shall also determine whether the pool has underpaid or overpaid the annual taxes required to be paid by the pool. If the quarterly tax payments paid by a pool are less than the actual tax calculated for the year, then the pool shall pay the difference on or before March 31 of the calendar year in which the taxes are due. If a pool has overpaid its annual taxes, then the Commission shall refund the amount as described in A.R.S. § 23-961(I). A pool shall pay to the Industrial Commission the pool's annual tax on or before March 31 based on premiums calculated for the preceding calendar year and adjusted for quarterly taxes previously paid.

- F. In addition to the penalty described under A.R.S. § 23-961(J), failure to pay annual or quarterly taxes as required is cause for revocation of a pool's certificate of authority.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

R20-5-733. Review of Initial and Renewal Applications for Authority to Self-insure by the Division

- A. Upon the filing of a completed initial or renewal application for authority to self-insure, the Division shall review the initial or renewal application to determine and verify whether the information contained in and submitted with the initial or renewal application for authorization to self-insure is complete and accurate. The Division shall also review the information provided to determine the following:
1. Whether the pool has met the requirements of A.R.S. § 23-961.01;
 2. Whether the pool has met the requirements of this Article; and
 3. Whether the pool has the ability to process and pay benefits required under the Arizona Workers' Compensation Act. A determination of a pool's financial ability to pay shall include a review of the ratios provided by each member at the time of an initial application and review of the following ratios for a pool at the time of renewal:
 - a. Total cash, receivables, and investments to total assets; and
 - b. Total revenue to total expenditures for loss fund and trustee fund.
- B. The Division shall present the findings of its review described in subsection (A) to the Commission. The Division shall also present its recommendations to the Commission regarding an initial or renewal application.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

R20-5-734. Decision by the Commission on Initial or Renewal Applications for Authority to Self-insure

- A. The Commission shall consider the following before granting or denying an initial or renewal application to self-insure:
1. The information submitted by an applicant or pool,
 2. The information and recommendations of the Division, and
 3. The requirements of A.R.S. § 23-961.01 and this Article.
- B. The Commission shall deny an application for authority to self-insure if the Commission finds one or more of the following conditions:
1. An applicant or pool does not meet the requirements of A.R.S. § 23-961.01,
 2. An applicant or pool does not meet the requirements of this Article, or
 3. An applicant or pool is unable to process and pay benefits required under the Arizona Workers' Compensation Act.
- C. A decision of the Commission shall be made by a majority vote of the quorum of Commission members present when the decision is rendered at a public meeting. The Commission shall issue written findings and an order granting or denying authorization to self-insure.
- D. The Division shall mail a copy of the Commission's written findings and order upon the applicant or pool within 10 days of the date the Commission issues its findings and order.
- E. In the case of an initial application, an applicant shall substitute written confirmation from an authorized insurance carrier to provide fidelity coverage with evidence of fidelity insurance coverage as required under R20-5-712 no later than 10 days after the Commission grants authority to self-insure under this

Section. The grant of authority to self-insure under this Section shall not become effective until the applicant provides evidence of actual fidelity coverage. The Commission shall deem an initial application withdrawn and the grant of authority to self-insure rescinded if an applicant fails to substitute written confirmation of fidelity coverage with evidence of fidelity coverage as required under this subsection.

- F. In the case of an initial application, an applicant shall substitute written confirmation from an authorized insurance carrier to provide excess insurance coverage with evidence of excess insurance coverage as required under R20-5-715 no later than 10 days after the Commission grants authority to self-insure under this Section. The grant of authority to self-insure under this Section shall not become effective until the applicant provides evidence of actual excess insurance coverage. The Commission shall deem an initial application withdrawn and the grant of authority to self-insure rescinded if an applicant fails to substitute written confirmation of excess insurance coverage with evidence of excess insurance coverage as required under this subsection.
- G. In the case of an initial application, an applicant shall deposit the guaranty bond, letter of credit, or other securities as required under R20-5-713 no later than 10 days after the Commission grants authority to self-insure under this Section. The grant of authority to self-insure under this Section shall not become effective until the applicant deposits the guaranty bond, letter of credit, or other security. The Commission shall deem an initial application withdrawn and the grant of authority to self-insure rescinded if an applicant fails to deposit the guaranty bond, letter of credit, or other securities as required under this subsection.
- H. Subject to subsections (E), (F), and (G), no later than 10 days after the Commission grants authorization to self-insure, the Division shall prepare a certificate of authority to self-insure and shall mail the certificate to the self-insured at the business address of the pool listed on the initial or renewal application.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

R20-5-735. Right to Request a Hearing

- A. An applicant or pool shall have 10 days from the date the Commission mails the findings and order under R20-5-734 to request a hearing.
- B. A request for hearing shall comply with A.R.S. § 23-945 and be signed by an authorized representative of the applicant or pool or the applicant's or pool's legal representative. The applicant or pool shall file the request for hearing with the Division.
- C. The Commission shall deem its findings and order final if a request for hearing is not received by the Division within the time specified in subsection (A).

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

R20-5-736. Hearing Rights and Procedures

- A. Burden of proof.
1. Except as provided in subsection (A)(2), in all proceedings arising out of this Article, the applicant or pool shall have the burden of proof to establish that it has met the requirements of A.R.S. § 23-901 et seq. and this Article.
 2. In a revocation hearing, the Commission shall have the burden of proof to establish that the self-insured has committed the acts described in R20-5-739.
- B. Roles of Chair and Chief Counsel.
1. The Chair of the Commission or designee shall preside over hearings held under this Article. Except as otherwise

provided in this Section, the Chair shall apply the provisions of A.R.S. § 41-1062 to hearings held under this Article and shall have the authority and power of a presiding officer as described in A.R.S. § 41-1062.

2. The Chief Counsel of the Commission shall represent the Commission in hearings held before the Commission and upon direction of the Chair of the Commission shall issue on behalf of the Commission all notices and subpoenas required under this Section. In the discretion of the Chief Counsel, the Chief Counsel may assign an attorney from the Legal Division of the Commission to represent the Division.

C. Appearance by a party.

1. Except as otherwise provided by law, the parties may appear on their own behalf or through counsel.
2. When an attorney appears or intends to appear before the Commission, the attorney shall notify the Commission, in writing, of the attorney's name, address, and telephone number and the name and address of the person on whose behalf the attorney appears.

D. Filing and service.

1. For purposes of this Section, a document is considered filed when the Commission receives the document. All documents required to be filed in this Section with the Commission shall be served upon the Chief Counsel of the Industrial Commission and upon all parties to the proceeding.
2. Except as otherwise provided in A.R.S. § 23-901, et seq. and this Article, service of all documents upon the Commission, applicant or pool shall be by personal service or by mail. Personal service includes delivery upon the Commission or party. Service by mail includes every type of service except personal service and is complete on mailing.

E. Notice of hearing.

1. The Commission shall give the parties at least 20 days notice of hearing.
2. A notice of hearing shall be in writing and mailed to the last known address of the applicant or pool as shown on the record of the Commission or upon the applicant's or pool's representative if a notice of appearance has been filed by a representative.
3. A notice of hearing shall comply with the requirements in A.R.S. § 41-1061(B).

F. Evidence.

1. The civil rules of evidence do not apply to hearings held under this Section.
2. A party may make an opening and closing statement with the permission of the Chair if the Chair determines that the statement will be helpful to a determination of the issues.
3. All witnesses at a hearing shall testify under oath or affirmation.
4. A party may present evidence and conduct cross-examination of witnesses.
5. Documentary evidence may be received into evidence and shall be filed no later than 15 days before the date of the hearing. Upon request or upon direction from the chair of the Commission, the Commission may issue a subpoena to the author of any document submitted into evidence to appear and testify at the hearing.
6. Upon written request by a party or upon direction from the Chair of the Commission, the Commission may issue a subpoena requiring the attendance and testimony of a witness whose testimony is material. A subpoena shall be

requested no later than 10 days before the date of the hearing.

7. Upon written request by a party or upon direction from the Chair of the Commission, the Commission may issue a subpoena duces tecum requiring the production of documents or other tangible evidence. The written request by a party shall contain a statement explaining the general relevance, materiality, and reasonable particularity of the documentary or other tangible evidence and the facts to be proven by them.

- G. Transcript of Proceedings.** Hearings before the Commission shall be stenographically reported or mechanically recorded. Any party desiring a copy of the transcript shall obtain a copy from the court reporter.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

R20-5-737. Decision Upon Hearing by Commission

- A.** A decision of the Commission to deny an initial or renewal application shall be based upon the grounds in R20-5-734(B) and shall be made by a majority vote of the quorum of Commission members present when the decision is rendered at a public meeting.
- B.** A decision of the Commission to revoke authority to self-insure shall be based upon the grounds in R20-5-739 and shall be made by a majority vote of the quorum of Commission members present when the decision is rendered at a public meeting.
- C.** A decision of the Commission to deny admission of an employer into a pool or deny authorization to add members without Commission approval shall be based upon the grounds in R20-5-721 and shall be made by a majority vote of the quorum of Commission members present when the decision is rendered at a public meeting.
- D.** After a decision is rendered at a public meeting, the Commission shall issue a written decision upon hearing which shall include findings of fact and conclusions of law, separately stated.
- E.** A Commission decision is final unless an applicant or pool requests review under R20-5-738 no later than 15 days after the written decision is mailed to the parties.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

R20-5-738. Request for Review

- A.** A party may request review of a Commission decision issued under R20-5-737 by filing with the Commission a written request for review no later than 15 days after the written decision is mailed to the parties.
- B.** A request for review shall be based upon one or more of the following grounds which have materially affected the rights of a party:
 1. Irregularities in the hearing proceedings or any order or abuse of discretion that deprives a party seeking review of a fair hearing;
 2. Accident or surprise which could not have been prevented by ordinary prudence;
 3. Newly discovered material evidence that could not have been discovered with reasonable diligence and produced at the hearing;
 4. Error in the admission or rejection of evidence, or errors of law occurring at, or during the course of, the hearing;
 5. Bias or prejudice of the Division or Commission; and
 6. The order, decision, or findings of fact are not justified by the evidence or are contrary to law.

- C. A request for review shall state the specific facts and law in support of the request and shall specify the relief sought by the request.
- D. The Commission shall issue a decision upon review no later than 30 days after receiving a request for review.
- E. The Commission's decision upon review is final unless an applicant or pool seeks judicial review as provided in A.R.S. § 23-946.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

R20-5-739. Revocation of Authority to Self-insure

- A. In addition to those specific grounds set forth in this Article, the following constitute grounds for revocation of authority to self-insure for workers' compensation:
 - 1. Failure to comply with requirements of this Article or applicable requirements of 20 A.A.C. 5, Article 1;
 - 2. Failure to comply with applicable requirements of A.R.S. § 23-901 et seq.;
 - 3. Unless otherwise provided, failure to comply with an order or award of the Commission within 30 days after the order or award becomes final;
 - 4. An inability to process and pay claims under the Arizona Workers' Compensation Act;
 - 5. The failure of a pool to provide the Commission the reports and taxes required under this Article; and
 - 6. The willful misstatement of any material fact in an application, report, or statement made to the Commission.
- B. Upon receipt of information demonstrating that a pool has committed an act described in subsection (A), the Division shall conduct an investigation of the facts of the alleged misconduct. If, upon completion of the investigation, the Division determines that sufficient evidence exists to warrant revocation of a pool's authority to self-insure, then the Division shall present its findings to the Commission.
- C. The Commission shall consider the findings and recommendation of the Division before revoking a pool's authority to self-insure.
- D. The Commission shall revoke a pool's authority to self-insure if the Commission finds one or more of the grounds set forth in subsection (A). The Commission shall issue written findings and an order revoking the authority to self-insure and shall serve a copy of the findings and order upon the pool.
- E. A pool shall have 10 days from the date the Commission serves the findings and order described in subsection (D) to request a hearing. The request for hearing shall comply with the requirements of A.R.S. § 23-945.
- F. R20-5-736, R20-5-737, and R20-5-738 govern hearing rights and procedures for revocation hearings.
- G. A pool shall immediately inform each of its members, in writing, of the Commission's order of revocation.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

**ARTICLE 8. OCCUPATIONAL SAFETY AND HEALTH
RULES OF PROCEDURE BEFORE THE INDUSTRIAL
COMMISSION OF ARIZONA**

R20-5-801. Notice of Rules

Sections R20-5-801 et seq. apply to all actions and proceedings of or before the Commission and Review Board pertaining to those issues arising out of Title 23, Chapter 2, Article 10.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-801 recodified from R4-13-801 (Supp. 95-1).

R20-5-802. Location of Office and Office Hours

The main office of the Industrial Commission of Arizona is located in Phoenix, Arizona. An office is also located in Tucson, Arizona. The offices are open for the transaction of business from 8:00 a.m. until 5:00 p.m. every day except Saturdays, Sundays and legal holidays.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-802 recodified from R4-13-802 (Supp. 95-1).

R20-5-803. Definitions

In these Rules of Procedures, unless the context otherwise requires, the following words and terms shall have the following meanings:

1. "Commission" means the Industrial Commission of Arizona.
2. "Affected employee" means an employee of a cited employer who is exposed to the alleged hazard described in the citation, as a result of his assigned duties.
3. "Authorized employee representative" means a labor organization which has a collective bargaining relationship with the cited employer and which represents affected employees.
4. "Representative" means any person, including an authorized employee representative, authorized by a party to represent him in a proceeding.
5. "Citation" means a written communication issued by the Division of Occupational Safety and Health of the Industrial Commission of Arizona pursuant to A.R.S. § 23-415.
6. "Notification of proposed penalty" means a written communication issued by the Industrial Commission of Arizona pursuant to A.R.S. § 23-418.
7. "Party" means the Occupational Safety and Health Division of the Commission, the affected employer and affected employees.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-803 recodified from R4-13-803 (Supp. 95-1).

R20-5-804. Computation of Time

In computing any period of time prescribed or allowed in these rules, the day from which the designated period begins to run shall not be included. The last day of the period so computed shall be included unless it is a Saturday, Sunday, or legal holiday. When the period of time prescribed or allowed is less than seven days, intermediate Saturdays, Sundays, and legal holidays shall be excluded in the computation.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-804 recodified from R4-13-804 (Supp. 95-1).

R20-5-805. Record Address

The initial pleading filed by any person shall contain his name, address and telephone number. Any change in such information must be communicated promptly in writing to the Commission and to all other parties. A party who fails to furnish such correct and current information shall be deemed to have waived his right to object to the validity of any notice and/or service which has been made to the last known address of the party as shown by the records of the Commission.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-805 recodified from R4-13-805 (Supp. 95-1).

R20-5-806. Service and Notice

- A. At the time of filing pleadings or other documents a copy thereof shall be served by the filing party on every other party.

- B. Service upon a party who has appeared through a representative shall be made only upon such representative.
- C. Unless otherwise herein indicated, service may be accomplished by postage prepaid first class mail or by personal delivery. Service is deemed effected at the time of mailing (if by mail) or at the time of personal delivery (if by personal delivery).
- D. Proof of service shall be accomplished by a written statement of the same which sets forth the date and manner of service. Such statement shall be filed with the pleading or document.
- E. Service and notice to employees represented by an authorized employee representative shall be deemed accomplished by serving the representative in the manner prescribed in subsection (C).
- F. In the event that there are any affected employees who are not represented by an authorized employee representative, the employer shall, immediately upon receipt of Notice of the Date of Hearing, post, where the citation is required to be posted, a copy of the Notice of Date of Hearing and a notice informing such affected employees of their right to appear at the hearing and state their position and of the availability of all pleadings for inspection and copying at reasonable times. A notice in the following form shall be deemed to comply with this subsection:

(Name of employer)

Your employer has been cited by the Industrial Commission of Arizona for violation of the Arizona Occupational Safety and Health Act of 1972. The citation has been contested and will be the subject of a hearing before the Industrial Commission. Affected employees are entitled to appear in this hearing under the terms and conditions established by the Industrial Commission in its Rules of Procedure. Notice of Intent to Participate should be sent to:

THE INDUSTRIAL COMMISSION
OF ARIZONA
1601 West Jefferson Street,
Phoenix, Arizona 85007.

All papers relevant to this matter may be inspected at:
(Place reasonably convenient to employees, preferably at or near workplace.)

Where appropriate, the second sentence of the above Notice will be deleted and the following sentence will be substituted:

The reasonableness of the period prescribed by the Industrial Commission for abatement of the violation has been contested and will be the subject of a hearing before the Industrial Commission.

- G. Where service is accomplished by posting, proof of such posting shall be filed not later than the first working day following the posting.
- H. The authorized employee representative, if any, shall be served with the notice set forth in subsection (G) and with a copy of the Notice of the Date of Hearing.
- I. A copy of the Notice of the Date of Hearing shall be served by the employer on affected employees who are not represented by an authorized employee representative by posting a copy of the Notice of such hearing at or near the place where the citation is required to be posted.
- J. A copy of the Notice of the Date of Hearing shall be served by the employer on the authorized employee representative of affected employees in the manner prescribed in subsection (C) of this Section, if the employer has not been informed that the

authorized employee representative has entered an appearance as of the date such Notice is received by the employer.

- K. Where a petition for hearing is filed by an affected employee who is not represented by an authorized employee representative and there are other affected employees who are represented by an authorized employee representative, the unrepresented employee shall, upon receipt of the Notice of the Date of Hearing, serve a copy thereof on such authorized employee representative in the manner prescribed in subsection (C) of this Section and shall file proof of such service.
- L. Where a Petition for Hearing is filed by an affected employee or an authorized employee representative, a copy of the Petition for Hearing shall be provided to the employer for posting by the employer at the place the citation is required to be posted.
- M. An authorized employee representative who files a Notice of Contest shall be responsible for serving any other authorized employee representative whose members are affected employees.
- N. Where posting is required by this Section, such posting shall be maintained until the commencement of the hearing or until earlier disposition.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-806 recodified from R4-13-806 (Supp. 95-1).

R20-5-807. Consolidation

Cases may be consolidated on the motion of any party, or on the hearing officer's own motion, where there exist common parties, common questions of law or fact, or both, or in such other circumstances as justice and the administration of the Act require.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-807 recodified from R4-13-807 (Supp. 95-1).

R20-5-808. Severance

Upon its own motion, or upon motion of any party, the hearing officer may, for good cause, order any proceeding severed with respect to some or all issues or parties.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-808 recodified from R4-13-808 (Supp. 95-1).

R20-5-809. Election to Appear

- A. Affected employees may elect to appear at a hearing for the purpose of testifying or stating their position concerning the subject matter of the hearing.
- B. If affected employees desire to appear at the hearing they must so notify in writing the Commission or the hearing officer, if the case has been assigned.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-809 recodified from R4-13-809 (Supp. 95-1).

R20-5-810. Employee Representatives

- A. Employees may appear in person or through a representative.
- B. An authorized employee representative shall be deemed to control all matters respecting the interest of such employees in the proceeding.
- C. Affected employees who are represented by an authorized employee representative may appear only through such authorized employee representative.
- D. Withdrawal of appearance of any representative may be effected by filing a written Notice of Withdrawal and by serving a copy thereof on all parties.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-810 recodified from R4-13-810 (Supp. 95-1).

R20-5-811. Form of Pleadings

- A. Except as provided herein, there are no specific requirements as to the form of any pleading. A pleading is simply required to contain a caption sufficient to identify the parties in accordance with R20-5-812, which shall include the Commission's citation number, and a clear and plain statement of the relief that is sought, together with the grounds therefor.
- B. Pleadings and other documents (other than exhibits and petitions for hearing) shall be typewritten and double spaced, on letter size opaque paper (approximately 8 1/2 inches by 11 inches). The left margin shall be 1 1/2 inches and the right margin 1 inch. Pleadings and other documents shall be fastened at the upper left corner.
- C. Pleadings shall be signed by the party filing or by his representative. Such signing constitutes a representation by the signer that he has read the document or pleading, that to the best of his knowledge, information and belief the statements made therein are true, and that it is not interposed for delay.
- D. The Commission may refuse for filing any pleading or document which does not comply with the requirements of subsections (A), (B), and (C) of this Section.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-811 recodified from R4-13-811 (Supp. 95-1).

R20-5-812. Caption; Titles of Cases

- A. Cases initiated by the cited employer filing a Petition for Hearing contesting the violations cited shall be titled:
Division of Occupational Safety and Health of the Industrial Commission of Arizona, Complainant, vs. (name of employer), Respondent.
- B. Cases initiated by the cited employer filing a Petition for Hearing for modification of the abatement period shall be titled:
(name of employer), Petitioner vs. Division of Occupational Safety and Health of the Industrial Commission of Arizona, Respondent.
- C. Cases initiated by an affected employee filing a Petition for Hearing for modification of the abatement period shall be titled:
(name of affected employee or authorized employee representative), Petition vs. Division of Occupational Safety and Health of the Industrial Commission of Arizona, Respondent, and (employer), Respondent.
- D. The Titles listed in subsections (A) and (B) of this Section shall appear at the left upper portion of the initial page of any pleading or document (other than exhibits and Petitions for Hearing filed).
- E. The initial page of any pleading or document (other than exhibits and requests for hearing) shall show the citation number at the upper right of the page, opposite the title.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-812 recodified from R4-13-811 (Supp. 95-1).

R20-5-813. Requests for Hearing

- A. Requests for hearing shall be filed with the Commission.
- B. Requests for hearing shall be in writing and contain a clear and plain statement of the relief that is sought, together with the grounds thereof.
- C. The Commission shall, after receipt of a request for hearing, refer the file to the Hearing Officer Division for determination.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-813 recodified from R4-13-813 (Supp. 95-1).

R20-5-814. Pre-hearing Conference

- A. At any time before a hearing, the hearing officer, on his own motion or on motion of a party, may direct the parties, or their representatives, to exchange information or to participate in a pre-hearing conference for the purpose of considering matters which will tend to simplify the issues or expedite the proceedings.
- B. The hearing officer may issue a pre-hearing order which includes the agreements reached by the parties. Such order shall be served on all parties and shall be part of the record.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-814 recodified from R4-13-814 (Supp. 95-1).

R20-5-815. Payment of Witness Fees and Mileage

Witnesses summoned before the hearing officer shall be paid the same fees and mileage that are paid witnesses in the courts of Arizona. Witness fees and mileage shall be paid by the party at whose instance the witness appears.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-815 recodified from R4-13-815 (Supp. 95-1).

R20-5-816. Notice of Hearing

Notice of the time, place and nature of a hearing shall be given to the parties at least five days in advance of such hearing.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-816 recodified from R4-13-816 (Supp. 95-1).

R20-5-817. Failure to Appear -- Withdrawal of Request for Hearing

- A. The failure of a party who has requested a hearing to appear at such scheduled hearing shall be deemed to be an admission of the validity of any citation, abatement period, or penalty issued or proposed, and additionally a waiver of all rights except the right to be served with a copy of the decision of the hearing officer and to request review.
- B. Withdrawal of request for hearing shall be construed as an admission of the validity of any citation, abatement period or penalty issued or proposed. No decision need be issued in this case as the subject instrument is deemed to be admitted.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-817 recodified from R4-13-817 (Supp. 95-1).

R20-5-818. Duties and Powers of Hearing Officers

It shall be the duty of the hearing officer to conduct a fair and impartial hearing, to assure that the facts are fully elicited, to adjudicate all issues and avoid delay. The hearing officer shall have authority with respect to cases assigned to him, between the time he is designated and the time he issued his decision, subject to the rules and regulations of the Commission, to:

1. Administer oaths and affirmations;
2. Rule upon admissibility of exhibits;
3. Rule upon applications for depositions;
4. Regulate the course of the hearing and, if appropriate or necessary, exclude persons or counsel from the hearing for contemptuous conduct and strike all related testimony of witnesses refusing to answer any proper questions;
5. Call and examine witnesses;

6. Request the parties at any time during the hearing to state their respective positions concerning any issue in the case or theory in support thereof;
7. Adjourn the hearing as the needs of justice and good administration require;
8. Issue appropriate orders for protection of trade secrets;
9. Take any other action necessary under the foregoing and authorized by the rules and regulations of the Commission.

Historical Note

Adopted effective August 27, 1975 (Supp. 75-1). R20-5-818 recodified from R4-13-818 (Supp. 95-1).

R20-5-819. Witnesses' Oral Deposition; In State

- A. After a request for hearing has been filed with the Commission, any party desiring to take the oral deposition of any other party or witness residing within the state of Arizona shall file with the hearing officer, in duplicate, notice of taking deposition by oral examination. Copies of such Notice shall be served at least five days prior to the date of the deposition upon the deponent and upon every party by the party desiring to take the oral deposition.
- B. If any party or the deponent has any objection to the taking of the oral deposition of the party or witness, he shall file with the presiding hearing officer and serve on all parties written objections thereto setting forth the basis of the opposition to the deposition. Such objection shall be filed with the hearing officer within two days after the notice of taking deposition by oral examination is served.
- C. If objections to the taking of the oral deposition are filed with the hearing officer as provided in subsection (B) hereof, the hearing officer shall rule on the objections within five days after the filing of the objections. The taking of the oral deposition shall be held in abeyance pending the ruling of the hearing officer. The hearing officer shall either order the deposition to proceed, order that the deposition not be taken, or enter such other protective order as may be appropriate.
- D. The party taking the deposition shall comply with the Arizona Rules of Civil Procedure governing the taking of depositions.
- E. The expense of any deposition shall be borne by the party taking the deposition but shall not include the expense of any other party.
- F. No scheduled hearing shall be cancelled or continued for failure to take or complete a deposition taken pursuant to the provisions of this rule.
- G. Depositions taken pursuant to the provisions of this rule shall only be used at the time of a hearing for impeachment of a witness, unless the deponent is deceased at the time of the scheduled hearing, in which event it may be admitted into evidence.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-819 recodified from R4-13-819 (Supp. 95-1).

R20-5-820. Witnesses' Oral Deposition; Out-of-State

- A. After a request for hearing is filed with the Commission, any party desiring to take the oral deposition of any other party or witness residing without the state of Arizona shall file with the hearing officer, in duplicate, a request for permission to take the deposition of such witness or witnesses. Such request shall show the name and address of such witness or witnesses and set forth the reason why said witness or witnesses' testimony is necessary for an adjudication of the issue. Copies of such request shall be served upon each party by the party requesting permission to take the deposition. If no objection to the request for permission to take the deposition is filed as provided in subsection (B) hereof, the hearing officer may, within 10 days,

in his discretion, grant or deny the permission to take the deposition. If the hearing officer permits the taking of the deposition, the party may proceed in the manner provided by and subject to the limitations of subsections (A), (D), (E), and (F).

- B. If any party has any objections to the taking of the oral deposition of the party or witness, he shall file with the hearing officer and serve on all other parties written objections thereto setting forth the basis for the opposition to the deposition. Such objection shall be filed with the hearing officer within five days after the request to take the deposition is served.
- C. If objections to the taking of the oral deposition are filed with the hearing officer as provided in subsection (B) hereof, the hearing officer shall rule on the objections within five days after the filing of the objections. The taking of the oral deposition shall be held in abeyance pending the ruling of the hearing officer. The hearing officer shall either order the deposition to proceed, order that the deposition not be taken, or enter such other protective order as may be appropriate. If the hearing officer orders that the deposition proceed, the party may proceed to take the deposition in the manner provided by and subject to the limitation of R20-5-819, subsections (A), (D), (E), and (F).
- D. Any deposition taken pursuant to the provisions of this rule shall be filed with the Commission at least five days prior to the hearing date or any scheduled hearing and may be admitted into evidence. If the deposition is not filed within the time prescribed herein, it shall not be considered for any purpose except by stipulation of all interested parties, and then only with the concurrence of the hearing officer.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-820 recodified from R4-13-820 (Supp. 95-1).

R20-5-821. Parties' Disposition upon Written Interrogatories

- A. After a request for hearing is filed with the Commission, any party desiring to take the deposition of another party upon written interrogatories shall file with the hearing officer, in duplicate, copies of the interrogatories sought to be submitted to the party. The written interrogatories submitted pursuant to this rule shall be limited to 25 in number with no subsections. Copies of such interrogatories shall be filed at least five days prior to any scheduled hearing.
- B. Answers to the interrogatories shall be served on all parties by the party answering the interrogatories within 10 days after service of the interrogatories, or within 10 days after a ruling by the hearing officer that the interrogatories be answered.
- C. No scheduled hearing shall be cancelled or continued for failure to take or complete the taking of a deposition taken pursuant to the provisions of this rule.
- D. Depositions taken pursuant to the provisions of this rule shall only be used at the time of hearing for impeachment of a witness unless the deponent is deceased at the time of the scheduled hearing in which event they may be admitted into evidence.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-821 recodified from R4-13-821 (Supp. 95-1).

R20-5-822. Refusal to Answer; Refusal to Attend

- A. If a party or other deponent refuses to answer any question propounded upon oral examination pursuant to R20-5-819 and R20-5-820, the examination shall be completed in other matters or adjourned, as the proponent of the question may prefer. Thereafter on reasonable notice to all persons affected thereby the proponent of the question may apply to the hearing officer for an order compelling an answer. Upon the refusal of a depo-

nent to answer any interrogatory submitted under R20-5-821, the proponent of the question may on like notice make like application for such an order. If the motion is granted and if the hearing officer finds that the refusal was without substantial justification, the hearing officer shall require the refusing party, or deponent and the party, or representative advising the refusal or either of them to pay to the examining party the amount of the reasonable attorney's fees incurred in obtaining the order and the reasonable expenses which will be incurred to obtain the requested answers. If the motion is denied and if the hearing officer finds that the motion was made without substantial justification, the hearing officer shall require the examining party or the representative advising the motion, or both of them, to pay to the refusing party or witness the amount of the reasonable attorney's fees incurred in opposing the motion.

- B.** If a party or an officer or managing agent of a party wilfully fails to appear before an officer who is to take his deposition after being served with the proper notice, or fails to serve answers to interrogatories after proper service of such interrogatories, the hearing officer, on motion and notice, may strike out all or any part of any pleading of that party, dismiss the action or proceeding or any part thereof, or preclude the introduction of evidence.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-822 recodified from R4-13-822 (Supp. 95-1).

R20-5-823. Burden of Proof

- A.** In all proceedings other than those stated in subsection (B) commenced by the filing of a request for hearing, the burden of proof shall rest with the Commission.
- B.** In proceedings commenced by a request for hearing requesting modification of the abatement period, the burden of establishing the necessity for such modification shall rest with the petitioner.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-823 recodified from R4-13-823 (Supp. 95-1).

R20-5-824. Intermediary Rulings or Orders by the Hearing Officer

No intermediary rulings or orders by the hearing officer may be appealed to the Review Board but shall become a part of the record.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-824 recodified from R4-13-824 (Supp. 95-1).

R20-5-825. Legal Memoranda

Legal memoranda may be filed if request is granted by the hearing officer. If such request is granted the hearing officer shall establish a reasonable time for such filing and response or simultaneous filing.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-825 recodified from R4-13-825 (Supp. 95-1).

R20-5-826. Decisions of Hearing Officers

- A.** The decision of the hearing officer shall include findings and conclusions of fact and law, and an order.
- B.** The hearing officer shall sign the decision. Upon issuance of the decision, jurisdiction shall rest solely in the Commission, and if a request for review is filed it shall be addressed to the Commission.

Historical Note

Amended effective August 27, 1975 (Supp. 75-1). R20-5-

826 recodified from R4-13-826 (Supp. 95-1).

R20-5-827. Settlement

- A.** Settlement is encouraged at any stage of the proceedings where such settlement is consistent with the provisions and objectives of the Act.
- B.** Settlement agreement submitted by the parties shall be accompanied by an appropriate proposed order which shall be signed by the assigned hearing officer or chief hearing officer.
- C.** Where parties to the settlement agree upon a proposal, it shall be served upon represented and unrepresented affected employees in the manner set forth in R20-5-806. Proof of such service shall accompany the proposed settlement when submitted to the Commission or the hearing officer.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-827 recodified from R4-13-827 (Supp. 95-1).

R20-5-828. Special Circumstances; Waiver of Rules

In special circumstances, or for good cause shown, the hearing officer may, upon application by any party, or on his own motion, waive any rule or make such orders as justice or the administration of the Act requires.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-828 recodified from R4-13-828 (Supp. 95-1).

R20-5-829. Variances

- A.** Any hearing concerning variances shall be filed before the Commissioners at a time set by the Commission.
- B.** Such proceeding shall be informal but shall be transcribed at the expense of the person seeking the variance if a written record of the proceeding is desired.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-829 recodified from R4-13-829 (Supp. 95-1).

ARTICLE 9. EXPIRED

R20-5-901. Expired

Historical Note

Adopted effective January 13, 1976 (Supp. 76-1). Former Section R4-13-901 repealed, new Section R4-13-901 adopted effective May 27, 1977 (Supp. 77-3). R20-5-901 recodified from R4-13-901 (Supp. 95-1). Section expired pursuant to A.R.S. § 41-1056(E), filed in the Office of the Secretary of State February 4, 2000 (Supp. 00-1).

R20-5-902. Expired

Historical Note

Adopted effective January 13, 1976 (Supp. 76-1). Former Section R4-13-902 repealed, new Section R4-13-902 adopted effective May 27, 1977 (Supp. 77-3). R20-5-902 recodified from R4-13-902 (Supp. 95-1). Section expired pursuant to A.R.S. § 41-1056(E), filed in the Office of the Secretary of State February 4, 2000 (Supp. 00-1).

R20-5-903. Expired

Historical Note

Adopted effective January 13, 1976 (Supp. 76-1). Former Section R4-13-903 repealed, new Section R4-13-903 adopted effective May 27, 1977 (Supp. 77-3). R20-5-903 recodified from R4-13-903 (Supp. 95-1). Section expired pursuant to A.R.S. § 41-1056(E), filed in the Office of the Secretary of State February 4, 2000 (Supp. 00-1).

R20-5-904. Expired

Historical Note

Adopted effective January 13, 1976 (Supp. 76-1). Former Section R4-13-904 repealed, new Section R4-13-904 adopted effective May 27, 1977 (Supp. 77-3). R20-5-904 recodified from R4-13-904 (Supp. 95-1). Section expired pursuant to A.R.S. § 41-1056(E), filed in the Office of the Secretary of State February 4, 2000 (Supp. 00-1).

R20-5-905. Expired

Historical Note

Adopted effective January 13, 1976 (Supp. 76-1). Former Section R4-13-905 repealed, new Section R4-13-905 adopted effective May 27, 1977 (Supp. 77-3). R20-5-905 recodified from R4-13-905 (Supp. 95-1). Section expired pursuant to A.R.S. § 41-1056(E), filed in the Office of the Secretary of State February 4, 2000 (Supp. 00-1).

R20-5-906. Expired

Historical Note

Adopted effective January 13, 1976 (Supp. 76-1). Former Section R4-13-906 repealed, new Section R4-13-906 adopted effective May 27, 1977 (Supp. 77-3). R20-5-906 recodified from R4-13-906 (Supp. 95-1). Section expired pursuant to A.R.S. § 41-1056(E), filed in the Office of the Secretary of State February 4, 2000 (Supp. 00-1).

R20-5-907. Expired

Historical Note

Adopted effective May 27, 1977 (Supp. 77-3). R20-5-907 recodified from R4-13-907 (Supp. 95-1). Section expired pursuant to A.R.S. § 41-1056(E), filed in the Office of the Secretary of State February 4, 2000 (Supp. 00-1).

R20-5-908. Expired

Historical Note

Adopted effective May 27, 1977 (Supp. 77-3). R20-5-908 recodified from R4-13-908 (Supp. 95-1). Section expired pursuant to A.R.S. § 41-1056(E), filed in the Office of the Secretary of State February 4, 2000 (Supp. 00-1).

R20-5-909. Expired

Historical Note

Adopted effective May 27, 1977 (Supp. 77-3). R20-5-909 recodified from R4-13-909 (Supp. 95-1). Section expired pursuant to A.R.S. § 41-1056(E), filed in the Office of the Secretary of State February 4, 2000 (Supp. 00-1).

R20-5-910. Expired

Historical Note

Adopted effective May 27, 1977 (Supp. 77-3). R20-5-910 recodified from R4-13-910 (Supp. 95-1). Section expired pursuant to A.R.S. § 41-1056(E), filed in the Office of the Secretary of State February 4, 2000 (Supp. 00-1).

R20-5-911. Expired

Historical Note

Adopted effective May 27, 1977 (Supp. 77-3). R20-5-911 recodified from R4-13-911 (Supp. 95-1). Section expired pursuant to A.R.S. § 41-1056(E), filed in the Office of the Secretary of State February 4, 2000 (Supp. 00-1).

R20-5-912. Expired

Historical Note

Adopted effective May 27, 1977 (Supp. 77-3). R20-5-912 recodified from R4-13-912 (Supp. 95-1). Section expired

pursuant to A.R.S. § 41-1056(E), filed in the Office of the Secretary of State February 4, 2000 (Supp. 00-1).

R20-5-913. Expired

Historical Note

Adopted effective May 27, 1977 (Supp. 77-3). R20-5-913 recodified from R4-13-913 (Supp. 95-1). Section expired pursuant to A.R.S. § 41-1056(E), filed in the Office of the Secretary of State February 4, 2000 (Supp. 00-1).

R20-5-914. Expired

Historical Note

Adopted effective May 27, 1977 (Supp. 77-3). R20-5-914 recodified from R4-13-914 (Supp. 95-1). Section expired pursuant to A.R.S. § 41-1056(E), filed in the Office of the Secretary of State February 4, 2000 (Supp. 00-1).

ARTICLE 10. WAGE CLAIMS

R20-5-1001. Definitions

In this Article, unless the context otherwise requires:

1. "Claim" means a wage claim pursuant to A.R.S. § 23-356.
2. "Claimant" means an individual who files a claim.
3. "Day" means calendar day.
4. "Department" means the Labor Department of the Industrial Commission of Arizona.
5. "Determination" means a finding by the Department under A.R.S. § 23-357 that a claim is either valid or invalid or that the Department cannot resolve the dispute.
6. "Director" means the Director of the Department.
7. "Dismissal" means an action by the Department in which the Department dismisses the claim and refers the claimant to other statutory remedies.
8. "Notice" or "notification" when made by the Department or the Director means a written communication transmitted to the employer or claimant, or both, by regular mail.

Historical Note

Adopted effective January 26, 1988 (Supp. 88-1). R20-5-1001 recodified from R4-13-1001 (Supp. 95-1). Amended by final rulemaking at 12 A.A.R. 1416, effective June 4, 2006 (Supp. 06-2).

R20-5-1002. Forms

The following forms are available upon request from the Department or from the Industrial Commission's Internet web site at www.ica.state.az.us:

1. Wage claim. When making a claim, a claimant shall provide the following information to the Department:
 - a. Claimant's name, address, telephone number, and date of birth;
 - b. Employer's name, address, telephone number, and description of business;
 - c. Claimant's dates of employment, position, and pay;
 - d. The amount of the wages claimed and whether the claimant requested payment of the wages from employer; and
 - e. Claimant's signature and signature date.
2. Employer response. The employer responding to a claim shall provide the following information to the Department:
 - a. Employer's name, address, telephone number, and description of business;
 - b. Claimant's dates of employment, position, and pay;
 - c. Whether claimant is owed any wages, and, if so, employer's reason for nonpayment; and
 - d. Employer's signature and signature date.

Historical Note

Adopted effective January 26, 1988 (Supp. 88-1). R20-5-1002 recodified from R4-13-1002 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 12 A.A.R. 1416, effective June 4, 2006 (Supp. 06-2).

R20-5-1003. Filing Requirements; Time for Filing; Computation of Time

- A. A claimant shall file a claim with the Department within one year of the date of the accrual of the claim.
- B. In computing any period of time prescribed or allowed by this Article, the day of the act or event from which the designated period of time begins to run is not included. The last day of the period and Saturdays, Sundays, and legal holidays are included in the computation of time.
- C. The date of filing of the claim is the date the claimant's wage claim form is received by the Department.
- D. The Department shall deem a form, document, instrument, or other written record filed at the Tucson office as filed at the Phoenix office for the purpose of computing time.
- E. An individual filing a form or document related to a claim shall legibly fill out the form or document in ink or type.
- F. If the wage claim form received from a claimant does not include the information required by R20-5-1002(1), the Department shall return the wage claim form to the claimant by regular mail with a request that the claimant provide the required information and return the completed wage claim form to the Department within 10 days from the date of the Department's request. If the Department does not receive the completed wage claim form within 10 days, the Department shall not initiate an investigation of the claim and the Department shall consider the claim withdrawn without prejudice. The claimant may re-file a withdrawn wage claim with the information required by R20-5-1002(1), if the claim is re-filed within one year of the date of the accrual of the claim.

Historical Note

Adopted effective January 26, 1988 (Supp. 88-1). R20-5-1003 recodified from R4-13-1003 (Supp. 95-1). Former R20-5-1003 renumbered to R20-5-1004; new R20-5-1003 made by final rulemaking at 12 A.A.R. 1416, effective June 4, 2006 (Supp. 06-2).

R20-5-1004. Investigation of Claim

- A. The Department shall mail a copy of a claimant's wage claim form within 10 days after the Department's receipt of the form to the employer listed on the wage claim, with a request that the employer complete and file the employer response form within 10 days of the date of the Department's mailing.
- B. If the Department does not receive the employer response form under subsection (A), the Department shall provide written notice to the employer stating that the employer must pay the amount claimed or file a written response to the wage claim within 10 days of the date of the Department's written notice.
- C. If the employer timely files the employer response under subsection (A), but the response is incomplete, the Department shall mail the employer a notice requesting that the employer file the required information within 10 days of the date of the Department's notice. If the Department does not receive the required information within 10 days, the Department shall make a determination regarding the claim based on the evidence in the file.
- D. If the employer's response disputes the amount of wages claimed by the claimant, the Department shall mail a copy of the employer's response to the claimant and offer the claimant the opportunity to file a written reply to the employer's response within 10 days from the date of the Department's

mailing. If the Department does not receive claimant's reply within 10 days, the Department shall make a determination of the claim based on the evidence in the file.

- E. If the employer fails or refuses to pay the amount claimed or submit a written response to the claim in accordance with subsection (B), the Department shall make a determination of the claim based on the evidence in the file.
- F. Upon request from the Department, and if necessary to complete the Department's investigation, the claimant, the employer, or both, shall submit further written information or meet with the Director or his designee. Except for statements made during settlement, mediation, or an informal conference, the Director or his designee shall administer oaths for the purpose of taking affidavits and shall tape record the meeting.
- G. Upon completion of its investigation, the Department shall notify the parties to the claim of the Department's determination in writing.

Historical Note

Adopted effective January 26, 1988 (Supp. 88-1). R20-5-1004 recodified from R4-13-1004 (Supp. 95-1). Former R20-5-1004 renumbered to R20-5-1005; new R20-5-1004 renumbered from R20-5-1003 and amended by final rulemaking at 12 A.A.R. 1416, effective June 4, 2006 (Supp. 06-2).

R20-5-1005. Mediation of Disputes

- A. During the investigation of a claim, the Department may mediate and conciliate a dispute between the claimant and the employer.
- B. If mediation results in an informal resolution of the claim, the Director or the Director's designee shall prepare and ensure execution of documents providing for the resolution of the claim.

Historical Note

Adopted effective January 26, 1988 (Supp. 88-1). R20-5-1005 recodified from R4-13-1005 (Supp. 95-1). Former R20-5-1005 renumbered to R20-5-1006; new R20-5-1005 renumbered from R20-5-1004 and amended by final rulemaking at 12 A.A.R. 1416, effective June 4, 2006 (Supp. 06-2).

R20-5-1006. Dismissal of Claim

- A. The Department shall dismiss a claim if:
 1. The claim is filed more than one year after the date of the accrual of the claim,
 2. The claimant does not comply with R20-5-1003(F),
 3. The amount of wages claimed exceeds \$2,500.00,
 4. The Department's investigation of the claimant's evidence reveals no possible violation of A.R.S. § 23-350 et seq.,
 5. The claimant has filed a civil action regarding the same claim,
 6. The employer listed on the claim is in bankruptcy,
 7. The Department is unable to locate the employer based on the information provided by the claimant, or
 8. The wages in question have been withheld from the claimant pursuant to the claimant's prior written authorization.
- B. The Department shall send a notice of dismissal to the claimant and, except as provided in subsections (A)(1) through (A)(3) and (7), the Department shall send a notice of dismissal to the employer. Notices of dismissal shall notify the claimant of the availability of other remedies.

Historical Note

Adopted effective January 26, 1988 (Supp. 88-1). R20-5-1006 recodified from R4-13-1006 (Supp. 95-1). Former

R20-5-1006 renumbered to R20-5-1007; new R20-5-1006 renumbered from R20-5-1005 and amended by final rulemaking at 12 A.A.R. 1416, effective June 4, 2006 (Supp. 06-2).

R20-5-1007. Notice of Right of Review

- A. A determination issued under A.R.S. § 23-357 shall include a notice informing the parties of their right to seek review under A.R.S. § 23-358 and § 12-901 et seq.
- B. The Department shall serve a determination on the parties by regular mail.

Historical Note

Adopted effective January 26, 1988 (Supp. 88-1). R20-5-1007 recodified from R4-13-1007 (Supp. 95-1). Former R20-5-1007 renumbered to R20-5-1008; new R20-5-1007 renumbered from R20-5-1006 and amended by final rulemaking at 12 A.A.R. 1416, effective June 4, 2006 (Supp. 06-2).

R20-5-1008. Payment of Claim

- A. The Department shall send any payment of a wage claim received by the Department to the claimant by certified mail, return receipt requested.
- B. If the Department discovers that payment of a wage claim is alleged to have been made directly to the claimant, the Department shall verify the payment by sending a letter to the claimant by regular mail. If the claimant does not respond to the Department's letter within 10 days of the date of the Department's letter, the Department shall deem the claim to have been paid.
- C. Payment of a partial amount of a wage claim does not preclude the Department from completing its investigation of the balance of the claim.
- D. In the case of a determination and directive for payment issued by the Department under A.R.S. § 23-357, the Department shall, if the employer agrees and with the written consent of the claimant, enter into a payment agreement with the employer for payment of the amount of wages found to be owed the claimant.

Historical Note

New R20-5-1008 renumbered from R20-5-1007; Section amended by final rulemaking at 12 A.A.R. 1416, effective June 4, 2006 (Supp. 06-2).

R20-5-1009. Service of Determinations, Notices, and Other Documents

- A. A determination, notice, or other document required by this Article or other law to be mailed or served upon a party, shall be made upon the party, or, if represented by legal counsel, the party's legal counsel. Service upon legal counsel is considered service upon the party.
- B. Service may be made and is deemed complete by depositing the document in regular or certified mail, addressed to the party served at the address shown in the records of the Department, or by personal delivery upon the party.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 1416, effective June 4, 2006 (Supp. 06-2).

ARTICLE 11. SELF-INSURANCE FOR INDIVIDUAL EMPLOYERS

R20-5-1101. Definitions

In addition to the definitions provided in A.R.S. § 23-901, the following definitions apply to this Article:

"Act" means the Arizona Workers' Compensation Act, A.R.S. § 23-901 et seq.

"Affiliate" or "affiliate relationship" means a person or entity that has the power to control, directly or indirectly, through one or more intermediaries, another person or entity.

"Anniversary date" means the date beginning one year from the initial effective date of the Authorization to Self-insure.

"Applicant" means an individual employer filing an initial application for authority to self-insure under A.R.S. § 23-961.

"Authorized signature" means the signature of an officer of the self-insurer.

"Cash-flow ratio" means a numerical relationship that reflects an ability to meet current financial obligations out of cash flow and is calculated by dividing funds provided by operations of a business by current liabilities.

"Chief counsel" means the chief counsel for the Industrial Commission of Arizona.

"Claim" means a worker's compensation claim.

"Claims Division," means the Claims Division of the Industrial Commission of Arizona.

"Classification code" means a number assigned by an approved rating organization that classifies employees by type of job performed.

"Control" means the possession, direct or indirect, of power to direct or cause the direction of, the management and policies of a person or entity, whether through the ownership of voting securities, by contract, or otherwise.

"Current ratio" means a numerical relationship that reflects an ability to pay current obligations and is calculated by dividing current assets by current liabilities.

"Debt-status ratio" means a numerical relationship that reflects the proportion of funds supplied internally relative to the funds contributed by creditors and is calculated by dividing net worth by total liabilities.

"Division" means the Accounting Division of the Industrial Commission of Arizona.

"Ex-medical plan" means a method of determining the premium upon which taxes are calculated that provides for rate revisions based upon the self-insurer operating a medical facility with a program for providing medical, surgical, or hospital services to a majority of the self-insurer's employees and that complies with the requirements of A.R.S. § 23-1070. Neither losses nor incurred loss reserves are used in this plan.

"Excess insurance carrier" means an insurance carrier authorized to issue policies of excess insurance coverage to a self-insured employer.

"Experience modification rate" means a ratio comparing actual losses to expected losses based on a formula determined by an approved rating organization and which includes three years of loss information.

"Fixed premium plan" means a method of determining the premium upon which taxes are calculated in which neither losses nor incurred loss reserves are used for calculation. The only discount is for premium size.

"Fully-funded risk management fund" means a fund that maintains a positive equity balance that is sufficient to cover all of the fund's actuarial losses.

"Guaranteed cost plan" means a method of determining the premium upon which taxes are calculated that provides for a direct relationship, on an annual basis, of the premium for tax purposes and the experience modification rate developed to reflect the loss payment and incurred loss experience of the self-insured employer.

"Individual employer" means an employer under the Act that is applying for authority to self-insure, or is approved to self-insure, that is not an entity described in A.R.S. § 23-961.01; § 11-952.01; or § 41-621.01.

“Parent company” means one that owns sufficient stock in a subsidiary company to have voting control of the subsidiary company, as “control” is defined in this Article.

“Profitability ratio” means a numerical relationship that represents the return on assets and the efficiency of assets and is calculated by dividing profit before taxes by total assets, multiplied by 100 expressed as a percentage.

“Public entity” means an individual employer that is a state, county, municipality, school district, or any other entity with taxing authority.

“Quick ratio” means a numerical relationship that represents the degree to which liabilities are covered by the most liquid current assets and is calculated by dividing cash and equivalents, plus receivables, by current liabilities.

“Rating organization,” means an entity that meets the requirements of A.R.S. § 20-363, and is approved by the Arizona Department of Insurance to establish rates, codes, and formulas used to calculate worker compensation premiums.

“Resolution of Authorization” means a document issued by the Commission that grants authority to self-insure for purposes of workers’ compensation.

“Retrospective rating plan” means a method of determining the premium upon which taxes are calculated that provides for the relationship between the premium for tax purposes, the experience modification rate developed to reflect the loss payment and incurred loss experience of the self-insured employer, and the actual incurred losses for the tax year.

“Securities” or “security” means a guaranty bond, a bond of the United States or its agencies, United States’ Treasury Notes, a letter of credit, or Local Government Investment Pool (LGIP) funds, or appropriate documents renewing or continuing any of these.

“Self-insurer” or “self-insured” means an individual employer that the Commission authorizes to self-insure for workers’ compensation insurance under A.R.S. § 23-961.

“Working capital ratio” means a numerical relationship that measures the sufficiency of working capital to support sales and is calculated by dividing working capital by sales. Working capital is calculated by subtracting current liabilities from current assets.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1).

R20-5-1102. Computation of Time

- A. In computing any period of time prescribed or allowed by this Article, the day of the act or event from which the designated period of time begins to run is not included. The last day of the period computed is included unless it is a Saturday, Sunday, or legal holiday, in which event the period runs until the end of the next day which is not a Saturday, Sunday, or legal holiday. When the period of time prescribed or allowed is less than 11 days, intermediate Saturdays, Sundays, and legal holidays are excluded in the computation.
- B. Except as otherwise provided by law, the Division may extend time limits prescribed by this Article for good cause. Any request for an extension of a time limit shall be submitted to the Division in writing at least 10 days before the expiration of the time limit for which an extension is sought.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1).

R20-5-1103. Forms

The following forms are available upon request from the Division or from the Commission’s Internet site at www.ica.state.az.us, and include the following information for each:

- A. Initial application for authority to self-insure:
 1. Legal name of the applicant and requested effective date for authority to self-insure;
 2. Mailing address and telephone number of applicant’s principal Arizona office and home office;
 3. Name of state under which applicant is incorporated, if applicant is a corporation;
 4. Name of parent company, if applicant is a subsidiary;
 5. Name, address, and status of partners (general, special, and limited), if applicant is a partnership;
 6. Length of time in business in Arizona and elsewhere, if applicable;
 7. Nature or type of business in Arizona;
 8. Arizona payroll data;
 9. Current workers’ compensation insurance data, including current expiration date;
 10. Statement of reasons for rejection or cancellation if an application for worker’s compensation insurance submitted by applicant has ever been rejected or a policy of workers’ compensation insurance held by the applicant has ever been cancelled;
 11. Listing of states where self-insurance was denied, if any, and where the applicant is currently self-insured;
 12. Arizona claims history and data for three years preceding application date;
 13. Arizona loss history and experience modification rates for three years preceding application date;
 14. Name of excess insurance carrier;
 15. Name, address, and telephone number of third-party administrator or individual responsible for processing Arizona workers’ compensation claims;
 16. Name and address of Arizona agent upon whom legal notice may be served;
 17. Selection of tax plan;
 18. Name, address, telephone and facsimile number, and e-mail address of person responsible for completing the premium tax information;
 19. Name, address, and telephone number of claims office where Arizona workers’ compensation claims will be processed;
 20. Name, address, telephone and facsimile number, and e-mail address of the primary and secondary points of contact for the application and self-insurance process;
 21. Statement that all information and assertions contained in the application and the documents accompanying the application are factually correct and true; and
 22. Listing of required attachments.
- B. Workers’ compensation liability form:
 1. Name of self-insurer;
 2. Selection and calculation of required securities and excess insurance, which includes calculation and reporting the following:
 - a. For all claims reported in the current calendar year, the number of open claims, total incurred liability, both medical and compensation, less the amount paid on these claims to equal the remaining liability or amount owing on these claims;
 - b. For all open claims incurred in prior years and remaining open in the current year, the number of open claims, the total incurred liability, both medical and compensation, less the amount paid on these

- claims to equal the remaining liability or amount owing on these claims;
 - c. The total remaining liability on all open claims less any reimbursement for excess insurance ceded to equal the net remaining liability owing on all claims; and
 - d. The amount calculated in subsection (B)(2)(c) multiplied by 125%;
 3. Name of excess insurance carrier that provides reimbursement to self-insurer; and
 4. A statement by the Chief Financial Officer or Chief Executive Officer attesting to the truthfulness of the information contained in the Workers' Compensation Liability Form;
- C. Self-insurance workers' compensation guaranty bond:**
1. Name of self-insurer;
 2. Name of the surety insurance company;
 3. Description of the bond, bond number, amount, and conditions of obligation;
 4. Statement regarding the responsibility for fees and costs associated with the collection of the bond and the responsibility for payment of any award or judgment against the surety; and
 5. Request for authorized signatures and titles of self-insurer, surety, and agent or attorney-in-fact, and a notarized power of attorney, and date of signing.
- D. Parent company guaranty:**
1. Name and state of incorporation of parent company;
 2. Name of self-insured subsidiary to be included in the guaranty;
 3. Statement that the parent company will assume the workers' compensation liabilities of the subsidiary if the subsidiary is unable to honor these liabilities, which guarantee is for the benefit of and may be enforced by any and all employees of subsidiary; and
 4. Corporate seal.
- E. Self-insured payroll report:**
1. Name of self-insured;
 2. Tax plan selection;
 3. Period covered by report;
 4. Payroll description (classification codes, methods, and types of pay);
 5. Amount paid for period covered by the report;
 6. Statement that all information contained in the report is correct; and
 7. Request for authorized signature, date, title, and telephone number of person signing the form.
- F. Self-insured medical report:**
1. Name of self-insured;
 2. Period covered by report;
 3. Amount paid relating to treatment of industrial injuries, including payment of medical personnel employed by the self-insurer and medical providers providing outside services;
 4. Compensation paid to worker's compensation claimants;
 5. Insurance premiums paid;
 6. Total expenditures for workers' compensation and occupational disease claims;
 7. Statement that all information contained in the report is correct; and
 8. Request for authorized signature, date, title, and telephone number of person signing the form.
- G. Self-insured hospital report:**
1. Name of self-insurer;
 2. Period covered by report;
 3. Amount paid for operational expenses, including payroll, employee benefits, surgeon and physician fees, pharmacy costs, miscellaneous supplies and services, utilities, depreciation, licenses, and taxes;
 4. Amount of revenue, including charges for inpatient and outpatient care, miscellaneous revenue, employee-paid premiums, and employer-paid premiums;
 5. Reconciliation of cash account, including cash balance, total cash available, investments, operating expenses, disbursements, and net cash balance;
 6. Statement that all information contained in the report is correct; and
 7. Request for authorized signature, date, title, and telephone number of person signing the form.
- H. Self-insured injury report:**
1. Name of self-insurer;
 2. Period covered by report;
 3. Description of individual claims for the current year and three preceding years requiring payment greater than \$5,000.00 for each claim, including name of claimant, date of injury, nature of injury, accumulated amount paid, and the amount of any expenses incurred but not paid;
 4. The total amount paid, and the amount of any expenses incurred but not paid, for the current year and three preceding years for all claims requiring a total payment less than \$5,000.00 for each claim;
 5. Statement that all information contained in the report is correct; and
 6. Request for authorized signature, date, title, and telephone number of person signing the form.
- I. Quarterly tax payment:**
1. Name and address of the self-insurer;
 2. Designation of the applicable quarter;
 3. Amount of annual tax paid in the previous calendar year; amount of the quarterly tax paid adjusted for any change in the tax rate for the applicable quarter;
 4. Statement that all information contained in the form is correct; and
 5. Request for authorized signature, date, title, and telephone number of person signing the form.
- J. Notice of self-insurer's termination of self-insurance:**
1. Name, address, and telephone number of self-insurer and all Arizona subsidiaries covered under the authority to self-insure, including if applicable:
 - a. Names and addresses of all Arizona operations or locations covered by self-insurance authority;
 - b. Names and addresses of all partners, if self-insurer is a partnership; and
 - c. Current and former names of self-insurer if the self-insurer has undergone a name change since the most recent effective date of the authority to self-insure;
 2. Effective date of termination of authority to self-insure;
 3. Name and address of workers' compensation insurance carrier providing coverage after the effective date of termination;
 4. For the new coverage; effective date of workers' compensation coverage;
 5. Statement that all information contained in the form is correct; and
 6. Request for authorized signature, date, title, and telephone number of person signing the form.
- K. Self-provider of medical benefits:**
1. Indication of whether the self-insurer is, or is not, directing medical care for all of its employees;
 2. If the self-insurer is directing medical care for its employees, the self-insurer shall:

- (a) Attach a copy of all contracts between the self-insurer and the medical providers; or
 - (b) Submit a list of names and addresses of all medical providers with whom the self-insurer contracts; and
 - (c) The effective date of the agreements between the employer and medical provider; and
3. Authorized signature, date, and title of person signing the form.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1).

R20-5-1104. Commission Approval to Act as Self-insurer

An employer does not have authority to act as a self-insurer under A.R.S. § 23-961 unless:

- 1. The Commission authorizes the employer to be self-insured; and
- 2. Except as provided in R20-5-1114, the employer posts security in an amount as required under this Article.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1).

R20-5-1105. Resolution of Authorization

The Commission shall issue a Resolution of Authorization to an applicant that meets the requirements of this Article. The Commission shall annually review and renew a Resolution of Authorization to self-insure. The authority to self-insure is valid and continues in effect until the Commission takes action under this Article or the self-insured terminates its authorization to self-insure under R20-5-1136.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1).

R20-5-1106. Time-frames**A. Administrative completeness review.**

- 1. Initial application.
 - a. The Division shall review an initial application for authority to self-insure within 20 days of receipt of the application to determine whether the application contains the information required by A.R.S. § 23-961 and this Article.
 - b. The Division shall inform the applicant by written notice if the application is incomplete. The Division shall include in its written notice to the applicant, a list of the missing information necessary to comply with this Article.
 - c. The Division shall deem the application withdrawn if the applicant fails to post security as required under this Article or fails to file a completed application within 10 days of being notified by the Division that the application is incomplete, unless the applicant obtains an extension to provide the missing information under subsection (D).
- 2. Request for renewal.
 - a. The Division shall review a request for renewal within 10 days of receipt of the request to determine whether the request contains the information in A.R.S. § 23-961 and this Article.
 - b. The Division shall inform a self-insurer by written notice if the request for renewal is incomplete. The Division shall include in its written notice to the self-insurer, a list of the missing information necessary to comply with this Article, and the right to request an extension under subsection (D).

B. Substantive review.

- 1. Initial application. Within 70 days after the Division determines an initial application complete, the Commission shall determine whether the initial application for authority to self-insure meets the substantive criteria of A.R.S. § 23-961 and this Article and shall issue either a Resolution of Authorization granting authority to self-insure, or an order denying authority to self-insure.
- 2. Request for renewal. Within 60 days after the Division receives all the required information under this Article, the Commission shall determine whether a request for renewal for authority to self-insure meets the substantive criteria of A.R.S. § 23-961 and this Article and shall renew the self-insurer's authority to self-insure, or issue an order denying or revoking authority to self-insure.

C. Overall time-frame.

- 1. Initial application. The overall time-frame is 90 days, unless extended under A.R.S. § 41-1072 et seq.
- 2. Request for renewal. The overall time-frame is 70 days, unless extended under A.R.S. § 41-1072 et seq.

- D.** If an applicant or self-insurer cannot timely submit to the Division information to complete an initial application or a request for renewal, the applicant or self-insurer may obtain an extension to submit the missing information by filing a written request with the Division. The written request for extension shall be filed no later than 10 days after receipt of the deficiency notice from the Division. The written request for an extension shall state the reasons the applicant or self-insurer is unable to meet the deadline. If an extension will enable the applicant or self-insurer to assemble and submit the missing information, the Division shall grant an extension of not more than 30 days and provide written notice of the extension to the applicant or self-insurer.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1).

R20-5-1107. Initial Application under A.R.S. § 23-961

- A.** A public entity may file an initial application for authority to self-insure under A.R.S. § 23-961 if the public entity:
 - 1. Provides an annual payroll in Arizona of at least \$2,000,000; and
 - 2. Has total assets of at least \$50,000,000.
- B.** An individual employer that is not a public entity may file an initial application for authority to self-insure under A.R.S. § 23-961 if the employer:
 - 1. Is engaged in business in Arizona and has been for at least five years before the date of the initial application;
 - 2. Provides an annual payroll in Arizona of at least \$2,000,000, including the combined payrolls of all subsidiary companies that will be under the self-insurance authorization;
 - 3. Meets either of the following thresholds:
 - a. Has assets of at least \$50,000,000; or
 - b. Has \$10,000,000 in net worth and a cash flow ratio of at least .25.
- C.** The applicant for authority to self-insure shall complete and file with the Division a typewritten application form approved by the Division. An application is considered filed when it is received at the Division.
- D.** The authorized representative of the applicant shall sign and date the initial application.
- E.** The authorized representative signing the initial application shall verify, in writing, that the information submitted with the application is correct.

F. The Division shall deem an initial application for authority to self-insure complete if an applicant that is not a subsidiary company provides the following information with the initial application:

1. A statement from the board of directors or governing body:
 - a. Authorizing the filing of the application, and
 - b. Designating the person given authority to sign the application on behalf of the applicant;
2. A statement classifying the applicant's Arizona employees using the workers' compensation classification codes of the approved rating organization used by the Arizona State Compensation Fund;
3. A copy of the applicable hospital or medical agreement or a detailed statement of the arrangements between the employer and the medical provider, if medical care is directed under A.R.S. § 23-1070;
4. If the applicant is not a public entity, a copy of the applicant's audited financial statements or internally-reviewed and signed financial statements for the most current and prior two fiscal years, including any notes to the financial statements;
5. If the applicant is a public entity, a copy of the applicant's audited financial statement for the most current and prior fiscal year; and
6. If the applicant is a public entity that qualifies for exemption under R20-5-1114(A), the certified statement required under R20-5-1114(B).

G. The Division shall deem an initial application for authority to self-insure complete if an applicant that is a subsidiary company provides the following information with the initial application:

1. The information required in Section (F);
2. A completed Parent Company Guaranty form signed by the authorized representative of the subsidiary's parent company;
3. A certified copy of the resolution of the parent company's board of directors authorizing a designated officer to complete, sign, and file the Parent Company Guaranty form; and
4. A copy of the parent company's audited financial statements for the most current and prior two fiscal years, including any notes to the financial statements.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1).

R20-5-1108. Self-insurance Renewal

A. A self-insurer that is required to post security under this Article shall request renewal of authorization to self-insure with the Division 30 days before the self-insurer's anniversary date, by filing a Workers' Compensation Liability form. The Commission shall deem the request for renewal complete if the self-insurer provides the following:

1. A copy of the self-insurer's most recent audited annual financial statement or internally reviewed and signed financial statement or annual report. A parent company shall submit a copy of its most recent audited annual financial statement or annual report;
2. If the self-insured company is a subsidiary, a completed Parent Company Guaranty form signed and dated by the authorized representative of the parent company, or if the parent company of the subsidiary is different from the last filing approved by the Commission, a certified copy of the parent company board of director's resolution authorizing a designated officer to complete, sign, and file the Parent Company Guaranty form;

Per claim data to support the summary information on the Workers' Compensation Liability form. The self-insurer shall provide this information in the same format as in R20-5-1103(B)(2)(a) and (b);

3. Deposit of security as shown on the completed Worker's Compensation Liability form no later than the self-insurer's anniversary date subject to R20-5-1127 and R20-5-1128;
4. A certificate of excess insurance or a continuing certificate of existing excess insurance if the self-insurer takes a credit for excess insurance under R20-5-1109;
5. If medical care is directed under A.R.S. § 23-1070, a copy of the current medical or hospital medical agreement, or detailed statement of the arrangements, if not previously provided;
6. A statement of the total number of full-time and part-time Arizona employees;
7. If the Division determines that the self-insurer's denial rate exceeds 12% of claims filed, a statement from the self-insurer identifying the reason for each denial of a workers' compensation claim;
8. If the Division determines that the self-insurer's experience modification rate is greater than 1.10, a statement from the self-insurer identifying the reasons for that level of losses;
9. Name of the third-party administrator;
10. Principal location of the self-insurer in Arizona;
11. A description of the self-insurer's current business in Arizona and a description of any changes in the nature of business in Arizona in the past year;
12. List of any subsidiary company located in Arizona; and
13. Primary and secondary points of contact, including addresses, telephone numbers, facsimile numbers, and e-mail information.

B. A self-insurer that is exempt from the requirement to post security, shall request renewal of authorization to self-insure by filing an annual statement described under R20-5-1114(B) no later than the employer's anniversary date. The Commission shall deem the request for renewal complete if the self-insurer provides the following:

1. Information required under subsections (A)(1), (A)(7) through (A)(10) and (A)(14); and
2. A certified statement that contains the information described in R20-5-1114 (A) and (B).

Historical Note

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1).

R20-5-1109. Security Deposit; Excess Insurance Policy

A. Except as provided in R20-5-1114, an applicant authorized to self-insure under this Article shall post security in the amount of at least \$100,000.00 under A.R.S. § 23-961. The self-insurer shall not reduce or offset this minimum amount by any credit for excess insurance.

B. Except as provided in R20-5-1114, and subject to the minimum security requirement of A.R.S. § 23-961, a self-insurer filing a request to renew its authority to self-insure under R20-5-1108 shall post security in an amount equal to 125% of its total estimated future liability, or in an amount determined by the Division under R20-5-1127.

C. Subject to review by the Commission, the self-insurer shall determine its total estimated liability by using the Workers' Compensation Liability form.

- D.** The Commission shall approve a credit for excess insurance against the amount of security required under this Article only if the following criteria are met:
1. The self-insurer satisfies the minimum-security requirement of A.R.S. § 23-961,
 2. The self-insurer does not reduce or offset the minimum-security amount by an excess insurance,
 3. The self-insurer calculates the credit on the Workers' Compensation Liability form,
 4. The excess insurance policy contains a 60-day notice of termination,
 5. The excess insurer does not have an affiliate relationship with the self-insurer,
 6. The excess insurance policy provides that the insolvency of the self-insurer does not relieve the excess insurer of liability under the policy, and
 7. The excess insurer posts a deposit under A.R.S. § 23-961(D).
- E.** If an excess insurance provider gives the self-insurer notice of its intent to terminate the policy, the self-insurer shall immediately:
1. Provide written notice of the notice of termination to the Division, and
 2. Deposit security as shown on the Worker's Compensation Liability form without credit for the excess insurance.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1).

R20-5-1110. Posting of Guaranty Bond; Bond Amount; Effective Date

- A.** A self-insurer shall ensure that a guaranty bond or rider for the guaranty bond filed with the Division bears the same effective date as the effective date of the Resolution of Authorization to self-insure.
- B.** The Commission shall permit the self-insurer to post a guaranty bond or rider of the guaranty bond instead of other security if:
1. The insurance carrier providing the guaranty bond or rider submits the bond or rider to the Division on a form approved for use by the Division;
 2. The guaranty bond is continuous in form;
 3. The penal sum of the guaranty bond or rider equals the amount the self-insured must post as security under this Article;
 4. The company issuing the guaranty bond or rider is authorized and licensed to transact the business of surety insurance in Arizona;
 5. An authorized agent of the surety executes the guaranty bond or rider;
 6. The bond is signed and dated by an authorized representative of the self-insurer;
 7. The surety issuing the bond or rider does not have an affiliate relationship with the applicant or self-insurer; and
 8. The surety issuing the guaranty bond or rider has a rating with A.M. Best of at least A-.
- C.** A guaranty bond or rider is subject to annual change based on unpaid liabilities as reported by the self-insurer on the Workers' Compensation Liability form.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1).

R20-5-1111. Posting of Other Bonds or Treasury Notes of the United States Instead of Guaranty Bond; Registration; Deposit

- A.** Instead of providing a guaranty bond under R20-5-1110, a self-insurer may deposit with the Commission for transmittal through the Arizona State Treasurer to the Treasurer's designated bank, bonds or treasury notes of the United States of America if the bonds or treasury notes are guaranteed as to principal and interest by the United States of America or by any agency or instrumentality of the United States of America.
- B.** The self-insurer shall ensure that bonds or treasury notes of the United States of America deposited with Commission under this subsection are registered to: "The Industrial Commission of Arizona, in trust for the fulfillment by ----- of its obligations under the Arizona Workers' Compensation Laws." The self-insured shall ensure that any contract between the self-insured and the custodial bank provides that the bonds or treasury notes are held for: "The Industrial Commission of Arizona, in trust for the fulfillment by ----- of its obligations under the Arizona Workers' Compensation Laws."
- C.** If one or more of the self-insurer's claims are assigned to the state compensation fund under A.R.S. § 23-966, the Commission shall:
1. Collect or order collection of the principal, or market value of the security, whichever is greater, as it becomes due;
 2. Sell or order the sale of the security or any part of the security; or
 3. Apply or order the application of the proceeds to the payment of any unpaid obligations of the self-insurer, as determined by the Commission, in the event of the default in the payment of its obligations.
- D.** The self-insurer may arrange for interest on bonds or treasury notes of the United States of America deposited under this subsection to be paid to the self-insurer.
- E.** Bonds or treasury notes deposited according to this Article by a self-insurer shall be in an amount not less than the security deposit amount required under R20-5-1109.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1).

R20-5-1112. Letter of Credit or Local Government Investment Pool Funds (LGIP)

- A.** Letter of Credit:
1. A self-insurer may satisfy the provision of R20-5-1110 by filing a letter of credit.
 2. The self-insurer shall ensure that the letter of credit is registered to: "The Industrial Commission of Arizona, in trust for the fulfillment by ----- of its obligations under the Arizona Workers' Compensation Laws."
 3. The self-insurer shall ensure that the letter of credit is issued by a federal or Arizona chartered bank with an Arizona branch office or correspondent bank in Arizona upon which demand may be made and from which funds will be immediately payable on demand.
 4. The letter of credit is acceptable only if:
 - a. The letter includes the name and address of the self-insurer, including all Arizona subsidiaries;
 - b. Is for a period of one year from the effective date;
 - c. Includes a provision that the letter of credit automatically extends for consecutive periods of one year, unless the issuing bank provides written notice to the Division 30 days before the expiration of any one-year term that the issuing bank will not renew the letter of credit for the additional period;

- d. Includes a provision that the written notice required in subsection (A)(4)(d) may be delivered to the Division or sent to the Division by United States Mail, certified mail return receipt requested;
- e. The letter of credit states the amount available under the letter of credit; and
- f. The self-insurer ensures that the letter of credit includes a statement that the sum available under the letter of credit shall be paid to the Industrial Commission of Arizona upon receipt by the issuing bank of a signed statement by an official of the Commission stating the following:
 - i. The self-insurer has failed to comply with its workers' compensation obligations; or
 - ii. The self-insurer has failed to renew or substitute acceptable security for its workers' compensation liability 15 days before the expiration of the letter of credit.

B. Local Government Investment Pool Funds (LGIP):

- 1. Instead of posting a guaranty bond, letter of credit, or United States of America bonds or Treasury Notes, a self-insured public agency may post a local government investment pool (LGIP) fund only if:
 - a. The self-insurer ensures that the funds are deposited through the Arizona State Treasurer as custodian subject to the order of, and in trust for, the Industrial Commission of Arizona, registered and assigned to: "The Industrial Commission of Arizona, in trust for the fulfillment by ----- of its obligations under the Arizona Workers' Compensation Laws;"
 - b. The LGIP funds posted as security in compliance with this Section are in an amount not less than the security deposit amount required under R20-5-1109;
 - c. The Commission has the ability to:
 - i. Collect or order collection of the funds; and
 - ii. Apply or order the application of the funds to the payment of any award rendered against the self-insurer, as determined by the Commission, if the self-insurer defaults in any of its obligations;
 - d. The self-insurer submits an assignment for the benefit of the Industrial Commission of Arizona, and an Endorsement-Receipt for Notice of Assignment, signed by the State of Arizona Treasurer and notarized. The Endorsement-Receipt shall contain the following language: Receipt is hereby acknowledged by the Treasurer of the State of Arizona of written notice of the assignment to the Industrial Commission ("Commission") of the above-identified account. We have noted our records to show the interest of the Commission in said account as shown in and by the above assignment. We have retained a copy of this document. We hereby certify that we have not received any notice of lien, encumbrance, hold, claim, or other obligation against the above-identified account prior to its assignment to the Commission. We further hereby waive any current or future right of set-off against such account. We agree to make payment as required by the Rules and Regulations of the Commission adopted in accordance with applicable laws and the law applicable to this institution.
- 2. Interest on the funds deposited under this Section may be remitted by the State of Arizona Treasurer directly to the self-insurer.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1).

R20-5-1113. Substitution of Securities

The Commission may authorize the return a self-insurer's security deposit with written approval from the Division. The Commission shall not authorize the return or release of security unless the self-insurer substitutes the security with new security in an amount sufficient to satisfy the self-insurer's obligations under R20-5-1109.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1).

R20-5-1114. Exemption from Requirement to Post Security

- A.** Conditions to qualify for exemption. A public entity applicant or public entity self-insurer is exempt from the requirements under this Article to post or provide security if the public entity:
 - 1. Has a fully-funded risk management fund sufficient to cover actuarial liabilities for workers' compensation as determined by the self-insurer in accordance with Government Accounting Standards Board Statement #10; and
 - 2. Provides funding to the risk management fund each year sufficient to cover actuarial liabilities for workers' compensation as determined by the self-insurer in accordance with Government Accounting Standards Board Statement #10.
- B.** Written request for exemption. A public entity applicant or public entity self-insurer that requests exemption from posting security shall file a certified statement along with its Workers' Compensation Liability form with the Commission before the effective date of initial self-insurance or before the anniversary date, if a renewal, that contains the following:
 - 1. A statement that the public entity meets the conditions required under subsection (A);
 - 2. A statement that the governing body of the public entity shall immediately notify the Commission and provide security required under this Article if the governing body learns that the risk management fund has insufficient funds to cover all workers' compensation liabilities of the public entity self-insurer;
 - 3. The signatures of a majority of the members of the public entities' governing body; and
 - 4. If the Commission has previously authorized the public entity to self-insure its workers' compensation obligations, a statement requesting the return of security previously posted or provided to the Commission, including a specific description of the type and amount of security previously posted or provided.
- C.** Approval or denial of request for exemption.
 - 1. If the Commission determines that a self-insurer qualifies for exemption under this Section, the Division shall return to the self-insurer security previously posted or provided to the Commission, within 30 days after receiving written notice under subsection (B).
 - 2. If the Commission denies a request for exemption under this subsection, the Commission shall provide written notice to the public entity within 10 days of the initial written request. The applicant or self-insurer has 10 days from the date the Commission's notice is received to request a hearing under A.R.S. § 23-945.
- D.** Failure to comply with conditions of exemption. The Commission shall order a self-insurer exempt under subsection (A) to immediately file with the Commission a completed, dated, and signed Workers' Compensation Liability form and post or pro-

vide security as required under this Article if any of the following occurs:

1. The self-insurer fails to file the certified statement to request renewal of self-insurance authority;
2. The self-insurer fails to comply with the conditions in subsection (A); or
3. The Commission determines, based upon receipt of information under subsection (B), or its own review, that the self-insurer's risk management fund has insufficient funds to cover all actuarial liabilities for workers' compensation liabilities of the self-insurer.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1).

R20-5-1115. Rating Plans Available for a Self-insurer

- A.** A self-insurer shall use one of the following rating plans to calculate the premium taxes required under A.R.S. §§ 23-961 and 23-1065:
 1. Fixed-premium plan;
 2. Ex-medical plan;
 3. Guaranteed-cost plan; or
 4. Retrospective-rating plan.
- B.** The provisions of the rating plans apply only to operations and payroll in Arizona. The self-insurer shall combine all operations in Arizona as a single base to calculate any premium modification.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1).

R20-5-1116. Fixed-Premium Plan; Formula; Eligibility; Necessary Information for Plan

- A.** The Division shall calculate the net taxable premium under a fixed-premium plan as follows: payroll multiplied by the applicable workers' compensation rate minus the premium discount.
- B.** A self-insurer shall use a fixed-premium plan to calculate its net taxable premium if:
 1. The self-insurer elects this plan;
 2. The self-insurer's annual net taxable premium does not exceed \$100,000; or
 3. The self-insurer is not eligible for any other plan authorized by the Commission under this Article.
- C.** A self-insurer shall provide the following information in support of the fixed-premium plan:
 1. Self-insurer's Payroll Report,
 2. Self-insurer's Medical Report, and
 3. Self-insurer's Quarterly Tax Payment form.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1).

R20-5-1117. Ex-medical Plan; Formula; Eligibility; Necessary Information for Plan

- A.** The Division shall calculate the net taxable premium under an ex-medical plan as follows: [(payroll multiplied by the applicable workers' compensation rate) multiplied by (1 minus the ex-medical factor)] minus the premium discount.
- B.** A self-insurer may use the ex-medical plan if:
 1. The self-insurer's program for medical, surgical, or hospital services meets the requirements of A.R.S. § 23-1070; and
 2. The self-insurer's annual net taxable premium exceeds \$100,000.

- C.** A self-insurer shall provide the following information in support of the plan submitted under this Section:

1. Self-insurer's Payroll Report,
2. Self-insurer's Hospital Report,
3. Self-insurer's Medical Report, and
4. Self-insurer's Quarterly Tax Payment form.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1).

R20-5-1118. Guaranteed-Cost Plan; Formula; Eligibility; Necessary Information for Plan

- A.** The Division shall calculate the net taxable premium under a guaranteed-cost plan as follows: [(payroll multiplied by the applicable worker's compensation rate) multiplied by (the experience modification rate) minus the premium discount].
- B.** A self-insurer may use the guaranteed-cost plan if:
 1. The self-insurer has an annual net taxable premium exceeding \$100,000; and
 2. Uses an experience modification rate calculated as follows:
 - a. In the first year of self-insurance, the experience modification rate is 1.0;
 - b. In the second and third years of self-insurance, the Division calculates the experience modification rate based upon the loss data accumulated by the self-insurer during its term of self-insurance; and
 - c. In the fourth year of self-insurance and all following years, the Division calculates the experience modification rate based upon the most recent three years of loss data provided on the Self-insured Injury Report, excluding the most recent year.
- C.** A self-insurer shall provide the following information in support of the guaranteed-cost plan:
 1. Self-insurer's Payroll Report,
 2. Self-insurer's Medical Report,
 3. Self-insurer's Injury Report, and
 4. Self-insurer's Quarterly Tax Payment form.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1).

R20-5-1119. Retrospective-Rating Plan; Formula; Eligibility; Necessary Information for Plan

- A.** The Division shall calculate the net taxable premium under a retrospective-rating plan as follows: [(payroll multiplied by the applicable worker's compensation rate multiplied by the experience modification rate multiplied by the basic premium factor) added to (losses for the current year plus adjusted losses from the previous year) multiplied by (the loss conversion factor)] multiplied by the tax multiplier. The net taxable premium is subject to a maximum and minimum premium level.
- B.** A self-insurer may use the retrospective-rating plan if:
 1. The self-insurer has an annual net taxable premium exceeding \$100,000; and
 2. The Division calculates the experience modification rate as follows:
 - a. In the first year of self-insurance, the experience modification rate is 1.0;
 - b. In the second and third years of self-insurance, the Division calculates the experience modification rate based upon the loss data accumulated by the self-insurer during its term of self-insurance; and
 - c. In the fourth year of self-insurance and all following years, the Division calculates the experience modification rate based upon the most recent three years of loss data provided on the Self-insured Injury Report, excluding the most recent year.

cation rate based upon the most recent three years of loss data provided on the Self-insured Injury Report, excluding the most recent year. The Division shall use the most recent year's data to calculate the actual premium tax.

- C. A self-insurer shall provide the following information in support of the retrospective-rating plan:
1. Self-insurer's Payroll Report;
 2. Self-insurer's Medical Report;
 3. Self-insurer's Injury Report; and
 4. Self-insurer's Quarterly Tax Payment form.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1).

R20-5-1120. Completion of Reports in Support of Tax Rating Plan; Calculation and Payment of Taxes Owed by Self-insurer under A.R.S. §§ 23-961 and 23-1065

- A. A self-insurer shall submit to the Division the information required in R20-5-1116, R20-5-1117, R20-5-1118, or R20-5-1119 by February 15 of each year.
- B. After receiving the information required under A.R.S. § 23-961, § 23-1065, and this Article, the Division shall determine the annual taxes owed by the self-insurer. The Division shall determine whether the self-insurer has overpaid or underpaid its taxes for the previous calendar year. If the total of the quarterly payments is less than the actual taxes for the year, the self-insurer shall pay the difference on or before March 31 of the calendar year in which the taxes are due. If the total of the quarterly payments exceeds the amount of the actual taxes for the year, then the Division shall refund the amount described in A.R.S. § 23-961 or § 23-1065 as applicable.
- C. A self-insurer shall pay to the Commission the self-insurer's annual workers' compensation premium taxes on or before March 31 based on the net taxable premium calculated for the preceding calendar year. A self-insurer shall pay a premium tax of at least \$250.00 per calendar year.
- D. The Division shall calculate a self-insurer's quarterly taxes owed under A.R.S. §§ 23-961 and 23-1065 in one of the following ways:
1. 25% of the tax calculated for the previous year; or
 2. A calculation based on actual payroll and losses calculated for each quarter, using the same rating plan to calculate the quarterly payment as used to calculate the taxes required under A.R.S. §§ 23-961 and 23-1065. If the Division selects this method, the self-insurer shall submit quarterly payroll and loss information by classification code.
- E. Quarterly tax payments are due April 30, July 31, October 31, and January 31 for the periods ending March 31, June 30, September 30, and December 31, respectively.
- F. If the self-insurer fails to pay the annual or quarterly taxes to the Commission when due, the self-insurer shall pay a penalty of \$25.00 or 5% of the tax or payment due, whichever is more, plus interest at the rate of 1% per month from the date the tax or payment was due until paid.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1).

R20-5-1121. Basis for Definitions, Classifications, Rating Procedures, and Plans

The Division shall use the definitions, classifications, rating procedures, and plans specified in the rating systems filed by the rating organization used by the State Compensation Fund under A.R.S.

Title 20, Chapter 2, Article 4 in calculating the net taxable premium under A.R.S. §§ 23-961 and 23-1065.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1).

R20-5-1122. Report, Book, Record, and Data Review by the Commission

- A. All reports, books, records, and data of a self-insurer relating to classifications, payroll, incurred-loss reserves, calculation of premiums, completion of Workers' Compensation Liability form, and procedures for development of statistical information for the development of rating information are subject to review by the Commission or its authorized representative upon request.
- B. A self-insurer shall ensure that the reports, books, records, and data described in subsection (A) are readily available for review by the Commission.
- C. A self-insurer shall ensure that the reports, books, records, and data described in subsection (A) are clear, valid, and understandable.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1).

R20-5-1123. Audit and Cost of Audit

The Commission may, at any time, perform or have performed for its benefit an audit of the payroll, loss payment, and loss reserve records for incurred losses of a self-insurer for the purpose of determining the scope and adequacy of the records. The entire cost of the audit shall be borne by the self-insurer.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1).

R20-5-1124. Requirement to Provide Information to the Commission

A self-insurer shall make available to the Commission, upon request and at an office of the Commission, information described in this Article.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1).

R20-5-1125. Notice to Commission of Location of Self-insurer's Claims Files

In addition to the requirements found in 20 A.A.C. 5, Article 1, a self-insurer shall advise the Claims Manager of the location of the self-insurer's open and closed workers' compensation claims files. Except for a claims file that is made available for copying and inspection under R20-5-131(C), if a self-insurer or third-party administrator intends to change the location of its claims files, the self-insurer shall provide written notice to the Claims Manager of the change in location at least 30 days before the files are moved.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1).

R20-5-1126. Processing of Workers' Compensation Claims by a Self-insured Employer

The Claims Division shall permit a self-insurer to process its own workers' compensation claims if the self-insurer provides information and supporting documentation establishing the following:

1. The self-insurer has facilities and equipment to manage, process, and store its own information pertaining to the self-insurer's workers' compensation claims;

2. The self-insurer's workers' compensation claims are processed by persons with experience, training by the Claims Division, or knowledge regarding the Arizona Workers' Compensation Act; and
3. The persons processing the self-insurer's workers' compensation claims attend and complete training provided by the Claims Division.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1).

R20-5-1127. Review of Initial Application and Request for Renewal to Self-insure

- A.** Upon the filing of a completed initial application or request for renewal, the Division shall:
1. Determine whether the applicant or self-insurer meets the requirements of A.R.S. § 23-961;
 2. Determine whether the applicant or self-insurer meets the requirements of this Article. Except for a self-insurer that is exempt under R20-5-1114, the self-insurer shall post security according to R20-5-1109 that is adequate to provide for the self-insurer's future estimated liability. If applicable, the Division shall advise the applicant or self-insurer of the need for additional security, and the self-insurer shall post the additional security before the Commission makes its decision under R20-5-1128;
 3. If a self-insurer requests a decrease of 10% or greater in the value or amount of security provided in the prior year, perform an additional review to determine the adequacy of the security deposit, including:
 - a. Mathematical verification of the accuracy of amounts reported on the Workers' Compensation Liability form;
 - b. Review of claims filed for the three preceding years;
 - c. Review of changes in the payroll of the self-insurer to determine changes in employment levels;
 - d. Review of changes in workers' compensation classification codes to determine changes in operations of the company in Arizona; and
 - e. Review of the financial condition of the self-insurer to determine changes in financial stability, including a review of the total incurred liability expenses for the past three years;
 4. Determine whether the applicant or self-insurer has the ability to process and pay benefits required under the Arizona Workers' Compensation Act.
 - a. For an applicant that is not a public entity, the Division shall determine whether the self-insurer has the ability to process and pay by:
 - i. Reviewing the financial statements to determine the current ratio, quick ratio, cash-flow ratio, working-capital ratio, debt-status ratio, profitability ratio, and the applicant's net profit or loss;
 - ii. Comparing the applicant's ratios with the ratios of existing self-insurers in the same or a closely related industry;
 - iii. Reviewing notes to the financial statements;
 - iv. Reviewing management reports of operations and other information provided by the self-insurer; and
 - v. Comparing the applicant's ratio of claims filed to total employees with that of other employers within the same or closely related industry;

- b. For an applicant that is a public entity, the Division shall determine whether the self-insurer has the ability to process and pay by:
 - i. Reviewing the public entity's general fund financial statement to determine the cash ratio and fund equity ratio;
 - ii. Reviewing excess revenues over expenditures and the ending balances in the general fund and all fund accounts for the past two years;
 - iii. Reviewing notes to the self-insurer's financial statements;
 - iv. Reviewing management reports of operations and other information provided by the self-insurer;
 - v. Comparing the public entity's ratio of claims filed to total employees with that of other public entities;
 - vi. Comparing cash and fund equity ratios with that of other self-insured public entities; and
 - vii. Reviewing the risk management fund to determine if it is sufficient to pay all workers' compensation liabilities;
- c. For a self-insurer requesting renewal that is not a public entity, the Division shall determine whether the self-insurer has the ability to process and pay by:
 - i. Reviewing the information in subsection (A)(4)(a);
 - ii. Reviewing the claims profile for the past three years, which includes a review of the claims filed, claims denied, and denial rate;
 - iii. Reviewing of the self-insurer's experience modification rate;
 - iv. Comparing of the self-insurer's ratio of claims filed to total employees with that of other self-insurer's; and
 - v. Reviewing the Parent Company Guaranty form; and
- d. For a self-insurer requesting renewal that is a public entity, the Division shall determine whether the self-insurer has the ability to process and pay by:
 - i. Reviewing the information in subsection (A)(4)(b);
 - ii. Reviewing the claims profile for the past three years, including a review of the claims filed, claims denied, and denial rate;
 - iii. Reviewing the self-insured's experience modification rate; and
 - iv. Comparing the self-insurer's ratio of claims filed to total employees with that of other self-insured public entities of similar size.

- B.** The Division shall present the findings and recommendations of its review to the Commission, and may include a recommendation regarding the adequacy of the security based on its review and determination whether the self-insurer has the ability to process and pay as set forth in subsection (A)(3).

Historical Note

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1).

R20-5-1128. Decision by the Commission on Initial Application or Request for Renewal of Authorization to Self-insure

- A.** The Commission shall consider the following before granting or denying an initial application or request for renewal to self-insure:
1. The information submitted by an applicant or self-insurer;

2. The information and recommendations of the Division; and
 3. The requirements of A.R.S. § 23-961 and this Article, including compliance with the requirement for posting additional security as recommended by the Division under R20-5-1127.
- B.** The Commission shall deny authority to self-insure if the Commission finds one or more of the following conditions:
1. The applicant or self-insurer does not meet the requirements of A.R.S. § 23-961,
 2. The applicant or self-insurer does not meet the requirements of this Article, or
 3. The applicant or self-insurer is unable to process and pay benefits under the Arizona Workers' Compensation Act.
- C.** The Commission may table consideration of, or action on, a request for renewal pending the self-insurer posting additional security based on a Division decision under R20-5-1127 that the posted security is insufficient.
- D.** Whether to grant, deny, or table an application for self-insurance authority shall be made by a majority vote of a quorum of Commission members present when the application for initial authority or renewal is presented at a public meeting.
- E.** If the Commission approves an initial application of an applicant that is not exempt under R20-5-1114:
1. The approval is contingent upon the self-insurer posting the required security;
 2. After the Commission takes action under subsection (D), the Division shall provide written notice to the applicant that the Commission approves the application for self-insurance authority effective on a date certain;
 3. The applicant shall provide to the Commission the required security before the effective date of the authority to self-insure; and
 4. After the applicant complies with the requirements of subsection (E)(3), the Division shall mail a Resolution of Authorization to Self-insure to the last known business address of the applicant.
- F.** If an applicant fails to comply with the requirements of subsection (E)(3), the Commission shall not grant authority to self-insure and the Commission shall deem the initial application withdrawn.
- G.** If the Commission approves an initial application of an applicant exempt under R20-5-1114, the Division shall mail a Resolution of Authorization to Self-insure, to the last known business address of the applicant.
- H.** If the Commission approves a request for renewal of authority to self-insure, or tables consideration of the request for renewal, the Division shall mail written notice of the Commission's action on the request for renewal to the last known business address of the self-insurer.
- I.** If the Commission denies authority to self-insure, the Commission shall issue and mail written findings and an order to the last known business address of the applicant or self-insurer no later than 10 days after the Commission denies authority to self-insure.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1).

R20-5-1129. Right to Request a Hearing

- A.** An applicant or self-insurer has 15 days from the date the Commission's findings and order is mailed to request a hearing.
- B.** A request for hearing shall comply with A.R.S. § 23-945 and be signed by an authorized representative of the applicant or self-insurer or the applicant's or self-insurer's legal representa-

tive. The applicant or self-insurer shall file the request for hearing with the Division.

- C.** The Commission shall deem its findings and order final if a request for hearing is not received by the Division within the time specified in subsection (A).

Historical Note

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1).

R20-5-1130. Hearing Rights and Procedures

- A.** Burden of proof.
1. Except as provided in subsection (A)(2), in all proceedings arising out of this Article, the applicant or self-insurer has the burden of proof to establish that it has met the requirements of A.R.S. § 23-901 et seq. and this Article.
 2. In a revocation hearing, the Commission has the burden of proof to establish that the self-insurer has committed the acts described in R20-5-1133.
- B.** Roles of Chair and Chief Counsel.
1. The Chair of the Commission or designee shall preside over hearings held under this Article. Except as otherwise provided in this Section, the Chair shall apply the provisions of A.R.S. § 41-1062 to hearings held under this Article and shall have the authority and power of a presiding officer as described in A.R.S. § 41-1062.
 2. The Chief Counsel of the Commission shall represent the Commission in hearings held before the Commission and upon direction of the Chair of the Commission shall issue on behalf of the Commission all notices and subpoenas required under this Section.
- C.** Appearance by a party.
1. Except as otherwise provided by law, a party to a hearing may appear on its own behalf or through counsel.
 2. When an attorney appears or intends to appear before the Commission, the attorney shall file a notice of appearance.
- D.** Filing and service.
1. For purposes of this Section, a document is considered filed when the Commission receives the document. All documents required to be filed under this Section with the Commission shall be served upon the Chief Counsel of the Commission and upon all parties to the proceeding.
 2. Except as otherwise provided in A.R.S. § 23-901, et seq. and this Article, service of all documents upon the Commission, applicant, or self-insurer shall be by personal service or mail. Personal service includes delivery upon the Commission or party. Service by mail includes every type of service except personal service and is complete on mailing.
- E.** Notice of hearing.
1. The Commission shall give the parties at least 20 days notice of hearing.
 2. A notice of hearing shall be in writing and mailed to the last known address of the applicant or self-insurer as shown on the records of the Commission, or upon the applicant's or self-insurer's representative if a notice of appearance has been filed by a representative.
 3. A notice of hearing shall comply with the requirements in A.R.S. § 41-1061.
- F.** Evidence.
1. The civil rules of evidence do not apply to hearings held under this Section.
 2. A party may make an opening and closing statement with the permission of the Chair if the Chair determines that

the statement will be helpful to a determination of the issues.

3. All witnesses at a hearing shall testify under oath or affirmation.
 4. A party may present evidence and conduct cross-examination of witnesses.
 5. The Commission Chair may admit documents into evidence if filed no later than 15 days before the date of the hearing. Upon request or upon direction from the Commission Chair, the Commission may issue a subpoena to the author of any document submitted into evidence to appear and testify at the hearing.
 6. Upon written request by a party or upon direction from the Commission Chair, the Commission may issue a subpoena requiring the attendance and testimony of a witness whose testimony is material. A party shall submit its subpoena request no later than 10 days before the date of the hearing.
 7. Upon written request by a party or upon direction from the Commission Chair, the Commission may issue a subpoena duces tecum requiring the production of documents or other tangible evidence. The written request by a party shall contain a statement explaining the general relevance, materiality, and reasonable particularity of the documentary or other tangible evidence and the facts to be proved by them.
- G.** Transcript of Proceedings. The Commission shall stenographically report or electronically record hearings. Any party desiring a copy of transcript shall obtain a copy from the court reporter. Any party desiring a copy of an electronic recording may obtain a copy from the Commission.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1).

R20-5-1131. Decision Upon Hearing by the Commission

- A.** A decision of the Commission to deny authority to self-insure shall be based upon the grounds in R20-5-1128 and shall be made by a majority vote of the quorum of Commission members present at a public meeting.
- B.** A decision of the Commission to revoke authority to self-insure shall be based upon the grounds in R20-5-1133 and shall be made by a majority vote of the quorum of Commission members present at a public meeting.
- C.** The Commission shall issue a written decision after the hearing that shall include findings of fact and conclusions of law, separately stated.
- D.** The Commission decision is final unless an applicant or self-insurer requests review under R20-5-1132 no later than 15 days after the written decision is mailed to the parties.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1).

R20-5-1132. Request for Review

- A.** A party may request review of a Commission decision issued under R20-5-1131 by filing with the Commission a written request for review no later than 15 days after the written decision is mailed to the parties.
- B.** A request for review of a Commission Decision shall be based upon one or more of the following grounds, which have materially affected the rights of a party:
 1. Irregularities in the hearing proceedings or any order or abuse of discretion that deprives a party seeking review of a fair hearing;

2. Accident or surprise, which could not have been prevented by ordinary prudence;
 3. Newly discovered material evidence that could not have been discovered with reasonable diligence and produced at the hearing;
 4. Error in the admission or rejection of evidence, or errors of law occurring at, or during the course of the hearing;
 5. Bias or prejudice of the Division or Commission; and
 6. The order, decision, or findings of fact are not justified by the evidence or are contrary to law.
- C.** The request for review shall state the specific facts and law in support of the request and shall specify the relief sought.
- D.** The Commission shall issue a decision upon review no later than 30 days after receiving a request for review.
- E.** The Commission's decision upon review is final unless an applicant or self-insurer seeks judicial review as provided in A.R.S. § 23-946.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1).

R20-5-1133. Revocation of Authorization to Self-insure

- A.** The Commission may revoke a Resolution of Authorization to Self-insure for good cause. Good cause includes any of the following:
 1. An inability or failure to process and pay any claim under the Arizona Workers' Compensation Act;
 2. Failure of the self-insurer to pay any taxes levied by the Commission as required under A.R.S. §§ 23-961 and 23-1065 and this Article;
 3. Failure of the self-insurer to comply with the requirements of this Article, including the failure of the self-insurer to:
 - a. Promptly provide the Commission reports or other information required under this Article; and
 - b. File the written Letter of Intent required under R20-5-1135;
 4. Failure or deliberate refusal to comply with the applicable requirements of A.R.S. § 23-901 et seq.;
 5. Failure to pay or comply with any award or order of the Commission after the award or order becomes final;
 6. Willful misstating of any material fact in a tax report, application, renewal documentation, or other report or statement made to or filed with the Commission;
 7. Failure or deliberate refusal to comply with the requirements of 20 A.A.C. 5, Article 1;
 8. Failure to deposit or file security timely as specified in this Article; or
 9. Failure to provide information or documentation necessary to timely renew the Authorization to Self-insure.
- B.** Upon receiving information that a self-insurer has committed an act described in subsection (A), the Division shall conduct an investigation of the facts of the alleged misconduct. If, upon completion of the investigation, the Division determines that sufficient evidence exists to warrant revocation of a self-insurer's authority to self-insure, the Division shall present its findings to the Commission.
- C.** The Commission shall consider the findings and recommendation of the Division before revoking a self-insurer's authorization to self-insure.
- D.** The Commission shall revoke a self-insurer's authority to self-insure if the Commission finds one or more of the grounds in subsection (A). The Commission shall issue written findings and an order revoking the Resolution of Authorization to Self-insure and shall serve a copy of the findings and order upon

the self-insurer addressed to the last known address of the self-insurer as shown by the records of the Commission.

- E. A self-insurer has 15 days from the date the Commission serves the findings and order described in subsection (D) to request a hearing. The request for hearing shall comply with the requirements of A.R.S. § 23-945.
- F. R20-5-1130, R20-5-1131, and R20-5-1132 govern hearing rights and procedures for revocation hearings and review.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1).

R20-5-1134. Notice of Bankruptcy, Change in Ownership Status, or Change in Business Address

- A. A self-insurer shall notify the Commission in writing within 24 hours of any bankruptcy filing under federal law or insolvency proceeding under any state's laws.
- B. A self-insurer shall notify the Commission in writing within 24 hours of any change in the ownership status or business address of the employer.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1).

R20-5-1135. Plan of Action for Retaining Self-insurance Authority in the Event of Insolvency or Bankruptcy

- A. If a self-insurer becomes insolvent or files for protection under the United States Bankruptcy Code seeking to reorganize, and desires to remain self-insured, it shall file with the Division a written Letter of Intent regarding its intent to reorganize under the applicable provisions of the United States Bankruptcy Code.
 - 1. If the self-insurer is incorporated, the chief executive officer shall sign the Letter of Intent and the board of directors shall approve the Letter if the corporation is still operating;
 - 2. If the self-insurer is not incorporated, an authorized representative of the self-insurer shall sign the Letter of Intent; or
 - 3. An attorney representing the entity in its bankruptcy reorganization case may sign the Letter of Intent instead of the chief executive officer or authorized representative.
- B. The self-insurer shall file the Letter of Intent with the Division within 10 days of the initial bankruptcy filing or insolvency proceeding.
- C. The self-insurer shall ensure that a provision addressing the self-insurer's obligations to workers' compensation claimants and the Commission is included in the Plan of Reorganization filed with the United States Bankruptcy Court. This Plan shall state the self-insurer's intentions and financial ability to continue self-insurance.
- D. During the period between the initial bankruptcy filing and the approval of a Plan of Reorganization or Plan of Liquidation, the self-insurer may continue its self-insurance status only upon the demonstration of adequate protection to cover its current workers' compensation claims, or those claims that may come due before the Bankruptcy Court approves the Reorganization or Insolvency Plan. As part of the adequate protection for the Commission, the self-insurer shall post or deposit additional security in an amount the Commission deems necessary to pay claims currently pending or anticipated before the approval of the Plan of Reorganization or liquidation.
- E. The self-insurer, or its legal representative, shall send a copy of the proposed Plan of Reorganization or Liquidation, including amendments to the Division.

- F. The Commission may file an Objection to the Plan of Reorganization in the appropriate bankruptcy court and take other actions as permitted under the United States Bankruptcy Code if it determines that the Plan of Reorganization or Liquidation does not adequately provide for the processing and payment of the self-insurer's workers' compensation claims.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1).

R20-5-1136. Notice of Self-insurer's Termination of Self-insurance

- A. A self-insurer shall file with the Division a completed and signed Notice of Self-insurer's Termination of Self-insurance form, if the self-insurer decides to terminate its self-insurance. The Notice of Self-insurer's Termination shall be filed with the Division 30 days before the effective date of termination of self-insurance.
- B. Before the effective date of the termination of self-insurance, the self-insurer shall file a certificate with the Claims Division designating an insurance carrier, or other proof, satisfactory to the Commission, of compliance with the requirements of A.R.S. § 23-961, to cover claims of the self-insurer that:
 - 1. Are pending at that time the self-insurer terminates self-insurance; and
 - 2. Occur after the effective date of the termination of self-insurance.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1).

**ARTICLE 12. ARIZONA MINIMUM WAGE ACT
PRACTICE AND PROCEDURE**

R20-5-1201. Notice of Rules

- A. This Article applies to all actions and proceedings before the Commission arising under the Raise the Arizona Minimum Wage for Working Arizonans Act, as added by 2006 Proposition 202, § 2.
- B. The Commission shall provide a copy of this Article upon request to any person free of charge.

Historical Note

New Section made by emergency rulemaking at 13 A.A.R. 473, effective January 25, 2007 for 180 days (Supp. 07-1). Emergency renewed at 13 A.A.R. 2785, effective July 17, 2007 for 180 days (Supp. 07-3). New Section made by final rulemaking at 13 A.A.R. 4315, effective January 13, 2008 (Supp. 07-4).

R20-5-1202. Definitions

In this Article, the definitions of A.R.S. § 23-362 (version two) apply. In addition, unless the context otherwise requires:

- 1. "Act" means the Raise the Arizona Minimum Wage for Working Arizonans Act, as added by 2006 Proposition 202, § 2.
- 2. "Affected employee" means an employee or employees on whose behalf a complaint may be filed alleging a violation under the Act.
- 3. "Authorized representative" means a person prescribed by law to act on behalf of a party who files with the Department a written instrument advising of the person's authority to act on behalf of the party.
- 4. "Casual Basis," when applied to babysitting services, means employment which is irregular or intermittent.
- 5. "Commission" means monetary compensation based on:
 - a. A percentage of total sales,

- b. A percentage of sales in excess of a specified amount,
- c. A fixed allowance per unit, or
- d. Some other formula the employer and employee agrees as a measure of accomplishment.
- 6. "Complainant" means a person or organization filing an administrative complaint under the Act.
- 7. "Department" means the Labor Department of the Industrial Commission of Arizona or other authorized division of the Industrial Commission as designated by the Industrial Commission.
- 8. "Filing" means receipt of a report, document, instrument, videotape, audiotape, or other written matter at an office of the Department.
- 9. "Hours worked" means all hours for which an employee covered under the Act is employed and required to give to the employer, including all time during which an employee is on duty or at a prescribed work place and all time the employee is suffered or permitted to work.
- 10. "Minimum wage" means the lowest rate of monetary compensation required under the Act.
- 11. "Monetary compensation" means cash or its equivalent due to an employee by reason of employment.
- 12. "On duty" means time spent working or waiting that the employer controls and that the employee is not permitted to use for the employee's own purpose.
- 13. "Tip" means a sum a customer presents as a gift in recognition of some service performed, and includes gratuities. The sum may be in the form of cash, amounts paid by bank check or other negotiable instrument payable at par, or amounts the employer transfers to the employee under directions from a credit customer who designates an amount to be added to a bill as a tip. Gifts in forms other than cash or its equivalent as described in this definition, including theater tickets, passes, or merchandise, are not tips.
- 14. "Violation" means a transgression of any statute or rule, or any part of a statute or rule, including both acts and omissions.
- 15. "Willfully" means acting with actual knowledge of the requirements of the Act or this Article, or acting with reckless disregard of the requirements of the Act or this Article.
- 16. "Workday" means any fixed period of 24 consecutive hours.
- 17. "Workweek" means any fixed and regularly recurring period of seven consecutive workdays.

Historical Note

New Section made by emergency rulemaking at 13 A.A.R. 473, effective January 25, 2007 for 180 days (Supp. 07-1). Emergency renewed at 13 A.A.R. 2785, effective July 17, 2007 for 180 days (Supp. 07-3). New Section made by final rulemaking at 13 A.A.R. 4315, effective January 13, 2008 (Supp. 07-4).

R20-5-1203. Duty to Provide Current Address

- A. A complainant shall provide and keep the Labor Department advised of the complainant's current mailing address and telephone number.
- B. An employer under investigation by the Department shall provide and keep the Labor Department advised of the employer's current mailing address and telephone number.

Historical Note

New Section made by emergency rulemaking at 13 A.A.R. 473, effective January 25, 2007 for 180 days (Supp. 07-1). Emergency renewed at 13 A.A.R. 2785,

effective July 17, 2007 for 180 days (Supp. 07-3). New Section made by final rulemaking at 13 A.A.R. 4315, effective January 13, 2008 (Supp. 07-4).

R20-5-1204. Forms Prescribed by the Department

Forms prescribed by the Department, including the poster required under R20-5-1208, shall not be changed, amended, or otherwise altered without the prior written approval of the Department.

Historical Note

New Section made by emergency rulemaking at 13 A.A.R. 473, effective January 25, 2007 for 180 days (Supp. 07-1). Emergency renewed at 13 A.A.R. 2785, effective July 17, 2007 for 180 days (Supp. 07-3). New Section made by final rulemaking at 13 A.A.R. 4315, effective January 13, 2008 (Supp. 07-4).

R20-5-1205. Determination of Employment Relationship

- A. Determination of an employment relationship under the Act, which includes whether an individual is an independent contractor, shall be based upon the economic realities of the relationship. Consideration of whether an individual is economically dependent on the employer for which the individual performs work shall be determined by factors showing dependence, which non-exclusive factors shall include:
 - 1. The degree of control the alleged employer exercises over the individual,
 - 2. The individual's opportunity for profit or loss and the individual's investment in the business,
 - 3. The degree of skill required to perform the work,
 - 4. The permanence of the working relationship, and
 - 5. The extent to which the work performed is an integral part of the alleged employer's business.
- B. An individual that works for another person without any express or implied compensation agreement is not an employee under the Act. This may include an individual that volunteers to work for civic, charitable, or humanitarian reasons that are offered freely and without direct or implied pressure or coercion from an employer, provided that the volunteer is not otherwise employed by the employer to perform the same type of services as those which the individual proposes to volunteer.
- C. An individual that works for another individual as a babysitter on a casual basis and whose vocation is not babysitting, is not an employee under the Act even if the individual performs other household work not related to caring for the children, provided the household work does not exceed 20% of the total hours worked on the particular babysitting assignment.

Historical Note

New Section made by emergency rulemaking at 13 A.A.R. 473, effective January 25, 2007 for 180 days (Supp. 07-1). Emergency renewed at 13 A.A.R. 2785, effective July 17, 2007 for 180 days (Supp. 07-3). New Section made by final rulemaking at 13 A.A.R. 4315, effective January 13, 2008 (Supp. 07-4).

R20-5-1206. Payment of Minimum Wage; Commissions; Tips

- A. Subject to the requirements of the Act and this Article, no less than the minimum wage shall be paid for all hours worked, regardless of the frequency of payment and regardless of whether the wage is paid on an hourly, salaried, commissioned, piece rate, or any other basis.
- B. If the combined wages of an employee are less than the applicable minimum wage for a work week, the employer shall pay monetary compensation already earned, and no less than the difference between the amounts earned and the minimum wage as required under the Act.

- C. The workweek is the basis for determining an employee's hourly wage. Upon hire, an employer shall advise the employee of the employee's designated workweek. Once established, an employer shall not change or manipulate an employee's workweek to evade the requirements of the Act.
- D. In computing the minimum wage, an employer shall consider only monetary compensation and shall count tips and commissions in the workweek in which the tip or commission is earned.
- E. An employer is allowed to:
 1. Require or permit employees to pool, share, or split tips; and
 2. Require an employee to report tips to the employer in order to meet reporting requirements of this Article and federal law.

Historical Note

New Section made by emergency rulemaking at 13 A.A.R. 473, effective January 25, 2007 for 180 days (Supp. 07-1). Emergency renewed at 13 A.A.R. 2785, effective July 17, 2007 for 180 days (Supp. 07-3). New Section made by final rulemaking at 13 A.A.R. 4315, effective January 13, 2008 (Supp. 07-4).

R20-5-1207. Tip Credit Toward Minimum Wage

- A. In this Section, unless the context otherwise requires, "customarily and regularly" means receiving tips on a consistent and recurrent basis, the frequency of which may be greater than occasional, but less than constant, and includes the occupations of waiter, waitress, bellhop, busboy, car wash attendant, hairdresser, barber, valet, and service bartender.
- B. For purposes of calculating the permissible credit for tips under A.R.S. § 23-363(C), the following applies:
 1. Tips are customarily and regularly received in the occupation in which the employee is engaged;
 2. Except as provided in R20-5-1206(E), the employee actually receives the tip free of employer control as to how the employee uses the tip and the tip becomes the employee's property;
 3. Employees who customarily and regularly receive tips may pool, share, or split tips between them, and the amount each employee actually retains is considered the tip of the employee who retains it;
 4. Employer-required sharing of tips with employees who do not customarily and regularly receive tips in the occupation in which the employee is engaged, including management or food preparers, are not credited toward that employee's minimum wage; and
 5. A compulsory charge for service imposed on a customer by an employer's establishment are not credited toward an employee's minimum wage unless the employer actually distributes the charge to the employee in the pay period in which the charge is earned.
- C. Upon hiring or assigning an individual to a position that customarily and regularly receives tips, an employer intending to exercise a tip credit shall provide written notice to the employee prior to exercising the tip credit. Thereafter, the employer shall notify the employee in writing each pay period of the amount per hour that the employer takes as a tip credit.

Historical Note

New Section made by emergency rulemaking at 13 A.A.R. 473, effective January 25, 2007 for 180 days (Supp. 07-1). Emergency renewed at 13 A.A.R. 2785, effective July 17, 2007 for 180 days (Supp. 07-3). New Section made by final rulemaking at 13 A.A.R. 4315, effective January 13, 2008 (Supp. 07-4).

R20-5-1208. Posting Requirements

Every employer subject to the Act shall place a poster prescribed by the Department informing employees of their rights under the Act in a conspicuous place in every establishment where employees are employed and where notices to employees are customarily placed. The employer shall ensure that the notice is not removed, altered, defaced, or covered by other material.

Historical Note

New Section made by emergency rulemaking at 13 A.A.R. 473, effective January 25, 2007 for 180 days (Supp. 07-1). Emergency renewed at 13 A.A.R. 2785, effective July 17, 2007 for 180 days (Supp. 07-3). New Section made by final rulemaking at 13 A.A.R. 4315, effective January 13, 2008 (Supp. 07-4).

R20-5-1209. Records Availability

- A. Each employer shall keep the records required under the Act and this Article safe and accessible at the place or places of employment, or at one or more established central recordkeeping offices where the records are customarily maintained. When the employer maintains the records at a central recordkeeping office other than in the place or places of employment, the employer shall make the records available to the Department within 72 hours following notice from the Department.
- B. Employers who use microfilm or another method for recordkeeping purposes shall make available to the Department any equipment that is necessary to facilitate inspection and copying of the records.
- C. Each employer required to maintain records under the Act shall make enlargement, recomputation, or transcription of the records and shall submit to the Department the records or reports in a readable format upon the Department's written request.

Historical Note

New Section made by emergency rulemaking at 13 A.A.R. 473, effective January 25, 2007 for 180 days (Supp. 07-1). Emergency renewed at 13 A.A.R. 2785, effective July 17, 2007 for 180 days (Supp. 07-3). New Section made by final rulemaking at 13 A.A.R. 4315, effective January 13, 2008 (Supp. 07-4).

R20-5-1210. General Recordkeeping Requirements

- A. Payroll records required to be kept under the Act include:
 1. All time and earning cards or sheets on which are entered the daily starting and stopping time of individual employees, or of separate work forces, or the amounts of work accomplished by individual employees on a daily, weekly, or pay period basis (for example, units produced) when those amounts determine in whole or in part the pay period wages of those employees;
 2. From their last effective date, all wage-rate tables or schedules of the employer that provide the piece rates or other rates used in computing wages; and
 3. Records of additions to or deductions from wages paid and records that support or corroborate the additions or deductions.
- B. Except as otherwise provided in this Section, every employer shall maintain and preserve payroll or other records containing the following information and data with respect to each employee to whom the Act applies:
 1. Name in full, and on the same record, the employee's identifying symbol or number if it is used in place of the employee's name on any time, work, or payroll record;
 2. Home address, including zip code;
 3. Date of birth, if under 19;
 4. Occupation in which employed;

5. Time of day and day of week on which the employee's workweek begins. If the employee is part of a workforce or employed in or by an establishment all of whose workers have a workweek beginning at the same time on the same day, then a single notation of the time of the day and beginning day of the workweek for the whole workforce or establishment is permitted;
 6. Regular hourly rate of pay for any workweek and an explanation of the basis of pay by indicating the monetary amount paid on a per hour, per day, per week, per piece, commission on sales, or other basis, including the amount and nature of each payment;
 7. Hours worked each workday and total hours worked each workweek;
 8. Total daily or weekly straight-time wages due for hours worked during the workday or workweek, exclusive of premium overtime compensation;
 9. Total premium pay for overtime hours and an explanation of how the premium pay was calculated exclusive of straight-time wages for overtime hours recorded under subsection (B)(8) of this Section;
 10. Total additions to or deductions from wages paid each pay period including employee purchase orders or wage assignments, including, for individual employee records, the dates, amounts, and nature of the items that make up the total additions and deductions;
 11. Total wages paid each pay period; and
 12. Date of payment and the pay period covered by payment.
- C.** For an employee who is compensated on a salary basis at a rate that exceeds the minimum wage required under the Act and who, under 29 CFR 541, is an exempt bona fide executive, administrative, or professional employee, including an employee employed in the capacity of academic administrative personnel or teachers in elementary or secondary schools, or in outside sales, an employer shall maintain and preserve:
1. Records containing the information and data required under subsections (B)(1) through (B)(5), (B)(11) and (B)(12) of this Section; and
 2. Records containing the basis on which wages are paid in sufficient detail to permit a determination or calculation of whether the salary received exceeds the minimum wage required under the Act, including a record of the hours upon which payment of the salary is based, whether full time or part time.
- D.** With respect to employees working on fixed schedules, an employer may maintain records showing instead of the hours worked each day and each workweek as required under this Section, the schedule of daily and weekly hours the employee normally works, provided:
1. In weeks in which an employee adheres to this schedule, the employer indicates by check mark, statement, or other method, that the employee actually worked the hours; and
 2. In weeks in which more or fewer than the scheduled hours are worked, the employer records the number of hours actually worked each day and each week.
- E.** With respect to an employee that customarily and regularly receives tips, the employer shall ensure that the records required under this Article include the following information:
1. A symbol, letter, or other notation placed on the pay records identifying each employee whose wage is determined in part by tips;
 2. Amount of tips the employee reports to the employer;
 3. The hourly wage of each tipped employee after taking into consideration the employee's tips;
 4. Hours worked each workday in any occupation in which the employee does not receive tips, and total daily or week straight-time payment made by the employer for the hours;
 5. Hours worked each workday in occupations in which the employee receives tips and total daily or weekly straight-time wages for the hours; and
 6. Copy of the notice required under R20-5-1207(C).
- F.** An employer who makes retroactive payment of wages, voluntarily or involuntarily, shall record on the pay records, the amount of the payment to each employee, the period covered by the payment, and the date of payment.

Historical Note

New Section made by emergency rulemaking at 13 A.A.R. 473, effective January 25, 2007 for 180 days (Supp. 07-1). Emergency renewed at 13 A.A.R. 2785, effective July 17, 2007 for 180 days (Supp. 07-3). New Section made by final rulemaking at 13 A.A.R. 4315, effective January 13, 2008 (Supp. 07-4).

R20-5-1211. Administrative Complaints

- A.** A person or organization alleging a minimum wage violation, shall file a complaint with the Labor Department within one year from the date the wages were due.
- B.** A person or organization alleging retaliation shall file a complaint with the Labor Department within one year from the date the alleged violation occurred or when the employee knew or should have known of the alleged violation.
- C.** The person or organization filing a complaint with the Labor Department shall sign the complaint.
- D.** Any person or organization other than an affected employee who files a complaint shall include the names of affected employees.
- E.** For good cause, and upon its own complaint, the Department may investigate violations under the Act.

Historical Note

New Section made by emergency rulemaking at 13 A.A.R. 473, effective January 25, 2007 for 180 days (Supp. 07-1). Emergency renewed at 13 A.A.R. 2785, effective July 17, 2007 for 180 days (Supp. 07-3). New Section made by final rulemaking at 13 A.A.R. 4315, effective January 13, 2008 (Supp. 07-4).

R20-5-1212. Conduct that Hinders Investigation

An employer hinders an investigation under the Act if the employer engages in conduct, or causes another person to engage in conduct, that delays or otherwise interferes with the Department's investigation, including:

1. Obstructing or refusing to admit the Department to any place of employment authorized under the Act;
2. Obstructing or refusing to permit interviews authorized under the Act;
3. Failing to make, keep, or preserve records required under the Act or this Article;
4. Failing to permit the review and copying of records required under the Act and this Article; and
5. Falsifying any record required under the Act or this Article.

Historical Note

New Section made by emergency rulemaking at 13 A.A.R. 473, effective January 25, 2007 for 180 days (Supp. 07-1). Emergency renewed at 13 A.A.R. 2785, effective July 17, 2007 for 180 days (Supp. 07-3). New Section made by final rulemaking at 13 A.A.R. 4315, effective January 13, 2008 (Supp. 07-4).

R20-5-1213. Findings and Order Issued by the Department

- A.** Except as provided in R20-5-1219, after receipt of a complaint alleging a violation of the minimum wage requirement of the Act, or alleging retaliation under the Act, the Department shall issue a Findings and Order of its determination. The Department shall send its Findings and Order to both the employer and the complainant at their last known addresses served personally or by regular first class mail. If the complaint named affected employees, the Department may send a copy of its Findings and Order to the affected employees.
- B.** If the Department determines that an employer has violated the minimum wage payment requirement, the Department shall order the employer to pay the employee, and if applicable, affected employees, the balance of the wages owed, including interest at the legal rate and an additional amount equal to twice the underpaid wages.
- C.** If the Department determines that a retaliation violation has occurred, the Department shall direct the employer or other person to cease and desist from the violation and may take action necessary to remedy the violation, including:
 - 1. Rehiring or reinstatement,
 - 2. Reimbursement of lost wages and interest,
 - 3. Payment of penalty to employees or affected employees as provided for in the Act and this Article, and
 - 4. Posting of notices to employees.
- D.** If the Department determines that no retaliation has occurred the Department shall notify the parties and shall dismiss the complaint without prejudice. After notification of the Department's determination, the complainant may bring a civil action under A.R.S. § 23-364(E).
- E.** The Department may assess civil penalties for recordkeeping, posting, and other violations under the Act and this Article as part of a Findings and Order issued under subsection (A) or the civil penalties and other violations may be assessed as a separate Findings and Order. If issued as a separate Findings and Order, the Department shall serve, personally or by regular first class mail, the Findings and Order on the employer and, if a complaint has been filed, the complainant.
- F.** The Director of the Department shall sign the written Findings and Order issued by the Department.
- G.** If an employer does not comply with a Findings and Order issued by the Department within 10 days following finality of the Findings and Order, the Department may refer the matter to a law enforcement officer.

Historical Note

New Section made by emergency rulemaking at 13 A.A.R. 473, effective January 25, 2007 for 180 days (Supp. 07-1). Emergency renewed at 13 A.A.R. 2785, effective July 17, 2007 for 180 days (Supp. 07-3). New Section made by final rulemaking at 13 A.A.R. 4315, effective January 13, 2008 (Supp. 07-4).

R20-5-1214. Review of Department Findings and Order; Hearings; Issuance of Decision Upon Hearing

- A.** Except as provided in R20-5-1213(D), a party aggrieved by a Findings and Order issued by the Department may request a hearing by filing a written request for hearing with the Department within 30 days after the Findings and Order is served upon the party. Failure to timely file a request for hearing means that the Findings and Order issued by the Department is final and res judicata to all parties.
- B.** A request for hearing shall be in writing and contain:
 - 1. The name and address of the party requesting the hearing,
 - 2. The signature of the party or the party's authorized representative, and
 - 3. A statement that a hearing is requested.

- C.** Upon receipt of a timely filed request for hearing, the Department shall refer the matter to the Administrative Law Judge Division of the Commission for hearing.
- D.** Except as otherwise provided in this Section, the hearing shall be conducted under A.R.S. § 41-1061 et seq.
- E.** A person submitting correspondence or other documents, including subpoena requests, to an administrative law judge concerning a matter pending before the administrative law judge, shall contemporaneously serve a copy of the correspondence or other document upon all other parties, or if represented, the parties' authorized representative.
- F.** The administrative law judge may dismiss a request for hearing when it appears to the judge's satisfaction that the parties have resolved the disputed issue or issues.
- G.** The administrative law judge shall issue a written decision upon hearing containing findings of fact and conclusions of law no later than 30 days after the matter is submitted for decision. The decision shall be sent to the parties at their last known addresses served personally or by regular first class mail.
- H.** A decision issued under this Section is final when entered unless a party files a request for rehearing or review as provided in R20-5-1215 or commences an action in the Superior Court as provided in R20-5-1216 and A.R.S. § 12-901 et seq. The decision shall contain a statement explaining the review rights of a party.

Historical Note

New Section made by emergency rulemaking at 13 A.A.R. 473, effective January 25, 2007 for 180 days (Supp. 07-1). Emergency renewed at 13 A.A.R. 2785, effective July 17, 2007 for 180 days (Supp. 07-3). New Section made by final rulemaking at 13 A.A.R. 4315, effective January 13, 2008 (Supp. 07-4).

R20-5-1215. Request for Rehearing or Review of Decision Upon Hearing

- A.** A party may request rehearing or review of a decision issued under R20-5-1214 by filing with the Administrative Law Judge a written request for rehearing or review no later than 15 days after the written decision is served personally or by regular first class mail upon the parties.
- B.** A request for rehearing or review shall be based upon any of the following causes that materially affected the rights of an aggrieved party:
 - 1. Irregularities in the hearing proceeding or any order, or abuse of discretion that deprives a party seeking review of a fair hearing;
 - 2. Accident or surprise that could not have been prevented by ordinary prudence;
 - 3. Newly discovered material evidence that could not have been discovered with reasonable diligence and produced at the hearing;
 - 4. Error in the admission or rejection of evidence, or errors of law occurring at the hearing;
 - 5. Bias or prejudice of the Department or administrative law judge; and
 - 6. The findings of fact or conclusions of law contained in the decision are not justified by the evidence or are contrary to law.
- C.** A request for rehearing or review shall state the specific facts and law in support of the request and shall specify the relief sought by the request.
- D.** A party shall have 15 days from the date of the filing of a request for rehearing or review to file a written response. Failure to respond shall not be deemed an admission against interest.

- E. The administrative law judge shall issue a decision upon review no later than 30 days after receiving a request for review or response, if one is filed.
- F. A decision upon review is final unless a party seeks judicial review as provided in R20-5-1216.

Historical Note

New Section made by emergency rulemaking at 13 A.A.R. 473, effective January 25, 2007 for 180 days (Supp. 07-1). Emergency renewed at 13 A.A.R. 2785, effective July 17, 2007 for 180 days (Supp. 07-3). New Section made by final rulemaking at 13 A.A.R. 4315, effective January 13, 2008 (Supp. 07-4).

R20-5-1216. Judicial Review of Decision Upon Hearing or Decision Upon Review

- A. A party aggrieved by a decision upon hearing issued under R20-5-1214 or a decision upon review issued under R20-5-1215 may seek review by commencing an action in the Superior Court as provided in A.R.S. § 12-901 et seq. within 35 days from the date a copy of the decision sought to be reviewed is served personally or by regular first class mail upon the party affected.
- B. A decision upon hearing issued under R20-5-1214 or a decision upon review issued under R20-5-1215 is final unless a party seeks judicial review as provided under A.R.S. § 12-901 et seq.

Historical Note

New Section made by emergency rulemaking at 13 A.A.R. 473, effective January 25, 2007 for 180 days (Supp. 07-1). Emergency renewed at 13 A.A.R. 2785, effective July 17, 2007 for 180 days (Supp. 07-3). New Section made by final rulemaking at 13 A.A.R. 4315, effective January 13, 2008 (Supp. 07-4).

R20-5-1217. Assessment of Civil Penalties Under A.R.S. § 23-364(F)

The Department may assess civil penalties for violations of the Act and this Article, including the assessment of civil penalties for engaging in conduct that hinders an investigation of the Department as specified in R20-5-1212.

Historical Note

New Section made by emergency rulemaking at 13 A.A.R. 473, effective January 25, 2007 for 180 days (Supp. 07-1). Emergency renewed at 13 A.A.R. 2785, effective July 17, 2007 for 180 days (Supp. 07-3). New Section made by final rulemaking at 13 A.A.R. 4315, effective January 13, 2008 (Supp. 07-4).

R20-5-1218. Collection of Wages or Penalty Payments Owed

- A. Upon determination that wages or penalty payments are due and unpaid to any employee, the employee may, or the Department may on behalf of an employee, obtain judgment and execution, garnishment, attachment, or other available remedies for collection of unpaid wages and penalty payments established by a final Findings and Order of the Department.
- B. If payment cannot be made to the employee, the Department shall receive monetary compensation or penalty payments on behalf of the employee and transmit monies it receives as payment in a special state fund as provided in A.R.S. § 23-356(C).
- C. The Department may amend a Findings and Order to conform to the legal name of the business or the person who is the defendant employer to a complaint under the Act, provided service of the Findings and Order was made on the defendant

or the defendant's agent. If a judgment has been entered on the order, the Department may apply to the clerk of the superior court to amend a judgment that has been issued under a final order, provided service was made on the defendant or the defendant's agent.

Historical Note

New Section made by emergency rulemaking at 13 A.A.R. 473, effective January 25, 2007 for 180 days (Supp. 07-1). Emergency renewed at 13 A.A.R. 2785, effective July 17, 2007 for 180 days (Supp. 07-3). New Section made by final rulemaking at 13 A.A.R. 4315, effective January 13, 2008 (Supp. 07-4).

R20-5-1219. Resolution of Disputes

Notwithstanding any other provision of law, the Department may mediate and conciliate a dispute between the parties.

Historical Note

New Section made by emergency rulemaking at 13 A.A.R. 473, effective January 25, 2007 for 180 days (Supp. 07-1). Emergency renewed at 13 A.A.R. 2785, effective July 17, 2007 for 180 days (Supp. 07-3). New Section made by final rulemaking at 13 A.A.R. 4315, effective January 13, 2008 (Supp. 07-4).

R20-5-1220. Small Employer Request for Exception to Recordkeeping Requirements

- A. In this Section, unless context otherwise requires, "small employer" means a corporation, proprietorship, partnership, joint venture, limited liability company, trust, or association that has less than \$500,000 in gross annual revenue.
- B. A small employer, or any category of small employer that is unreasonably burdened by the recordkeeping requirements of the Act and this Article may file a written petition for exception with the Department requesting relief from certain recordkeeping requirements under this Article. The petition shall:
 1. State the reasons for the request for relief;
 2. State an alternate manner or method of making, keeping, and preserving records that will enable the Department to determine hours worked and wages paid; and
 3. Include the signature of the employer or an authorized representative of the employer.
- C. Subject to any conditions or limitations necessary to ensure fulfillment of the purpose and intent of Act, the Department may grant a petition for exception if it finds that:
 1. The small employer, or category of small employer is unreasonably burdened by the recordkeeping requirements of the Act and this Article; and
 2. The relief requested and alternative proposed will not hinder the Department's enforcement of the Act and this Article.
- D. For good cause, the Department may rescind a prior order granting relief under this Section.
- E. Relief under this Section is effective upon the Department's written authorization.

Historical Note

New Section made by emergency rulemaking at 13 A.A.R. 473, effective January 25, 2007 for 180 days (Supp. 07-1). Emergency renewed at 13 A.A.R. 2785, effective July 17, 2007 for 180 days (Supp. 07-3). New Section made by final rulemaking at 13 A.A.R. 4315, effective January 13, 2008 (Supp. 07-4).

TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE**CHAPTER 6. DEPARTMENT OF INSURANCE**

Authority: A.R.S. § 20-101 et seq.

20 A.A.C. 6, consisting of R20-6-101 through R20-6-159, R20-6-201 through R20-6-218, R20-6-301 through R20-6-308, R20-6-401 through R20-6-409, R20-6-501, R20-6-601 through R20-6-607, R20-6-701 through R20-6-709, R20-6-801 through R20-6-802, R20-6-901, R20-6-1001 through R20-6-1016, R20-6-1101 through R20-6-1120, R20-6-1201 through R20-6-1205, R20-6-1401 through R20-6-1408, R20-6-1601 through R20-6-1607, and R20-6-1701 through R20-6-1704 recodified from 4 A.A.C. 14, consisting of R4-14-101 through R4-14-159, R4-14-201 through R4-14-218, R4-14-301 through R4-14-308, R4-14-401 through R4-14-409, R4-14-501, R4-14-601 through R4-14-607, R4-14-701 through R4-14-709, R4-14-801 through R4-14-802, R4-14-901, R4-14-1001 through R4-14-1016, R4-14-1101 through R4-14-1120, R4-14-1201 through R4-14-1205, R4-14-1401 through R4-14-1408, R4-14-1601 through R4-14-1607, and R4-14-1701 through R4-14-1704, pursuant to R1-1-102 (Supp. 95-1).

ARTICLE 1. HEARING PROCEDURES AND RULEMAKING PETITIONS

Section

R20-6-101.	Scope of Article; Definitions
R20-6-102.	Appearance and Practice before the Director
R20-6-103.	Filing; Service
R20-6-104.	Expired
R20-6-105.	Expired
R20-6-106.	Answer to Notice of Hearing
R20-6-107.	Expired
R20-6-108.	Expired
R20-6-109.	Expired
R20-6-110.	Expired
R20-6-111.	Hearings
R20-6-112.	Order of Presentation
R20-6-113.	Expired
R20-6-114.	Request for Rehearing or Review
R20-6-115.	Response to Request for Rehearing
R20-6-116.	Reserved through
R20-6-158.	Reserved
R20-6-159.	Repealed
R20-6-160.	Petition for Rulemaking Action

ARTICLE 2. TRANSACTION OF INSURANCE

Section

R20-6-201.	Advertisements of Health Insurance
R20-6-201.01.	Insurer Advertising Responsibility and Records
R20-6-201.02.	Procedures for Filing Advertising Materials; Transmittal Form
R20-6-202.	Advertising, Solicitation, and Transaction of Life Insurance
R20-6-203.	Form Filings; Translations
R20-6-204.	Surplus Lines Brokers' Filing Requirements; List of Unauthorized Insurers
R20-6-205.	Local or Regional Retaliatory Tax Information
R20-6-206.	Industrial Insureds
R20-6-207.	Gender Discrimination
R20-6-208.	Group Coverage Discontinuance and Replacement
R20-6-209.	Life Insurance Solicitation
R20-6-210.	Readable and Understandable Policy: Private Passenger Automobile, Homeowner, Personal Line Dwelling, and Mobile Homeowner
R20-6-211.	Discrimination on the Basis of Blindness or Partial Blindness
R20-6-212.	Forms for Replacement of Life Insurance Policies and Annuities
R20-6-212.01.	Forms for Buyer's Guide for Annuities
R20-6-213.	Life and Disability Insurance Policy Language Simplification
R20-6-214.	Coordination of Benefits
Exhibit A.	Expired
R20-6-215.	Renumbered

R20-6-215.01.	Renumbered
R20-6-216.	Renumbered
R20-6-217.	Renumbered
R20-6-218.	Repealed

ARTICLE 3. FINANCIAL PROVISIONS AND PROCEDURES

Section

R20-6-301.	Expired
R20-6-302.	Expired
R20-6-303.	Termination of Certificate of Authority and Release of Deposit
R20-6-304.	Reserved
R20-6-305.	Expired
R20-6-306.	Reserved
R20-6-307.	Life and Disability Reinsurance Agreements
Table A.	Risk Categories
R20-6-308.	Determination of Insurer's Hazardous Financial Condition
R20-6-309.	Expired
R20-6-309.01.	Expired
R20-6-309.02.	Expired
R20-6-309.03.	Expired
R20-6-309.04.	Expired
Appendix A.	Expired

ARTICLE 4. TYPES OF INSURANCE COMPANIES

Section

R20-6-401.	Proxies, Consents, and Authorizations of Domestic Stock Insurers
R20-6-402.	Expired
Exhibit A.	Expired
Exhibit B.	Expired
R20-6-403.	Expired
Appendix A.	Expired
Appendix B.	Expired
Appendix C.	Expired
R20-6-404.	Repealed
R20-6-405.	Health Care Services Organization
R20-6-406.	Expired
R20-6-407.	Service Companies
R20-6-408.	Motor Vehicle Service Contract Program
R20-6-409.	Hospital, Medical, Dental, and Optometric Service Corporations

ARTICLE 5. THE INSURANCE CONTRACT

Section

R20-6-501.	Ten-day Period to Examine Disability Insurance Policy
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ARTICLE 6. TYPES OF INSURANCE CONTRACTS

Section

R20-6-601.	Regulations Governing Bail Transactions
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R20-6-602. Nationwide Inland Marine Definition
 R20-6-603. Repealed
 R20-6-604. Definitions
 Exhibit A. Repealed
 R20-6-604.01. Rights and Treatment of Debtors
 R20-6-604.02. Satisfying the Reasonableness Standard
 R20-6-604.03. Determination of Prima Facie Rates
 R20-6-604.04. Credit Life Insurance Rates and Provisions
 R20-6-604.05. Credit Disability Insurance Rates and Provisions
 R20-6-604.06. Refund Methods
 R20-6-604.07. Experience Reports
 R20-6-604.08. Use of Prima Facie Rates; Rate Deviations
 R20-6-604.09. Supervision of Consumer Credit Insurance Operations
 R20-6-604.10. Prohibited Transactions
 R20-6-605. Emergency Expired
 R20-6-606. Repealed
 R20-6-607. Reasonableness of Benefits in Relation to Premium Charged

ARTICLE 7. LICENSING PROVISIONS AND PROCEDURES

Section

R20-6-701. Repealed
 R20-6-702. Expired
 R20-6-703. Expired
 R20-6-704. Expired
 R20-6-705. Expired
 R20-6-706. Expired
 R20-6-707. Expired
 R20-6-708. Licensing Time-frames
 R20-6-709. Repealed
 Table A. Licensing Time-frames Table

ARTICLE 8. PROHIBITED PRACTICES, PENALTIES

Section

R20-6-801. Unfair Claims Settlement Practices
 R20-6-802. Emergency Expired

ARTICLE 9. TERMINATION OR DISSOLUTION

Section

R20-6-901. Reserved

ARTICLE 10. LONG-TERM CARE INSURANCE

Article 10, consisting of Sections R4-14-1001 through R4-14-1016 and Appendices A through C, adopted effective August 10, 1992 (Supp. 92-2). R20-6-1001 through R20-6-1016 recodified from R4-14-1001 through R4-14-1016 (Supp. 95-1).

Section

R20-6-1001. Applicability and Scope
 R20-6-1002. Definitions
 R20-6-1003. Policy Terms
 R20-6-1004. Required Policy Provisions
 R20-6-1005. Unintentional Lapse
 R20-6-1006. Inflation Protection
 R20-6-1007. Required Disclosure Provisions
 R20-6-1008. Required Disclosure of Rating Practices to Consumers
 R20-6-1009. Initial Filing Requirements
 R20-6-1010. Requirements for Application Forms and Replacement Coverage
 R20-6-1011. Prohibition Against Post-claims Underwriting
 R20-6-1012. Discretionary Powers of Director
 R20-6-1013. Reserve Standards
 R20-6-1014. Loss Ratio
 R20-6-1015. Premium Rate Schedule Increase

R20-6-1016. Filing Requirement for Group Policies
 R20-6-1017. Standards for Marketing
 R20-6-1018. Suitability
 R20-6-1019. Nonforfeiture Benefit Requirement
 R20-6-1020. Standards for Benefit Triggers
 R20-6-1021. Additional Standards for Benefit Triggers for Qualified Long-term Care Insurance Contracts
 R20-6-1022. Standard Format Outline of Coverage
 R20-6-1023. Requirement to Deliver Shopper's Guide
 R20-6-1024. Instructions for Appendices
 Appendix A. Long-term Care Insurance Personal Worksheet
 Appendix B. Long-term Care Insurance Potential Rate Increase Disclosure Form
 Appendix C. Notice to Applicant Regarding Replacement of Individual Health or Long-term Care Insurance
 Appendix D. Notice to Applicant Regarding Replacement of Health or Long-term Care Insurance
 Appendix E. Long-term Care Insurance Replacement and Lapse Reporting Form
 Appendix F. Long-term Care Insurance Claims Denial Reporting Form
 Appendix G. Rescission Reporting Form for Long-term Care Policies
 Appendix H. Things You Should Know Before You Buy Long-term Care Insurance
 Appendix I. Long-term Care Insurance Suitability Letter
 Appendix J. Long-term Care Insurance Outline of Coverage

ARTICLE 11. MEDICARE SUPPLEMENT INSURANCE

Article 11, consisting of Sections R20-6-1101 through R20-6-1121 and Appendices A through F, repealed; new Section R20-6-1101 made by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

Article 11, consisting of Sections R4-14-1101 through R4-14-1120 and Appendices A through E, adopted again by emergency effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1).

Article 11, consisting of Sections R4-14-1101 through R4-14-1120 and Appendices A through E, adopted by emergency effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). R20-6-1101 through R20-6-1120 recodified from R4-14-1101 through R4-14-1120 (Supp. 95-1).

Section

R20-6-1101. Incorporation by Reference and Modifications
 R20-6-1102. Repealed
 R20-6-1102.01. Repealed
 R20-6-1103. Repealed
 R20-6-1104. Repealed
 R20-6-1105. Repealed
 R20-6-1106. Repealed
 R20-6-1107. Repealed
 R20-6-1108. Repealed
 R20-6-1109. Repealed
 R20-6-1110. Repealed
 R20-6-1111. Repealed
 R20-6-1112. Repealed
 R20-6-1113. Repealed
 R20-6-1114. Repealed
 R20-6-1115. Repealed
 R20-6-1116. Repealed
 R20-6-1117. Repealed
 R20-6-1118. Repealed
 R20-6-1119. Repealed
 R20-6-1120. Repealed
 R20-6-1121. Repealed

Department of Insurance

Appendix A. Repealed
 Appendix B. Repealed
 Appendix C. Repealed
 Appendix D. Repealed
 Appendix E. Repealed
 Appendix F. Repealed

ARTICLE 12. HIV/AIDS: PROHIBITED AND REQUIRED PRACTICES

Section

R20-6-1201. Definitions
 R20-6-1202. Applications for Insurance
 R20-6-1203. Testing for HIV; Consent Form
 R20-6-1204. Release of Confidential HIV-related Information; Release Form
 R20-6-1205. Benefits; Prohibited Practices

ARTICLE 13. RESERVED

ARTICLE 14. INSURANCE HOLDING COMPANY

Article 14, consisting of Sections R4-14-1401 through R4-14-1408 and Appendices A through E, adopted effective February 22, 1993 (Supp. 93-1). R20-6-1401 through R20-6-1408 recodified from R4-14-1401 through R4-14-1408 (Supp. 95-1).

Section

R20-6-1401. Definitions
 R20-6-1402. Acquisition of Control – Statement Filing
 R20-6-1403. Annual Registration of Insurers – Statement Filing
 R20-6-1404. Summary of Registration – Statement Filing
 R20-6-1405. Alternative and Consolidated Registrations
 R20-6-1406. Disclaimers and Termination of Registration
 R20-6-1407. Transactions Subject to Prior Notice – Notice Filing
 R20-6-1408. Extraordinary Dividends and Other Distributions
 Appendix A. Form A - Statement Regarding the Acquisition of, Control of, or Merger with a Domestic Insurer
 Appendix B. Form B - Insurance Holding Company System Annual Registration Statement
 Appendix C. Form C - Summary of Registration Statement
 Appendix D. Form D - Prior Notice of a Transaction
 Appendix E. Instructions on Forms A, B, C, D

ARTICLE 15. RESERVED

ARTICLE 16. CREDIT FOR REINSURANCE

Article 16, consisting of Sections R4-14-1601 through R4-14-1607 and Appendix A, adopted effective February 3, 1993 (Supp. 93-1). R20-6-1601 through R20-6-1607 recodified from R4-14-1601 through R4-14-1607 (Supp. 95-1).

Section

R20-6-1601. Credit for Reinsurance
 R20-6-1602. Reduction from Liability for Reinsurance Ceded to an Unauthorized Assuming Insurer
 R20-6-1603. Trust Agreements
 R20-6-1604. Letters of Credit
 R20-6-1605. Other Security
 R20-6-1606. Reinsurance Contract
 R20-6-1607. Contracts Affected
 Exhibit A. Form AR-1 - Power of Attorney and Certificate of Assuming Insurer
 Exhibit B. Certified Copy of Resolution

ARTICLE 17. EXAMINATIONS

Article 17, consisting of Sections R4-14-1701 through R4-14-1704, adopted effective February 22, 1993 (Supp. 93-1). R20-6-1701 through R20-6-1704 recodified from R4-14-1701 through R4-14-1704 (Supp. 95-1).

Section

R20-6-1701. Definitions
 R20-6-1702. Authority, Scope, and Scheduling of Examinations
 R20-6-1703. Conduct of Examinations
 R20-6-1704. Examination Reports

ARTICLE 18. PREPAID DENTAL PLAN ORGANIZATIONS

Article 18, consisting of Sections R20-6-1801 through R20-6-1813, made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

Section

R20-6-1801. Definitions
 R20-6-1802. Application for Certificate of Authority
 R20-6-1803. Chief Executive Officer
 R20-6-1804. Dental Director
 R20-6-1805. Required Reporting
 R20-6-1806. Basic Dental Services
 R20-6-1807. System for Delivery of Services
 R20-6-1808. Geographic Areas
 R20-6-1809. Contract Requirements
 R20-6-1810. Records
 R20-6-1811. Quality Improvement
 R20-6-1812. Confidentiality of Records
 R20-6-1813. Assignment of Members

ARTICLE 19. HEALTH CARE SERVICES ORGANIZATIONS OVERSIGHT

Article 19, consisting of Sections R20-6-1901 through R20-6-1911, made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2).

Section

R20-6-1901. Applicability
 R20-6-1902. Definitions
 R20-6-1903. Documentation
 R20-6-1904. Health Care Plan
 R20-6-1905. Geographic Area
 R20-6-1906. Chief Executive Officer
 R20-6-1907. Medical Director
 R20-6-1908. Quality Assurance
 R20-6-1909. Evaluation of Network
 R20-6-1910. Process for Referral, Prior Authorization, Pre-certification, or Network Exception
 R20-6-1911. HCSC Communication with Providers
 R20-6-1912. Network Directories
 R20-6-1913. Demographic Information Reports
 R20-6-1914. Access
 R20-6-1915. Alternative Access
 R20-6-1916. Availability Ratios
 R20-6-1917. Geographic Availability in an Urban Area
 R20-6-1918. Geographic Availability in a Suburban Area
 R20-6-1919. Geographic Availability in a Rural Area
 R20-6-1920. Travel Requirements
 R20-6-1921. Enforcement Consideration

ARTICLE 20. CAPTIVE INSURERS

Article 20, consisting of Sections R20-6-2001 and R20-6-2002, made by final rulemaking at 8 A.A.R. 2478, effective July 1, 2002 (Supp. 02-2).

Section

R20-6-2001. Reserved
 R20-6-2002. Fees; Examination Costs

ARTICLE 21. CUSTOMER INFORMATION SECURITY PROGRAM

Article 21, consisting of R20-6-2101 through R20-6-2104,

made by final rulemaking at 10 A.A.R. 2260, effective July 13, 2004 (Supp. 04-2).

Section

- R20-6-2101. Definitions
- R20-6-2102. Customer Information Security Program
- R20-6-2103. Objectives of Customer Information Security Program
- R20-6-2104. Guidelines of Methods of Development and Implementation

ARTICLE 22. MILITARY PERSONNEL

Section

- R20-6-2201. Military Sales Practices

ARTICLE 23. THRESHOLD RATE REVIEW – INDIVIDUAL HEALTH INSURANCE

Article 23, consisting of R20-6-2301 through R20-6-2305, made by final rulemaking at 18 A.A.R. 2721, effective October 3, 2012 (Supp. 12-4).

Section

- R20-6-2301. Applicability; Definitions
- R20-6-2302. Disclosure of Preliminary Justification
- R20-6-2303. Timing for Submission of Preliminary Justification
- R20-6-2304. Response to Unreasonableness Determination
- R20-6-2305. Threshold Rate Increase Documentation Requirements

ARTICLE 1. HEARING PROCEDURES AND RULEMAKING PETITIONS

R20-6-101. Scope of Article; Definitions

- A.** Scope. This Article and Title 20 of the Arizona Revised Statutes govern contested cases before the Department. Except as otherwise provided in R20-6-160 for rulemaking petitions, this Article does not apply to rulemaking or investigative proceedings before the Department. Unless expressly applicable by rule or statute, the Arizona Rules of Civil Procedure do not apply to contested cases.
- B.** Definitions. In this Article, the following definitions apply:
 1. "Attorney General" means the Attorney General of Arizona, and the Attorney General's assistants or special agents.
 2. "Contested case" means any proceeding in which the legal rights, duties or privileges of a party are required by law to be determined by the Director after an opportunity for hearing.
 3. "Department" means the Arizona Department of Insurance.
 4. "Hearing Officer" means a person appointed by the Director to hear a contested case and make recommendations.
 5. "Party" has the meaning prescribed in A.R.S. § 41-1001(12).
 6. "Person" has the meaning prescribed in A.R.S. § 41-1001(13).
 7. "Director" means the Director of the Department or a hearing officer or any deputy, assistant or examiner of the Director acting in the Director's name in accordance with A.R.S. § 20-150.

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-101 recodified from R4-14-101 (Supp. 95-1). Amended by final rulemaking at 5 A.A.R. 618, effective February 4, 1999 (Supp. 99-1).

R20-6-102. Appearance and Practice before the Director

- A.** Any person may appear in his own behalf or through counsel. An insurer may appear through legal counsel or through a duly authorized officer of the corporation.
- B.** When an attorney other than the Attorney General appears or intends to appear before the Director, he shall promptly advise the Director of his name, address and telephone number and the name and address of the person on whose behalf he intends to appear.
- C.** Conduct at any hearing which, in the discretion of the Director, is deemed contemptuous shall be grounds for exclusion from the hearing. Contemptuous conduct shall include willful noncompliance with an order of the Director or hearing officer, willful disruption or obstruction of any hearing, or any other willful conduct during any hearing which lessens the dignity or authority of the Director or hearing officer.

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-102 recodified from R4-14-102 (Supp. 95-1).

R20-6-103. Filing; Service

- A.** No paper shall be deemed filed until received by the Director.
- B.** Unless otherwise provided by these rules, copies of all papers filed shall, at or before the time of filing, be served on the hearing officer, the Attorney General, and all parties to the proceeding.
- C.** Whenever under these rules service is required or permitted to be made upon a party represented by an attorney, the service shall be made upon the attorney.
- D.** Service upon the attorney, or upon a party, shall be made personally in accordance with Rule 5(c) of the Arizona Rules of Civil Procedure, or by mail by enclosing a copy thereof in a sealed envelope and depositing same, postage prepaid, in the United States mail, addressed to the party to be served or his attorney at the address as shown by the records of the Director. Service by mail is complete upon deposit in the United States Mail.
- E.** All notices of hearing and final decisions issued by the Director shall be served by mail.
- F.** Proof of service shall be made by filing with the Director a written statement that service was made.

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-103 recodified from R4-14-103 (Supp. 95-1).

R20-6-104. Expired

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-104 recodified from R4-14-104 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 1421, effective May 31, 2011 (Supp. 11-3).

R20-6-105. Expired

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-105 recodified from R4-14-105 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 1421, effective May 31, 2011 (Supp. 11-3).

R20-6-106. Answer to Notice of Hearing

- A.** In any notice of hearing, the Director may require that one or more parties shall file a written answer to the allegations contained in the notice of hearing. Even if not directed to do so, any party may file such an answer.
- B.** Except where a different period is provided by the notice of hearing, a party directed to file a written answer shall do so

within 20 days after issuance of the notice of hearing. Where amendments to the assertions contained in the notice of hearing are made subsequent to service of the notice of hearing, one or more of the parties may be required to answer within a reasonable time the amended assertions.

- C. Unless otherwise directed by the Director, an answer filed under this rule shall briefly state the party's position or defense to the proceeding and shall specifically admit or deny each of the assertions contained in the notice of hearing. If the answering party is without or is unable to reasonably obtain knowledge or information sufficient to form a belief as to the truth of an assertion, he shall so state, which shall have the effect of a denial. Any assertion not denied shall be deemed to be admitted. When answering party intends in good faith to deny only a part of an assertion, he shall specify so much of it as is true and shall deny only the remainder.
- D. If a party fails to file an answer required by the Director within the time provided, such person shall be deemed in default and the proceeding may be determined against him by the Director and one or more of the assertions contained in the notice of hearing may be deemed to be admitted.
- E. Any defenses not raised in the answer shall be deemed to be waived.

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-106 recodified from R4-14-106 (Supp. 95-1).

R20-6-107. Expired

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-107 recodified from R4-14-107 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 1421, effective May 31, 2011 (Supp. 11-3).

R20-6-108. Expired

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-108 recodified from R4-14-108 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 1421, effective May 31, 2011 (Supp. 11-3).

R20-6-109. Expired

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-109 recodified from R4-14-109 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 1421, effective May 31, 2011 (Supp. 11-3).

R20-6-110. Expired

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-110 recodified from R4-14-110 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 1421, effective May 31, 2011 (Supp. 11-3).

R20-6-111. Hearings

- A. Hearings may be presided over by a hearing officer designated by the Director. All such hearings shall be open to the public, except as provided in A.R.S. § 20-164. A hearing officer appointed by the Director may make all determinations and enter all orders and process which the Director is authorized to make or issue under these rules or any other order necessary for the orderly conduct of the hearing.
- B. Any challenge of the hearing officer shall be made in the form of a written motion specifying the grounds for disqualification of the hearing officer and shall be served as soon as practicable

under the circumstances, but no later than 15 days after the person discovers that such grounds exist or should have discovered with reasonable diligence. The Director shall rule upon the challenge prior to the commencement or continuation of the hearing.

- C. The hearing officer shall regulate the course of the hearing in an impartial manner and shall rule upon procedural and evidentiary matters incidental thereto. The hearing officer may question witnesses. Upon motion of any party, a witness may be excluded from the hearing by the hearing officer prior to his or her testimony, except that this rule shall not be used to exclude a party to the proceeding.
- D. All motions and objections made during the course of a hearing shall be made to the hearing officer who shall rule thereon or take them under advisement for later determination. Objections to the admission or exclusion of evidence shall be made on the record and shall state the grounds of objections relied upon.
- E. The hearing proceedings shall be stenographically reported by a certified court reporter or mechanically recorded under the direction of a hearing officer who shall retain control of the used reel or tape following conclusion of the hearing.
- F. By order of the Director or the hearing officer, proceedings involving a common question of fact or a common respondent may be consolidated for hearing of any or all of the matters at issue where such consolidation may tend to facilitate a just and efficient resolution.
- G. At the discretion of the Director, the hearing record may be held open for a reasonable period of time at the conclusion of the hearing to permit the presentation of additional written arguments, memoranda, evidence or responsive pleadings. At the close of such period, the hearing record shall close.

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-111 recodified from R4-14-111 (Supp. 95-1).

R20-6-112. Order of Presentation

All witnesses at a hearing shall testify under oath or affirmation. The parties may make an opening and closing statement. In matters brought at the request of the Director, evidence in support of the Director's action shall be presented first, then the respondent may present evidence in support of his or her position, and then there may be rebuttal and surrebuttal evidence presented. In matters brought at the request of a person other than the Director, including requests for hearing on the denial of a license and other hearings brought pursuant to A.R.S. § 20-161(B), the person seeking the hearing shall present his or her evidence first. The parties may present evidence and conduct cross-examination. The hearing officer shall rule upon the admissibility of evidence sua sponte or upon objection of any party.

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-112 recodified from R4-14-112 (Supp. 95-1).

R20-6-113. Expired

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-113 recodified from R4-14-113 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 1421, effective May 31, 2011 (Supp. 11-3).

R20-6-114. Request for Rehearing or Review

- A. Within 30 days after service of the Director's order on the hearing, any aggrieved party may request a rehearing or review of the order. The request shall be in writing and shall be served upon the Director as provided by R20-6-103, and a

copy shall be served upon all other parties to the hearing, including the Attorney General if the Attorney General is not the party filing the request.

- B.** A request for rehearing or review shall be based upon one or more of the following grounds which have materially affected the rights of a party:
1. Irregularity in the hearing proceedings, or any order or abuse of discretion whereby the party seeking rehearing or review was deprived of a fair hearing;
 2. Misconduct by the Director, the hearing officer or any party to the hearing;
 3. Accident or surprise which could not have been prevented by ordinary prudence;
 4. Newly discovered material evidence which could not have been discovered with reasonable diligence and produced at the hearing;
 5. Excessive or insufficient sanctions or penalties imposed;
 6. Error in the admission or rejection of evidence, or errors of law occurring at the hearing or during the course of the hearing;
 7. Bias or prejudice of the Director or hearing officer;
 8. That the order, decision, or findings of fact are not justified by the evidence or are contrary to law.
- C.** A request for rehearing or review shall specify which of the grounds listed in subsection (B) it is based upon and shall set forth specific facts and laws in support of the request. A request may cite relevant portions of testimony from the hearing by referring to the pages or lines of the reporter's transcript of the hearing and may cite hearing exhibits by reference to the exhibit number.
- D.** A request for rehearing shall specify the relief sought by the request, such as a different finding of fact, conclusion of law or order. A request for rehearing or review may seek multiple forms of relief in the alternative.
- E.** When a request for rehearing is based upon affidavits, they shall be attached to and filed with the request unless leave for later filing of affidavits is granted by the Director or hearing officer. Leave may be granted ex parte.
- F.** A request for rehearing or review of the Director's order on the hearing which is not timely made is deemed waived for the purpose of judicial review. A party who fails to request rehearing or review of the Director's order on the hearing shall be barred from raising a claim in any proceeding in which the Director, the hearing officer or the Department of Insurance is a party, except as otherwise required by law.
- G.** A party may file a written request for a stay of the Director's decision. An order entered by the Director shall not be stayed by the filing of a stay request or a request for rehearing or review. The Director may stay an order pending the resolution of a request for rehearing or review or when justice requires.

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-114 recodified from R4-14-114 (Supp. 95-1). Amended effective June 15, 1998 (Supp. 98-2).

R20-6-115. Response to Request for Rehearing

- A.** Each party served with a request for rehearing pursuant to R20-6-114 shall be permitted to file a response within 15 days after the request for rehearing has been filed. This response shall be designated as a "response to request for rehearing or review" and shall be in writing. Affidavits may be attached to and filed with the response. If not filed in this manner, an affidavit shall be filed only if leave for later filing of affidavits is granted by the hearing officer or Director. Leave may be granted ex parte. The original response shall be filed with the Department as provided in R20-6-103, and one copy shall be

served upon all other parties to the hearing, including the Attorney General if the Attorney General is not the party filing the response.

- B.** The hearing officer or Director has the discretion to convene a hearing or hear oral argument to consider a request for rehearing.

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-115 recodified from R4-14-115 (Supp. 95-1). Amended effective June 15, 1998 (Supp. 98-2).

R20-6-116. Reserved through

R20-6-158. Reserved

R20-6-159. Repealed

Historical Note

Adopted effective February 17, 1977 (Supp. 77-1). R20-6-159 recodified from R4-14-159 (Supp. 95-1). Repealed effective June 15, 1998 (Supp. 98-2).

R20-6-160. Petition for Rulemaking Action

- A.** The following definitions apply in this Section.
1. "Department" means the Arizona Department of Insurance.
 2. "Director" means the Director of the Department of Insurance.
 3. "Petitioner" means a person who petitions the Department for rulemaking action.
 4. "Rulemaking action" means the process for formulation and finalization of a new rule, or amendment or repeal of an existing rule.
- B.** Any person may petition the Department under A.R.S. § 41-1033 for rulemaking action.
- C.** A person who seeks rulemaking action shall file, with the Director, a petition with the following information:
1. The petitioner's name, address, and telephone number;
 2. The name and address of any organization the petitioner represents;
 3. A statement of the rulemaking action the petitioner seeks, including:
 - a. A citation to any existing rule, substantive policy statement, or Department practice to be amended or repealed; and
 - b. The specific language of a proposed new rule or rule amendment;
 4. The reasons for the rulemaking action, including an explanation of why an existing rule, substantive policy statement, or Department practice is inadequate, unreasonable, unduly burdensome, or unlawful; and
 5. The petitioner's dated signature.
- D.** The petitioner may submit additional supporting information, including:
1. Statistical data; and
 2. A list of other persons and entities likely to be affected by the proposed rulemaking action, with an explanation of the likely effects.
- E.** Within 60 days of the date the Department receives the petition, the Department shall send the petitioner a written decision indicating whether the Department is denying the petition or will initiate the requested rulemaking action, with the reasons for the decision.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 618, effective February 4, 1999 (Supp. 99-1). Section heading corrected at Department Request, Office File No.

M11-401, filed October 27, 2011 (Supp. 11-3).

ARTICLE 2. TRANSACTION OF INSURANCE

R20-6-201. Advertisements of Health Insurance

A. Definitions. The following definitions apply to this Section and to R20-6-201.01, R20-6-201.02, and R20-6-203:

1. "Advertisement" means materials and information used by an insurer to generate insurance business.
 - a. Advertisement includes the following information:
 - i. Printed and published material, audio visual material, or other forms of electronic communication that an insurer uses or displays in direct mail, newspapers, magazines, radio, television, billboards, Internet web sites, and similar media to inform the public about the insurer or its products;
 - ii. Descriptive literature and sales aids an insurer issues or releases for presentation to members of the public, including circulars, leaflets, booklets, depictions, illustrations, and form letters;
 - iii. Prepared sales talks and presentations and material for use by an insurer or prepared by an insurer for use by authorized producers; and
 - iv. Material included with a policy when the policy is delivered and material used in the solicitation of renewals and reinstatements;
 - b. "Advertisement" does not include the following:
 - i. Material used solely for training and educating an insurer's employees or producers;
 - ii. Material used in-house by insurers;
 - iii. Communications within an insurer's own organization not intended for dissemination to the public;
 - iv. Individual communications with current policy holders regarding a member's personal information other than material urging the policyholders to increase or expand coverages;
 - v. Correspondence between a prospective group or blanket policyholder and an insurer in the course of negotiating a group or blanket contract;
 - vi. Court-approved material ordered by a court to be disseminated to policyholders;
 - vii. Material in connection with promotion or sponsorship of a charitable event in which only the name of the insurer is displayed;
 - viii. A general announcement from a group or blanket policyholder to eligible individuals on an employment or membership list that a contract or program has been written or arranged. The announcement shall clearly indicate that it is preliminary to the issuance of a booklet and that does not describe the specific benefits under the contract or program nor the advantages as to the purchase of the contract or program;
 - ix. A general announcement by the sponsor that endorses the program;
 - x. Health and wellness material with general health and wellness information; or
 - xi. Press releases and news releases not intended to generate business.
 2. "Disability insurance" has the same meaning prescribed in A.R.S. § 20-253.
 3. "Elimination period" means the time between the date a loss occurs and the date that benefits begin to accrue for that loss.
 4. "Exclusion" means a policy term stating a risk that an insurer has not assumed.
 5. "Health insurance" means:
 - a. Disability insurance;
 - b. Insurance provided by a service corporation regulated under A.R.S. § 20-821 et seq.;
 - c. Insurance provided by a prepaid dental plan organization regulated under A.R.S. § 20-1001 et seq.; and
 - d. Insurance provided by a health care services organization regulated under A.R.S. § 20-1051 et seq.
 6. "Insurance administrator" or "administrator" has the meaning prescribed in A.R.S. § 20-485(A)(1).
 7. "Insurer" has the same meaning prescribed in A.R.S. § 20-104.
 8. "Limitation" means a policy term, other than an exclusion or reduction, that decreases the risk assumed by the insurer or the insurer's obligation to provide benefits.
 9. "Person" has the meaning in A.R.S. § 20-105.
 10. "Policy" means any plan, certificate, contract, agreement, statement of coverage, evidence of coverage, subscription contract, membership coverage, rider, or endorsement that provides disability benefits, health insurance, medical, surgical or hospital expense benefits, long-term care benefits, or Medicare supplement benefits in the form of a cash indemnity, reimbursement, or service.
 11. "Reduction" means a policy term that reduces the amount of an insured's benefits. A reduction means that the insurer has assumed the risk of a particular loss, but the amount or period of the insurer's coverage is less than what the insurer would have paid for the loss without the reduction.
 12. "Spokesperson" means a person making a testimonial about or an endorsement of an insurer's product who:
 - a. Has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee, or independent contractor;
 - b. Has been formed by the insurer, is owned or controlled by the insurer or its employees, or is a person who owns or controls an insurer;
 - c. Is in a policy-making position and affiliated with the insurer in any capacity described in subsections (a) or (b); or
 - d. Is directly or indirectly compensated for making the testimonial or endorsement.
- B. Scope.**
1. This Section applies to all advertisements for health insurance.
 2. This Section applies to the conduct of insurers, producers, and third-party administrators.
- C. General requirements.** Insurers, producers, and third-party administrators shall ensure that health insurance advertisements meet the requirements of this Section.
1. Advertisements shall be truthful and not misleading. The insurer shall not use words or phrases, the meaning of which is clear only by implication or by familiarity with insurance terminology.
 2. An advertisement shall not omit information or use words, phrases, statements, references, or illustrations if the omission of information or use of words, phrases, statements, references, or illustrations may mislead or deceive purchasers or prospective purchasers.
 3. The words and phrases used to describe a policy shall accurately describe the benefits of the policy and not

- exaggerate any benefit through the use of phrases such as “all,” “full,” “complete,” “comprehensive,” “unlimited,” “up to,” “as high as,” “this policy will pay your hospital and surgical bills” or “this policy will replace your income,” or similar words and phrases.
4. If a policy covers only one disease or a list of specified diseases, any advertisement for the policy shall not imply coverage beyond the specified diseases.
 5. If a policy pays varying amounts for the same loss occurring under different conditions or pays benefits only when a loss occurs under certain conditions, any advertisement for the policy shall disclose the limited conditions.
 6. If an advertisement specifies payment of a particular dollar amount for hospital room and board expenses, the advertisement shall also include the maximum daily benefit and the maximum time limit for which those expenses are covered.
 7. An advertisement that refers to any dollar amount, period of time for which a benefit is payable, cost of policy, or specific policy benefit or the loss for which a benefit is payable shall also disclose any related exclusions, reductions, and limitations without which the advertisement would have the capacity and tendency to mislead or deceive.
 8. An advertisement covered by subsection (C)(7) shall disclose the existence of a waiting period if a policy contains a period between the effective date of the policy and the effective date of coverage under the policy. The advertisement shall disclose the existence of an elimination period.
 9. An advertisement shall disclose any exclusion, reduction, or limitation applicable to a pre-existing condition; however, an insurer is not required to make disclosure in an advertisement that does not reference specific product information, benefit level, or dollar amounts.
 10. If a policy has an exclusion, reduction, or limitation applicable to a preexisting condition, an advertisement shall not state or imply that the applicant’s physical condition or medical history will not affect the issuance of the policy or payment of a claim and shall not use the phrase “no medical examination required” or other similar phrase.
 11. If an advertisement refers to renewability, cancellation, or termination of a policy, or states or illustrates time or age in connection with eligibility of applicants or continuation of the policy, the advertisement shall disclose the provisions relating to renewability, cancellation, and termination and any modification of benefits, losses covered, or premiums because of age or for other reasons, in a manner that does not minimize or obscure the qualifying conditions.
 12. An advertisement shall not make any offer prohibited under A.R.S. § 20-452(4).
 13. An advertisement shall not advertise any health insurance policy or form that has not been approved by the Department, unless the policy or form being advertised is exempt from approval or not subject to approval by order or statute.
 14. An advertisement shall not state or imply that a product being offered is an introductory, special, or initial offer that will entitle the applicant to receive advantages not described in the policy by accepting the offer.
 15. An advertisement designed to produce leads either by use of a coupon, a request to write or call the company, or subsequent advertisement before contact, shall disclose that a producer may contact the potential applicant.
- D.** Method of disclosure of required information. If an insurer is required by law to disclose particular information, the information shall be conspicuous and in close proximity to the statements to which the information relates, or under a prominent caption so that the required disclosure is not minimized, obscured, presented in an ambiguous fashion, or intermingled with the content of the advertisement.
- E.** Testimonials.
1. Testimonials used in advertisements shall be genuine, represent the current opinion of the author, be applicable to the policy advertised, and be accurately reproduced. The insurer shall provide the Department with the full name of the author and a copy of the full testimonial if the advertisement is filed with the Department or requested by the Department. If an insurer uses a testimonial, the insurer adopts the statements in the testimonial as the insurer’s own statements. If a testimonial or endorsement is used more than one year after it is given, the insurer shall obtain a written confirmation from the author that the testimonial represents the current opinion of the author.
 2. The insurer shall disclose that a spokesperson has a financial interest or the proprietary or representative capacity of a spokesperson in an advertisement in the introductory portion of a testimonial or endorsement in the same form and with equal prominence as the endorsement. If a spokesperson is directly or indirectly compensated for making a testimonial or endorsement, the insurer shall disclose that fact in the advertisement by language that states, “Paid Endorsement,” or words of similar import in type, style, and size at least equal to that used for the spokesperson’s name or the body of the testimonial or endorsement, whichever is larger. For television or radio advertising, the insurer shall place the required disclosure prominently in the introductory portion of the advertisement.
- F.** Statistics. An advertisement with information on the dollar amounts of claims paid, the number of persons insured, or similar statistical information relating to any insurer or policy shall not use facts that are irrelevant to the sale of insurance and shall accurately reflect all of the relevant facts specific to the advertised policy or insurer. An advertisement shall not state or imply that statistics are derived from the policy being advertised unless that is true. The insurer shall identify in the advertisement the source of any statistics used.
- G.** Inspection of policy. An offer in an advertisement of free inspection of a policy or offer of a premium refund does not cure misleading or deceptive statements in the advertisement.
- H.** Identification of plan or number of policies.
1. If an advertisement offers a choice in the amount of benefits the advertisement shall disclose that the amount of benefits depends on the policy selected and that the premium will vary with the amount of the benefits.
 2. If an advertisement refers to benefits contained in more than one policy, other than a group master policy, the advertisement shall disclose that the benefits are provided only if multiple policies are purchased.
- I.** Disparaging comparisons and statements. An advertisement shall not make unfair, incomplete, or unsubstantiated comparisons of other insurers’ policies or benefits or falsely disparage other insurers’ policies, services, or business methods. A comparison is unsubstantiated if the insurer has no empirical study, analysis, or documentation supporting the comparative statement or comparison of policies or benefits.

- J.** Jurisdictional limits. If an insurer has an advertisement that is meant to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed, the advertisement shall indicate that the insurer is licensed in a specified state or states only, or is not licensed in a specified state or states, by use of language such as "This Company is licensed only in State A" or "This Company is not licensed in State B."
- K.** Identity of insurer. The insurer shall state the name of the actual insurer in all of its advertisements. An advertisement shall clearly identify the insurer and shall not use a trade name, an insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol, or other device that may mislead or deceive the public as to the insurer's identity.
- L.** Group insurance. An advertisement shall not state or imply that prospective policyholders become group or quasi-group members and enjoy special rates or underwriting privileges, unless it is true. An advertisement to join an association, trust, or group that is also an invitation to contract for insurance coverage shall disclose that the applicant will be purchasing both membership in the association, trust, or group and insurance coverage.
- M.** Government approval. An advertisement shall not state or imply any of the following:
1. That a governmental agency or regulator is connected with or has provided or endorsed a policy or endorsed an insurer;
 2. That a governmental agency or regulator has examined an insurer's financial condition and found it satisfactory. This subsection does not apply if an insurer is responding to a specific documented, public, false allegation about its financial condition.
- N.** Endorsements. An advertisement may state that an individual, group, society, association, or other organization has approved or endorsed the insurer or its policy if the organization or group has done so in writing and if any proprietary relationship between the organization and the insurer is disclosed.
- O.** Claims handling. An advertisement shall not contain false statements about the time within which claims are paid or statements that imply that claim settlements will be liberal or generous beyond the terms of the policy.
- P.** Statements about the insurer. An advertisement shall not contain false or misleading statements about an insurer's assets, corporate structure, financial standing, length of time in business, or relative position in the insurance business.
- a.** Each printed, published, recorded, or prepared advertisement of individual policies; and
- b.** Typical printed, published, recorded, or prepared advertisements of blanket, franchise, and group policies.
2. A notation attached to each advertisement specifying the manner and extent of distribution and the form number of any policy advertised; and
 3. Documentation supporting any testimonials, statistical claims, or comparisons shown in the advertising.
- C.** An insurer shall maintain the advertisements, notations, and supporting documentation for at least three years from the date of first dissemination.

Historical Note

New Section made by final rulemaking at 13 A.A.R 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-201.02. Procedures for Filing Advertising Materials; Transmittal Form

- A.** An insurer that is required to file a health insurance advertisement with the Department as specified in A.R.S. §§ 20-826(T), 20-1018, 20-1057(X), 20-1110(E), or 20-1662 shall file the advertisement with a transmittal form prescribed by the Department.
- B.** The transmittal form shall include the following information:
1. Identifying information of the insurer, including name, address, National Association of Insurance Commissioners' identification number, and type of insurer;
 2. A contact person at the insurer with whom the Department can communicate about the advertisement;
 3. Description of the type of advertisement being filed;
 4. Planned use and dissemination of the advertisement, including date of first use, or a statement that the advertisement will not be used any earlier than a specified date;
 5. Description of product being advertised;
 6. Form number and name for the advertised product;
 7. A certification from an officer of the insurer that the advertisement complies with applicable laws; and
 8. The dated signature of the insurer's officer.

Historical Note

New Section made by final rulemaking at 13 A.A.R 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-202. Advertising, Solicitation, and Transaction of Life Insurance

- A.** The definitions in R20-6-201(A) and the following definition apply in this Section:
- "Life insurance" means a life insurance contract, including all benefits payable under the policy.
- B.** Applicability
1. This Section applies to:
 - a. All persons subject to regulation under A.R.S. Title 20; and
 - b. Advertising, promotion, solicitation, negotiation, and sale of life insurance policies, regardless of the form of dissemination.
 2. This Section does not apply to group insurance, franchise insurance, or to annuities without life contingencies.
- C.** General provisions. A life insurance advertisement shall not mislead the public by:
1. Omitting information that fairly describes the subject matter as a life insurance policy and the benefits available under the policy;
 2. Placing undue emphasis on facts that, even if true, are not relevant to the sale of life insurance; or

Historical Note

Former General Rule Number 2. R20-6-201 recodified from R4-14-201 (Supp. 95-1). Amended by final rulemaking at 13 A.A.R 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-201.01. Insurer Advertising Responsibility and Records

- A.** An insurer shall establish, and at all times maintain, a system of control over the content, form, and method of dissemination of all advertisements. The insurer whose policies are advertised is responsible for the advertisements, regardless of who writes, creates, designs, or presents the advertisement, except the insurer is not responsible for any advertisement placed by a person to whom the insurer gave no actual or apparent authority. Before using an advertisement about an insurer or its products, a producer shall get written approval from the insurer for use of advertisements that were not supplied by the insurer.
- B.** An insurer shall maintain, at its home or principal office, the following:
1. Advertisements disseminated by the insurer in Arizona or any other state, including:

3. Placing undue emphasis on features of incidental or secondary importance to the life insurance aspects of the policy.
- D. The Department deems the following acts misleading and deceptive:
 1. Using any statement, including phrases such as “investment,” “investment plan,” “founders plan,” “charter plan,” “expansion plan,” “profit,” “profits,” or “profit sharing,” in a context or under circumstances or conditions that may mislead a purchaser or prospective purchaser to believe that the insurer is selling something other than a life insurance policy or will provide some benefit not included in the policy, or not available to other persons of the same class and equal expectation of life;
 2. Using any phrase as the name or title of a life insurance policy if the phrase does not include the words “life insurance,” unless other language in the same document expressly provides that the contract is a life insurance policy;
 3. Making any statement relating to the growth or earnings of the life insurance industry or to the tax status of life insurance companies in a context that would reasonably be understood as attempting to interest a prospective applicant in the purchase of shares of stock in the insurance company rather than in the purchase of a life insurance policy;
 4. Making any statement that reasonably tends to imply that the insured will enjoy a status common to a stockholder or will acquire a stock ownership interest in the insurance company by purchasing the policy, unless the statement is made with reference to policies of domestic life insurers engaged in a program allowed under A.R.S. § 20-453;
 5. Providing a policyholder with a premium receipt book, policy jacket, return envelope, or other printed or electronic material referring to the insurer’s “investment department,” “insured investment department,” or similar terminology in a manner implying that the policy is sold, issued, or serviced by the insurer’s investment department;
 6. Making any statement that reasonably tends to imply that, by purchasing a policy, the purchaser or prospective purchaser will become a member of a limited group of persons who may receive the payment of dividends, special advantages, benefits, or favored treatment unless the insurance contract specifically provides for the described payment of dividend, special advantages, benefits, or favored treatment;
 7. Stating or implying that only a limited number of persons or limited class of persons may buy a particular kind of policy, unless the limitation is related to recognized underwriting practices or specifically stated in the policy or rider;
 8. Describing premium payments in language that states the payment is a “deposit,” unless:
 - a. The payment establishes a debtor-creditor relationship between the insurance company and the policyholder; or
 - b. The term is used with the word “premium” in a manner as to clearly indicate the true character of the payment;
 9. Providing any illustration or projection of future dividends that:
 - a. Is not based on the company’s actual scale for payment of current dividends, and
 - b. Does not clearly indicate that the dividends are not guarantees;
 10. Using the words “dividends,” “cash dividends,” “surplus,” or similar phrases in a manner that states or implies that the payment of dividends is guaranteed or certain to occur;
 11. Stating, without qualification, that a purchaser of a policy will share in a stated percentage or portion of the insurer’s earnings;
 12. Making any statement that projected dividends under a participating policy will be or can be sufficient at any future time to assure the receipt of benefits such as a paid-up policy without further payment of premiums unless the statement also explains:
 - a. The benefits or coverage that would be provided at the future time, and
 - b. The conditions under which the receipt of benefits without further payment of premiums would occur;
 13. Describing a life insurance policy or premium payments in terms of “units of participation,” unless accompanied by other language clearly indicating that the references are to a life insurance policy or to premium payments, as applicable.
 14. Advising producers to avoid disclosing that life insurance is the subject of the solicitation or sale;
 15. Stating that an insured is guaranteed certain benefits if the policy is allowed to lapse, without explaining the non-forfeiture benefits;
 16. Using a dollar amount in printed material to be shown to a prospective policyholder, unless the amount is accompanied by language that:
 - a. States the nature of the dollar amount,
 - b. Prohibits including the use of dollar amounts not related to guaranteed values and properly projected dividend figures, and
 - c. Prohibits the use of figures showing growth of stock values, or other values not a part of the life insurance contract.
 17. Stating that a policy provides features not found in any other insurance policy, unless the insurer can demonstrate that other policies do not have the same feature;
 18. Making any statement or implication about an insurance policy that cannot be verified by reference to the policy contract, a sample of the policy being described, or the company’s officially published rate book and dividend illustrations;
 19. Stating that life insurance is “loss proof” or “depression proof,” except that an insurer may make statements that life insurance benefits, other than dividends, are guaranteed by the company regardless of economic conditions;
 20. Making any statement that a company makes a profit as a result of policy lapses or surrenders;
 21. Making comparisons to the past experience of other life insurance companies as a means of projecting possible experience for the company issuing the advertising; and
 22. Conduct or statements designed to mislead a prospective applicant or purchaser.

Historical Note

Former General Rule Number 68-14. R20-6-202 recodified from R4-14-202 (Supp. 95-1). Amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-203. Form Filings; Translations

- A. An insurer, rate service organization, or rating organization shall provide to the Department, at the time of filing, an English language translation of each form, advertisement, or other document or material that the insurer is required by stat-

ute or rule to file with the Department, if the filed document or material contains communication in a language other than English.

- B. The translation filed under subsection (A) shall compare the foreign language version in a side-by-side format with the English language translation. An insurer, rate service organization, or rating organization shall ensure that the translation is performed by a person with formal college-level or specialized training in the foreign language, including training in grammar and sentence syntax.
- C. With each translation, an insurer, rate service organization, or rating organization shall also provide to the Department a sworn statement signed by the translator who translated the document that includes the qualifications of the translator under subsection (B) and attests that the translation is identical in substance to the English document or material.
- D. If an insurer, rate service organization, or rating organization files a foreign language version of a document or material that the insurer has previously filed in English, the insurer is not required to refile the English version, but shall identify the English version, provide the side-by-side comparison under subsection (B), and file the sworn statement required under subsection (C).

Historical Note

Former General Rule Number 71-23; Repealed effective January 1, 1981 (Supp. 80-6). R20-6-203 recodified from R4-14-203 (Supp. 95-1). New Section made by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-204. Surplus Lines Brokers' Filing Requirements; List of Unauthorized Insurers

A. Definitions.

1. "Alien insurer" has the meaning prescribed in A.R.S. § 20-201.
2. "Foreign insurer" has the meaning prescribed in A.R.S. § 20-204.
3. "Listed insurer" means an unauthorized insurer who is on the list created by the Director under subsection (C)(1) and A.R.S. § 20-413.
4. "Surplus lines broker" means a person licensed under A.R.S. § 20-411.
5. "Surplus lines insurance" means the type of insurance described in A.R.S. § 20-407.
6. "Unauthorized insurer" means an insurer that does not have a certificate of authority to transact insurance in Arizona.

- B. Filing requirements. An unauthorized insurer writing surplus lines insurance in Arizona and each surplus line broker shall comply with the filing requirements of this Section.

C. List of unauthorized insurers.

1. The Director shall create and maintain a list of unauthorized insurers that may write surplus lines insurance in this state under A.R.S. § 20-413. The list shall contain the names of unauthorized insurers for which a surplus lines broker has made the filings required by this Section.
2. The Director shall retain a listed insurer on the list until:
 - a. The Director removes the insurer from the list under A.R.S. § 20-413 or subsection (H) or (I) below, or
 - b. The insurer requests the Director to remove its name from the list.

- D. Placing surplus lines insurance. A surplus lines broker shall place all surplus lines business with insurers listed under subsection (C). An insurer's removal from the list does not affect the validity of any contract existing at the time of removal.

- E. Requirements for foreign unauthorized insurers and insurance exchanges. A surplus lines broker shall file the following documents for a foreign unauthorized insurer:

1. An original or a certified copy of the insurer's certificate of compliance from the supervisory official of the insurer's state of domicile;
2. A current Certificate of Deposit, Capital, and Surplus for Foreign Insurers from the public officials or other persons who have supervision over the insurer in any other state;
3. A certification from the surplus lines broker of the insurer's compliance with the financial requirements of A.R.S. § 20-413;
4. The insurer's most recent report of financial examination, certified by the insurance supervisory official of its state of domicile; and
5. A certified copy of a full-size National Association of Insurance Commissioners (N.A.I.C.) annual statement for the insurer as of December 31 of the preceding year.

- F. Requirements for initial listing of alien unauthorized insurers. A surplus lines broker shall file a certification of the insurer's compliance with the financial requirements of A.R.S. § 20-413. For all alien insurers other than title insurers, the surplus lines broker may rely on the information contained in the most recent N.A.I.C. Financial Review of Alien Insurers as prima facie evidence of the insurer's compliance.

- G. Filing requirements to maintain listing. To ensure that a foreign or alien unauthorized insurer remains on the Director's list, a surplus lines broker shall file, before June 1 of each year:

1. A copy of a full-size National Association of Insurance Commissioners (N.A.I.C.) convention blank annual statement (Form 2) for the insurer, as of December 31 of the preceding year; and
2. An affidavit, on a form approved by the Director, that meets the following requirements:
 - a. The surplus lines broker and a duly authorized officer of the unauthorized insurer shall sign the affidavit.
 - b. The insurer's officer shall state whether there have been any changes in the insurer's name, address, state of domicile, statutory producer, and any material changes in its operations since the insurer's initial qualification for listing or the last annual filing under this subsection. If there have been material changes in operations, the officer shall describe the changes. Material changes under this subsection include a change in any one or more of the following:
 - i. A director, officer, or controlling person;
 - ii. The insurer's holding company or affiliates;
 - iii. The insurer's charter documents, including its articles of incorporation, articles of agreement, or by-laws governing its conduct of business;
 - iv. The insurer's marketing or administration plans, operations, or agreements with third parties;
 - v. Any other matter material to the insurer meeting its obligations to its policyholders; and
 - vi. Any other matter that relates to any of the grounds for removal from the list as prescribed in A.R.S. § 20-413.
 - c. The insurer's officer shall state whether the insurer is in good standing in all jurisdictions where it conducts insurance business and whether the insurer has been, since the date of initial listing or the last annual filing under this subsection, or currently is, the subject of any action or order by any regulatory

official in any jurisdiction. If the insurer has been or is the subject of a disciplinary action or order, the insurer's officer shall describe the matter in the affidavit and shall attach a copy of any applicable official document regarding the disciplinary action or order. Regulatory action or order under this subsection includes any one or a combination of the following:

- i. Denial, suspension, or revocation of a license, permit, or certificate of authority;
 - ii. A corrective action or operation plan, consent order, memorandum of understanding, or cease and desist order;
 - iii. Action against the insurer's bond or securities held in trust by a regulatory official; and
 - iv. Supervision, conservatorship, receivership, or any other form of possession or control by a regulatory official in any jurisdiction.
- d. The insurer's officer shall state whether the report of examination, if any, previously filed with the Director under subsection (E)(4) or with a previous annual filing, remains the most current, filed report. If a more recent report of examination exists, the surplus lines broker shall file a copy of the report with the affidavit.

H. Supplemental information; removal. A surplus lines broker and an unauthorized insurer shall provide any additional information the Director requests to determine whether the insurer meets the requirements of A.R.S. § 20-413, or to clarify information in documents filed under this Section. The Director may remove an insurer from the list if the surplus lines broker or insurer does not submit the requested information within 30 days after the date of a written request for information.

I. Removal for failure to make annual filing. The Director shall remove an unauthorized insurer from the list if a surplus lines broker fails to timely file the documents required by subsection (G). The Director shall not restore the insurer to the list until a surplus lines broker files all applicable documents required under subsections (E) or (F) and the insurer requalifies under A.R.S. § 20-413.

J. Organizations of surplus lines brokers; unauthorized insurer.

1. A surplus lines broker may file records or reports that are subject to examination by the director under A.R.S. § 20-408 with any voluntary organization of surplus lines brokers. The Director may examine the records or reports filed with an organization of surplus lines brokers to ascertain compliance with A.R.S. Title 20, Chapter 2, Article 5. An examination performed under this authority shall not preclude examination of records of a surplus lines broker.
2. Nothing in this subsection requires that a surplus lines broker become a member of any surplus lines organization to file or preserve or maintain any affidavit or statement.

Historical Note

Former General Rule Number 71-24; Former Section R4-14-204 repealed, new Section R4-14-204 adopted effective January 1, 1981 (Supp. 80-6). R20-6-204 recodified from R4-14-204 (Supp. 95-1). Amended effective July 14, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 475, effective January 5, 2000 (Supp. 00-1). Amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-205. Local or Regional Retaliatory Tax Information

A. Definitions.

1. "Addition to the rate of tax" means the tax rate determined under subsection (D) to be applied under A.R.S. 20-230(A) and this Section to foreign or alien insurers domiciled in a foreign country or other state that impose local or regional taxes.
 2. "Alien insurer" has the meaning prescribed in A.R.S. § 20-201.
 3. "Arizona life insurer" means a domestic insurer authorized to issue life insurance policies in this state within the meaning of A.R.S. § 20-254 or annuities within the meaning of A.R.S. § 20-254.01, regardless of whether the insurer is authorized to transact disability insurance in this state.
 4. "Department" means the Arizona Department of Insurance.
 5. "Director" has the meaning prescribed in A.R.S. § 20-102.
 6. "Domestic insurer" has the meaning prescribed in A.R.S. § 20-203.
 7. "Foreign insurer" has the meaning prescribed in A.R.S. § 20-204.
 8. "Foreign or alien life insurer" means a foreign or alien insurer authorized to issue life insurance policies in this state within the meaning of A.R.S. § 20-254 or annuities within the meaning of A.R.S. § 20-254.01, regardless of whether the insurer is authorized to transact disability insurance in this state.
 9. "Local or regional taxes" means any tax, license, or other obligation imposed upon domestic insurers or their producers by any:
 - a. City, county, or other political subdivision of a foreign country or other state; or
 - b. Combination of cities, counties, or other political subdivisions of a foreign country or other state.
 10. "Other Arizona insurer" means a domestic insurer authorized to transact one or more lines of insurance in this state but not authorized to transact life insurance or annuities in this state.
 11. "Other foreign or alien insurer" means a foreign or alien insurer authorized to transact one or more lines of insurance in this state but not authorized to transact life insurance or annuities in this state.
 12. "Other state" means any state in the United States, the District of Columbia, and territories or possessions of the United States, excluding Arizona.
 13. "Premium Tax and Fees Report," includes the "Survey of Arizona Domestic Insurers" and the "Retaliatory Taxes and Fees Worksheet," and means the form prescribed by the Director and filed annually by insurers under A.R.S. § 20-224.
- B.** Scope. This Section applies to all foreign, alien, and domestic insurers and to Premium Tax and Fees Reports filed by all insurers.
- C.** Data to be reported by domestic insurers. As a part of its Premium Tax and Fees Report, each domestic insurer shall file a Survey of Arizona Domestic Insurers that reports the following data for the calendar year covered by the insurer's Premium Tax and Fees Report with respect to each foreign country or other state in which the insurer was required to pay any local or regional taxes:
1. Total local or regional taxes paid; and
 2. Total premiums taxed under the premium taxing statute of the foreign country or other state, as reported by the insurer in any premium tax report filed under the laws of the foreign country or other state.

- D.** Computation of statewide and foreign countrywide additions to the rate of tax. For each foreign country or other state having one or more local or regional taxes on domestic insurers, the Department shall compute on a statewide or foreign countrywide basis an addition to the rate of tax. The Department shall compute the addition to the rate of tax payable by Arizona life insurers separately from the addition to the rate of tax payable by other Arizona insurers. The addition to the rate of tax payable by each category of Arizona domestic insurers shall be the quotient of:
1. The aggregate local or regional taxes reported as paid to the foreign country or other state by domestic insurers in each category for the calendar year covered by the Premium Tax and Fees Report divided by,
 2. The aggregate statewide or foreign countrywide premiums taxed under the premium taxing statute of the other state or foreign country reported by domestic insurers in each category for the calendar year covered by the Premium Tax and Fees Report.
- E.** Publication of additions to the rate of tax. The Department shall publish additions to the rate of tax determined under A.R.S. § 20-230(A) and this Section, based upon the survey information gathered from domestic insurers for the preceding calendar year under subsection (C). The Department shall publish the information annually on the Department web site, on or before November 1, and in the Retaliatory Taxes and Fees Worksheet for the next year's Premium Tax and Fees Report.
- F.** Foreign and Alien Insurers' Report of the Effect of Local or Regional Taxes. Each foreign or alien insurer domiciled in a foreign country or other state for which the Department publishes an addition to the rate of tax shall include in the "State or Country of Incorporation" column of its Retaliatory Taxes And Fees Worksheet for the calendar year covered by its Premium Tax and Fees Report an amount equal to:
1. The total premiums received in Arizona that would be taxed under the laws of the domiciliary jurisdiction, as reported in the "State or Country of Incorporation" column of its premium tax and fees report multiplied by,
 2. The applicable addition to the rate of tax published by the Department for the calendar year covered by the insurer's Premium Tax and Fees Report.
- G.** Contesting computation. A foreign or alien insurer subject to this Section may preserve the right to contest the computation of the addition to the rate of tax by submitting a notice of appeal under A.R.S. Title 41, Chapter 6, Article 10 before or at the time the retaliatory tax is paid. Subject to A.R.S. § 20-162, the filing of a notice of appeal to contest the computation of the applicable addition to the rate of tax does not relieve a foreign or alien insurer of the obligation to timely pay the retaliatory tax, and does not stay accrual of any applicable interest and penalties.
- Historical Note**
- Former General Rule Number 71-25; Repealed effective March 19, 1976 (Supp. 76-2). R20-6-205 recodified from R4-14-205 (Supp. 95-1). Section R20-6-205 renumbered from R20-6-206 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).
- R20-6-206. Industrial Insureds**
- A.** Definitions. In this Section, unless the context otherwise requires:
1. "Admitted insurer" means an insurer to which the Director has issued a certificate of authority to transact insurance in this state under A.R.S. §§ 20-216 and 20-217.
 2. "Director" means the Director of Insurance of the state of Arizona;
 3. "Gross premium" means the total premium charged, deducted or allocated, including membership fees, assessments, dues and any other consideration for insurance, less premiums returned on account of cancellation or reduction of premium;
 4. "Industrial insured" has the same meaning as in A.R.S. § 20-401.07(B) and includes self-insureds for any risk or partial risk of exposure;
 5. "Insurer" has the same meaning prescribed in A.R.S. § 20-106(C);
 6. "Transact" or "transaction" has the same meaning as prescribed in A.R.S. § 20-106(A) and (B).
 7. "Unauthorized insurer" means an insurer transacting business in this state who is not an admitted insurer, is not a listed qualified unauthorized insurer under R20-6-204(C), and has not been issued a certificate of exemption under A.R.S. § 20-401.05.
- B.** A.R.S. § 20-401.07 and this Section apply to all insurance transacted by an unauthorized insurer with an industrial insured for which premiums, in whole or in part, are remitted directly or indirectly from within or outside this state and whether procured by direct application, by mail, by an insurance producer on the industrial insured's behalf, or by any other means.
- C.** Tax to be paid by industrial insureds contracting with an unauthorized insurer. Every industrial insured under a contract procured from an unauthorized insurer shall pay to the Director, before March 1st after the calendar year in which the insurance was effectuated, continued, or renewed, a premium receipt tax of 3% of the gross premiums charged, deducted or allocated to persons, residents or property located in, or contracts to be performed in this state and under A.R.S. § 20-401.07 deemed to be insurance effectuated or continued in this state. The return for premium receipts tax shall be prepared, executed and filed on a form prescribed by the Director.
- D.** If an industrial insured claims that an insurance contract with an unauthorized insurer covers risks or exposures only partly in this state, the industrial insured shall file with the Department on a form prescribed by the Director, the premium receipts tax return, and a certified statement containing the following information:
1. Percentage of physical assets in Arizona,
 2. Percentage of employee payroll in Arizona,
 3. Percentage of sales in Arizona, and
 4. Percentage of taxable income reportable in Arizona.
- E.** A person contracting with an unauthorized insurer claiming to be an industrial insured under A.R.S. § 20-401.07(B) shall file with the Department a certified statement that discloses the following information for the person:
1. The insurance risks that are subject to the requirements of A.R.S. Title 20, Chapter 2, Article 4.1 and the identity of the insurer;
 2. The name of the full-time employee or third-party consultant retained to act as risk manager and the third-party consultant's qualifications under A.R.S. § 20-401.07(B)(2);
 3. The total aggregate annual gross premiums paid for insurance on all property and casualty risks that are subject to A.R.S. Title 20, Chapter 2, Article 4.1 as of the preceding fiscal year end;
 4. Net worth as of the preceding fiscal year end, as verified by a certified public accountant; and
 5. The total number of full-time employees or equivalent and if less than 80, the total number of full-time or equivalent employees of its holding company system, as of the date the policy was issued by the unauthorized insurer.

- F. The Director may require that the industrial insured provide the following additional information to the Director:
1. The mode of premium payment showing the percentage paid by employer and employee;
 2. The amount of annual premium applied to life, disability and annuity policies if additional risks are insured;
 3. A statement of loss-claim ratio for the preceding year by policy type; and
 4. The amount of reserve for policies and contracts by type of policy.

Historical Note

Former General Rule Number 72-30. Repealed effective February 22, 1993 (Supp. 93-1). R20-6-206 recodified from R4-14-206 (Supp. 95-1). New Section adopted effective December 29, 1995 (Supp. 95-4). Amended effective November 5, 1998 (Supp. 98-4). Former R20-6-206 renumbered to R20-6-205; new R20-6-206 renumbered from R20-6-207 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-207. Gender Discrimination

- A. The following definitions apply to this Section:
1. "Applicant" means a person who is applying for a policy.
 2. "Policy" means an insurance policy, plan, contract, certificate, evidence of coverage, subscription contract, or binder, including a rider or endorsement offered by an insurer.
 3. "Insurer" means any company that issues a policy.
- B. Applicability and scope. This Section applies to any policy or certificate delivered or issued for delivery in this state.
- C. Availability requirements.
1. An insurer shall not deny availability of any insurance policy on the basis of the gender or marital status of the insured or prospective insured.
 2. An insurer shall not restrict, modify, exclude, reduce, or limit the amount of benefits payable, or any term, conditions or type of coverage on the basis of an applicant's or insured's gender or marital status, except to the extent the amount of benefits, term, conditions, or type of coverage vary as a result of the application of rate differentials permitted under A.R.S. Title 20.
 3. An insurer may consider marital status to determine whether a person is eligible for dependent coverage or benefits.
- D. Prohibited practices. The following practices and any other practice that treats similarly situated persons differently based on gender unless the different treatment is specifically allowed by law, is prohibited.
1. Denying coverage to a person of one gender who is self-employed, employed part-time, or employed by relatives, if coverage is offered to a person of the opposite gender who is similarly employed;
 2. Denying a policy rider to a person of one gender if the rider is available to a person of the opposite gender;
 3. Denying maternity benefits to an applicant or insured who buys a policy for individual coverage if the insurer offers comparable family coverage policies with maternity benefits;
 4. Denying, under group policies, dependent coverage to an employee of one gender if dependent coverage is available to an employee of the opposite gender;
 5. Denying a disability income policy to an employed person of one gender if a policy is offered to a person of the opposite gender who is similarly employed;

6. Treating complications of pregnancy differently from any other illness or sickness covered under a policy;
7. Restricting, reducing, modifying, or excluding benefits relating to coverage involving the genital organs of only one gender;
8. Offering lower maximum monthly benefits to a person of one gender than to a person of the opposite gender who is in the same classification under a disability income policy;
9. Offering more restrictive benefit periods or more restrictive definitions of disability to a person of one gender than to a person of the opposite gender who is in the same classification under a disability income policy;
10. Establishing different conditions for a policyholder of one gender to exercise benefit options contained in the policy than for a person of the opposite gender;
11. Limiting the amount of coverage an insured or prospective insured may purchase based upon the insured's or prospective insured's marital status unless the limitation is for the purpose of defining persons eligible for dependent's benefits; and
12. Otherwise restricting, modifying, excluding or reducing the availability of any insurance contract, the amount of benefits payable, or any term, condition or type of coverage on account of gender or marital status in all lines of insurance.

Historical Note

Former General Rule Number 73-32. R20-6-207 recodified from R4-14-207 (Supp. 95-1). Former R20-6-207 renumbered to R20-6-206; new R20-6-207 renumbered from R20-6-209 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-208. Group Coverage Discontinuance and Replacement

- A. Definitions. The following definitions apply in this Section:
1. "Group insurance" means an insurance benefit that meets all the following conditions:
 - a. Coverage is provided through insurance policies or subscriber contracts to classes of employees or members defined in terms of conditions pertaining to employment or membership;
 - b. The coverage is not available to the general public and can be obtained and maintained only because of the covered person's membership in or connection with the particular organization or group;
 - c. Coverage is paid for by bulk payment of premiums to the insurer; and
 - d. An employer, union, or association sponsors the plan.
 2. "Health insurance coverage" means a hospital and medical expense incurred policy, a nonprofit health care service plan contract, a health maintenance organization subscriber contract, or any other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise, but does not include the following:
 - a. Coverage only for accident, or disability income insurance, or any combination of accident and disability income insurance;
 - b. Coverage issued as a supplement to liability insurance;
 - c. Liability insurance, including general liability insurance and automobile liability insurance;
 - d. Workers' compensation or similar insurance;

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- e. Automobile medical payment insurance;
 - f. Credit-only insurance;
 - g. Coverage for onsite medical clinics; and
 - h. Other insurance coverage similar to the coverage specified in subsections (2)(a) through (g), of the Health Insurance Portability and Accountability Act of 1996 (Pub.L.No. 104-191) (HIPAA), under which benefits for medical care are secondary or incidental to other insurance benefits.
 - i. The following benefits, if the benefits are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the coverage:
 - i. Limited-scope dental or vision benefits;
 - ii. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination of those benefits;
 - iii. Other similar, limited benefits specified in federal regulations issued under HIPAA.
 - j. The following benefits if provided under a separate policy, certificate, or contract of insurance with no coordination between provision of benefits and any exclusion of benefits under a group health plan maintained by the same plan sponsor and if the benefits are paid for an event regardless of whether the benefits are provided under a group health plan maintained by the same plan sponsor:
 - i. Coverage only for a specified disease or illness, or
 - ii. Hospital indemnity or other fixed indemnity insurance.
 - k. The following benefits if the benefits are offered as a separate policy, certificate, or contract of insurance:
 - i. Medicare supplemental policy as defined under § 1882(g)(1) of the Social Security Act, 42 U.S.C. 1395ss;
 - ii. Coverage supplemental to the coverage provided under, 10 U.S.C. Title 10, Chapter 55; or
 - iii. Similar supplemental coverage provided to coverage under a group health plan.
3. "Health status-related factor" means any of the following:
- a. Health status;
 - b. Medical condition, including a physical or mental illness;
 - c. Claims experience;
 - d. Receipt of health care;
 - e. Medical history;
 - f. Genetic information;
 - g. Evidence of insurability, including conditions arising out of acts of domestic violence; or
 - h. Disability.
4. "Insurer" means an insurer that offers or provides group health insurance coverage, and includes an insurer that issues disability insurance as defined in A.R.S. § 20-253, a medical, dental, or optometric service corporation as defined in A.R.S. § 20-822, and a health care services organization as defined in A.R.S. § 20-1051.
- B.** This Section applies to all group insurance issued by an insurer.
- C.** Effective date of discontinuance for non-payment of premium.
1. If a group insurance policy provides for automatic discontinuance of the policy after a premium remains unpaid through the grace period allowed for payment, the insurer is liable for valid claims for covered losses incurred before the end of the grace period.
 2. If the insurer's actions after the end of the grace period indicate that the insurer considers the group insurance policy as continuing in force beyond the end of the grace period the insurer is liable for valid claims for losses beginning before the effective date of written notice of discontinuance to the policyholder or other entity responsible for paying premiums.
 - a. The following actions indicate that the insurer considers the policy in force:
 - i. Continued recognition, acknowledgement, or payment of subsequently incurred claims, or
 - ii. Continued enrollment of employees or dependents.
 - b. The following actions shall not indicate that the insurer considers that policy in force:
 - i. Recognition, payment, or acknowledgement of a claim by an insurer or processing a denial based on eligibility or other denial reasons set forth in the group benefit plan booklet; or
 - ii. Recognition, payment, or acknowledgement of claims due to the group's failure to notify the insurer that the employee or member is no longer eligible for coverage or the group policy is terminated.
 3. The effective date of discontinuance shall not be before midnight at the end of the third scheduled work day after the date on which the notice of discontinuance is delivered.
- D.** Requirements for notice of discontinuance.
1. An insurer's notice of discontinuance shall include a request to the group policyholder to notify covered employees of the date when the group policy or contract will discontinue and to advise that, unless otherwise provided in the policy or contract, the insurer is not liable for claims for losses incurred after the date of discontinuance. If the plan involves employee contributions, the notice of discontinuance shall also advise that if the policyholder continues to collect employee contributions beyond the date of discontinuance, the policyholder is solely liable for benefits for the period which contributions were collected.
 2. The insurer shall also provide the policyholder with a supply of notice forms that the policyholder can distribute to the covered employees. The notice forms shall explain the discontinuance and the effective date, and advise employees to refer to their certificates or contracts to determine their rights on discontinuance.
- E.** Extension of benefits.
1. A group policy shall provide a reasonable provision for extension of benefits for an employee or dependent who is totally disabled on the date of discontinuance as follows:
 - a. For a group life plan with a disability benefit extension of any type such as a premium waiver extension, extended death benefit in the event of total disability, or payment of income for a specified period during total disability, the discontinuance of the group policy shall not terminate the benefit extension.
 - b. For a group plan providing benefits for loss of time from work or specific indemnity during hospital confinement, discontinuance of the policy during a disability or hospital confinement shall not effect benefits payable for that disability or hospital confinement.

- c. A hospital or medical expense coverage, other than dental and maternity expense, shall include a reasonable extension of benefits or accrued liability provision. A provision is reasonable if:
 - i. It provides an extension of at least 12 months under “major medical” and “comprehensive medical” type coverage; or
 - ii. Under other types of hospital or medical expense coverage, it provides either an extension of at least 90 days or an accrued liability for expenses incurred during a period of disability or during a period of at least 90 days starting with a specific event that occurred while coverage was in force, such as an accident.
 - 2. An insurer shall ensure that the policy and group insurance certificates includes a description of the extension of benefits or accrued liability provision.
 - 3. An insurer shall ensure that benefits payable during a period of extension or accrued liability are subject to the policy’s regular benefit limits, such as benefits ceasing at exhaustion of a benefit period or of maximum benefits.
 - 4. For hospital or medical expense coverage, an insurer may limit benefit payments to payments applicable to the disabling condition only.
 - F. Continuance of coverage in situations involving replacement of one plan by another.
 - 1. When a group policyholder secures replacement coverage with a new insurer, self-insures, or foregoes provision of coverage, the replaced insurer is liable only to the extent of its accrued liabilities and extensions of benefits after the date of discontinuance.
 - 2. The succeeding insurer shall cover each individual who:
 - a. Was eligible for coverage under the prior plan on the date of discontinuance, and
 - b. Is eligible for coverage according to the succeeding insurer’s plan of benefits with respect to a class of individuals eligible for coverage.
 - 3. For the purpose of successive health insurance coverage under subsection (F)(2), a succeeding insurer’s plan of benefits shall:
 - a. Not have any non-confinement rules; and
 - b. Provide, as to any actively-at-work rules, that absence from work due to a health status-related factor is treated as being actively-at-work.
 - 4. Nothing in subsection (F)(2) prohibits an insurer from performing coordination of benefits.
 - 5. A succeeding insurer shall cover each individual not covered under the succeeding insurer’s plan of benefits under subsection (F)(2) according to subsections (a) and (b) if the individual was validly covered, including benefit extension, under the prior plan on the date of discontinuance and is a member of a class of individuals eligible for coverage under the succeeding insurer’s plan. Any reference in subsection (a) or (b) to an individual who was or was not totally disabled is a reference to the individual’s status immediately before the effective date of coverage for the succeeding insurer.
 - a. The minimum level of benefits to be provided by the succeeding insurer shall be the level of benefits of the prior insurer’s plan reduced by any benefits payable by the prior plan.
 - b. The succeeding insurer shall provide coverage until at least the earliest of the following dates:
 - i. The date the individual becomes eligible under the succeeding insurer’s plan as described in subsection (F)(2);
 - ii. The date the individual’s coverage would terminate according to the succeeding insurer’s plan provisions applicable to individual termination of coverage such as at termination of employment or ceasing to be eligible dependent; or
 - iii. For an individual who was totally disabled, and covered by a type of coverage for which subsection (E) requires an extension of accrued liability, the end of any period of extension of benefits or accrued liability that is required of the prior insurer under subsection (E), or if the prior insurer’s policy is not subject to subsection (E), would have been required of the insurer had its policy been subject to subsection (E) at the time the prior plan was discontinued and replaced by the succeeding insurer’s plan;
 - c. For health insurance coverage, if an individual who was totally disabled at the time the prior insurer’s plan was discontinued and replaced by the succeeding insurer’s plan, and if subsection (E) requires an extension of benefits or accrued liability, the minimum level of benefits to be provided by the succeeding insurer shall be the level of benefits of the prior insurer’s plan, reduced by any benefits paid by the prior plan.
 - d. If the succeeding insurer’s plan has a preexisting conditions limitation, the level of benefits applicable to preexisting conditions of persons becoming covered by the succeeding insurer’s plan according to subsection (F) during the period the limitation applies under the new plan shall be the lesser of:
 - i. The benefits of the new plan determined without application of the preexisting conditions limitation, or
 - ii. The benefits of the prior plan.
 - e. The succeeding insurer, in applying any deductibles, coinsurance amounts applicable to out-of-pocket maximums, or waiting periods, shall give credit for the satisfaction or partial satisfaction of the same or similar provisions under a prior plan providing similar benefits. For deductibles or coinsurance amounts applicable to out-of-pocket maximums, the credit shall apply for the same or overlapping benefit periods and shall be given for expenses actually incurred and applied against the deductible or coinsurance provisions of the prior plan during the 90 days before the effective date of the succeeding insurer’s plan but only to the extent these expenses are recognized under the terms of the succeeding insurer’s plan and are subject to similar deductible or coinsurance provisions.
 - f. If the succeeding insurer is required under this Section to make a determination about the benefits in the prior plan, the succeeding insurer may ask the prior plan to provide a statement of the benefits available or other pertinent information sufficient to permit the succeeding insurer to verify the benefit determination. For the purposes of this Section, all definitions, conditions, and covered-expense provisions of the prior plan shall govern the benefit determination. The benefit determination is made as if the succeeding insurer had not replaced coverage.

Historical Note

Former General Rule Number 73-34. R20-6-208 recodified from R4-14-208 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 491, effective September 30, 2001 (Supp. 02-1). Section R20-6-208 renumbered from R20-6-210 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-209. Life Insurance Solicitation**A. Scope.**

1. This Section applies to any solicitation, negotiation, or procurement of life insurance occurring in Arizona. This Section applies to any issuer of life insurance contracts, including fraternal benefit societies.
2. Unless otherwise specifically included, the Section does not apply to:
 - a. Annuities,
 - b. Credit life insurance,
 - c. Group life insurance,
 - d. Life insurance policies issued in connection with a pension and welfare plan as defined by and subject to the federal Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 et seq.; or
 - e. Variable life insurance under which the death benefits and cash values vary according to unit values of investments held in a separate account.

B. In this Section, the following apply:

1. "Buyer's Guide" means a document that contains the language in the Appendix to this Section or language approved by the Director.
2. "Cash dividend" means the current illustrated dividend that can be applied toward payment of the gross premium.
3. "Equivalent Level Annual Dividend" is calculated as follows:
 - a. Accumulate the annual cash dividends at 5% interest compounded annually to the end of the 10th and 20th policy years;
 - b. Divide each accumulation in subsection (a) by an interest factor that converts the accumulation into one equivalent level annual amount that, if paid at the beginning of each year, would accrue to the values in subsection (a) over the periods stipulated in subsection (a). If the period is 10 years, the factor is 13.207 and if the period is 20 years, the factor is 34.719.
 - c. Divide the results in subsection (b) by the number of thousands of the Equivalent Level Death Benefit to arrive at the "Equivalent Level Annual Dividend."
4. "Equivalent Level Death Benefit" means the amount of benefit of a policy or term life insurance rider calculated as follows:
 - a. Accumulate the guaranteed amount payable upon death, regardless of the cause of death, at the beginning of each policy year for 10 and 20 years at 5% interest compounded annually to the end of the 10th and 20th policy years, respectively.
 - b. Divide each accumulation in subsection (a) by an interest factor that converts the accumulation into one equivalent level annual amount that, if paid at the beginning of each year, would accrue to the value in subsection (a) over the periods stipulated in subsection (a). If the period is 10 years, the factor is 13.207 and if the period is 20 years, the factor is 34.719.
5. "Generic name" means a short title that is descriptive of the premium and benefit patterns of a policy or a rider.
6. "Life Insurance Surrender Cost Index" means the cost index that is calculated as follows:
 - a. Determine the guaranteed cash surrender value, if any, available at the end of the 10th and 20th policy years.
 - b. For policies participating in dividends, add the terminal dividend payable upon surrender, if any, to the accumulation of the annual Cash Dividends at 5% interest compounded annually to the end of the period selected and add this sum to the amount determined in subsection (a).
 - c. Divide the result in subsection (b) (subsection (a) for guaranteed-cost policies) by an interest factor that converts into an equivalent level annual amount that, if paid at the beginning of each year, would accrue to the value in subsection (b) or subsection (a) for guaranteed cost policies, over the periods stipulated in subsection (a)). If the period is 10 years, the factor is 13.207 and if the period is 20 years, the factor is 34.719.
 - d. Determine the equivalent level premium by accumulating each annual premium payable for the basic policy or rider at 5% interest compounded annually to the end of the period stipulated in subsection (a) and dividing the result by the respective factors stated in subsection (c). This amount is the annual premium payable for a level premium plan.
 - e. Subtract the result of subsection (c) from subsection (d).
 - f. Divide the result of subsection (e) by the number of thousands of the Equivalent Level Death Benefit to arrive at the Live Insurance Surrender Cost Index.
7. The Life Insurance Net Payment Cost Index is calculated in the same manner as the comparable Life Insurance Cost Index except that the cash surrender value and any terminal dividend are set at zero.
8. "Policy Summary" means a written statement describing elements of the policy, including:
 - a. The following prominently placed title: Statement of Policy Cost and Benefit Information.
 - b. The name and address of the insurance producer, or, if no producer is involved, a statement of the procedure to be followed to receive responses to inquiries regarding the Policy Summary.
 - c. The full name and home office or administrative office address of the company by which the life insurance policy is to be or has been written.
 - d. The generic name of the basic policy and each rider.
 - e. For the first five policy years and representative policy years thereafter sufficient to clearly illustrate the premium and benefit patterns, including the years for which Life Insurance Cost Indexes are displayed and at least one age from 60 through 65 or maturity, whichever is earlier, the following amounts, where applicable:
 - i. The annual premium for the basic policy;
 - ii. The annual premium for each optional rider;
 - iii. Guaranteed amount payable upon death at the beginning of the policy year regardless of the cause of death except for suicide, or other specifically enumerated exclusions provided by the basic policy and each optional rider, with benefits provided under the basic policy and each rider shown separately;

- iv. Total guaranteed cash surrender values at the end of the year with values shown separately for the basic policy and each rider;
 - v. Cash dividends payable at the end of the year with values shown separately for the basic policy and each rider. Dividends need not be displayed beyond the twentieth policy year; and
 - vi. Guaranteed endowment amounts payable under the policy that are not included under guaranteed cash surrender values in subsection (iv).
- f. The effective policy loan annual percentage interest rate, if the policy contains this provision, specifying whether the rate is applied in advance or in arrears. If the policy loan interest rate is variable, the Policy Summary shall include the maximum annual percentage rate.
- g. Life Insurance Cost Indexes for 10 and 20 years but not beyond the premium-paying period. Separate indexes shall be displayed for the basic policy and for each optional term life insurance rider. The indexes need not be included for optional riders that are limited to benefits such as accidental death benefits, disability waiver of premium, preliminary term life insurance coverage of less than 12 months, and guaranteed insurability benefits, nor for basic policies or optional riders covering more than one life.
- h. The Equivalent Level Annual Dividend in the case of participating policies and participating optional term life insurance riders, under the same circumstances and for the same durations at which Life Insurance Cost Indexes are displayed.
- i. If the Policy Summary includes dividends, a statement that dividends are based on the insurer's current dividend scale and are not guaranteed and a statement in close proximity to the Equivalent Level Annual Dividend as follows: "An explanation of the intended use of the Equivalent Level Annual Dividend is included in the Life Insurance Buyer's Guide."
- j. A statement in close proximity to the Life Insurance Cost Indexes as follows: "An explanation of the intended use of these indexes is provided in the Life Insurance Buyer's Guide."
- k. The date on which the Policy Summary is prepared. The Policy Summary shall consist of a separate document. All information required to be disclosed shall not be minimized or obscure. Any amounts that remain level for two or more years of the policy may be represented by a single number that clearly indicates the amounts that are applicable for each policy year. Amounts in subsection (8)(e) shall be listed in total, not on a per thousand nor per unit basis. If more than one insured is covered under one policy or rider, guaranteed death benefits shall be displayed separately for each insured or for each class of insured if death benefits do not differ within the class. Zero amounts shall be displayed as zero and shall not be displayed as a blank space.

C. Disclosure requirements.

1. The insurer shall provide to all prospective purchasers, a Buyer's Guide and a Policy Summary before accepting the applicant's initial premium or premium deposit, unless the policy for which application is made contains an unconditional refund provision of at least 10 days or unless the Policy Summary contains an unconditional refund offer, in which case the Buyer's Guide and Policy

Summary shall be delivered with the policy or before delivery of the policy.

2. The insurer shall provide a Buyer's Guide and a Policy Summary to any prospective purchaser upon request.
 3. If the Equivalent Level Death Benefit of a policy does not exceed \$5,000, the requirement for providing a Policy Summary is satisfied by delivery of a written statement containing the information described in subsections (D)(8)(b), (c), (d), (e)(i) through (e)(iii), (f), (g), (j), and (k).
- D. General rules.**
1. Each insurer shall maintain at its home office or principal office for at least three years after its last authorized use a copy of each form the insurer authorized for use.
 2. A producer shall inform a prospective purchaser, before commencing a life insurance sales presentation, that the producer is acting as a life insurance producer and inform the prospective purchaser of the full name of the insurance company that the producer is representing. If an insurance producer is not involved in the sale, the insurer shall inform the prospective purchaser of the insurance company's full name.
 3. An insurer or producer shall not use terms such as financial planner, investment advisor, financial consultant, or financial counseling to imply that the insurance producer is generally engaged in an advisory business in which compensation is unrelated to sales unless that is true.
 4. If an insurer or producer refers to policy dividends, the reference shall include a statement that dividends are not guaranteed.
 5. An insurer shall not use a system or presentation that does not recognize the time value of money through the use of appropriate interest adjustments for comparing the cost of two or more life insurance policies unless the system or presentation is used to demonstrate the cash flow pattern of a policy and the presentation is accompanied by a statement disclosing that the presentation does not recognize that, because of interest, a dollar in the future has less value than a dollar today.
 6. In a presentation of benefits, an insurer shall not display guaranteed and non-guaranteed benefits as a single sum unless they are shown separately and in close proximity.
 7. An insurer shall include with a statement regarding the use of the Life Insurance Cost Indexes an explanation that the indexes are useful only for the comparison of the relative costs of two or more similar policies.
 8. An insurer shall include with a Life Insurance Cost Index that reflects dividends or an Equivalent Level Annual Dividend a statement that it is based on the company's current dividend scale and is not guaranteed.
 9. If an insurer reserves the right to change the premium for a basic policy or rider, the annual premium shall be the maximum annual premium.
- E.** An insurer's failure to provide or deliver a Buyer's Guide or a Policy Summary as provided in subsection (C) constitutes an omission that misrepresents the benefits, advantages, conditions, or terms of an insurance policy.

APPENDIX

Life Insurance Buyer's Guide

The face page of the Buyer's Guide shall read as follows:

Life Insurance Buyer's Guide

This guide can show you how to save money when you shop for life insurance. It helps you to:

- Decide how much life insurance you should buy,
- Decide what kind of life insurance policy you need, and
- Compare the cost of similar life insurance policies.

Prepared by the National Association of Insurance Commissioners

Reprinted by (Company Name)

(Month and year of printing)

The Buyer's Guide shall contain the following language at the bottom of page 2:

The National Association of Insurance Commissioners is an association of state insurance regulatory officials. This association helps the various Insurance Departments to coordinate insurance laws for the benefit of all consumers. You are urged to use this Guide in making a life insurance purchase.

Buying Life Insurance

When you buy life insurance, you want a policy that fits your needs without costing too much. Your first step is to decide how much you need, how much you can afford to pay and the kind of policy you want. Then, find out what various companies charge for that kind of policy. You can find important differences in the cost of life insurance by using the life insurance cost indexes that are described in this guide. A good life insurance producer or company will be able and willing to help you with each of these shopping steps.

If you are going to make a good choice when you buy life insurance, you need to understand what kinds are available. If one kind does not seem to fit your needs, ask about the other kinds that are described in this guide. If you feel that you need more information than is given here, you may want to check with a life insurance producer or company or books on life insurance in your public library.

This guide does not endorse any company or policy.

The remaining text of the buyer's guide shall begin on page 3 as follows:

Choosing the Amount

One way to decide how much life insurance you need is to figure how much cash and income your dependents would need if you were to die. You should think of life insurance as a source of cash needed for expenses of final illnesses, paying taxes, mortgages or other debts. It can also provide income for your family's living expenses, educational costs and other future expenses. Your new policy should come as close as you can afford to making up the difference between (1) what your dependents would have if you were to die now, and (2) what they would actually need.

Choosing the Right Kind

All life insurance policies agree to pay an amount of money if you die. But all policies are not the same. There are three basic kinds of life insurance.

1. Term insurance
2. Whole life insurance
3. Endowment insurance

Remember, no matter how fancy the policy title or sales presentation might appear, all life insurance policies contain one or more of the three basic kinds. If you are confused about a policy that sounds complicated, ask the producer or company if it combines more than one kind of life insurance. The following is a brief description of the three basic kinds:

Term Insurance

Term insurance is death protection of a "term" of one or more years. Death benefits will be paid only if you die within that term of years. Term insurance generally provides the largest immediate death protection for your premium dollar.

Some term insurance policies are "renewable" for one or more additional terms even if your health has changed. Each time you renew the policy for a new term, premiums will be higher. You should check the premiums at older ages and the length of time the policy can be continued.

Some term insurance policies are also "convertible." This means that before the end of the conversion period, you may trade the term policy for a whole life or endowment insurance policy even if you are not in good health. Premiums for the new policy will be higher than you have been paying for the term insurance.

Whole Life Insurance

Whole life insurance gives death protection for as long as you live. The most common type is called "straight life" or "ordinary life" insurance, for which you pay the same premiums for as long as you live. These premiums can be several times higher than you would pay initially for the same amount of term insurance. But they are smaller than the premiums you would eventually pay if you were to keep renewing a term insurance policy until your later years.

Some whole life policies let you pay premiums for a shorter period such as 20 years, or until age 65. Premiums for these policies are higher than for ordinary life insurance since the premium payments are squeezed into a shorter period.

Although you pay higher premiums, to begin with, for whole life insurance than for term insurance, whole life insurance policies develop "cash values" which you may have if you stop paying premiums. You can generally either take the cash, or use it to buy some continuing insurance protection. Technically speaking, these values are called "nonforfeiture benefits." This refers to benefits you do not lose (or "forfeit") when you stop paying premiums. The amount of these benefits depends on the kind of policy you have, its size, and how long you have owned it.

A policy with cash values may also be used as collateral for a loan. If you borrow from the life insurance company, the rate of interest is shown in your policy. Any money that you owe on a policy loan would be deducted from the benefits if you were to die, or from the cash value if you were to stop paying premiums.

Endowment Insurance

An endowment insurance policy pays a sum or income to you – the policyholder – if you live to a certain age. If you were to die before then, the death benefit would be paid to your beneficiary. Premiums and cash values for endowment insurance are higher than the same amount of whole life insurance. Thus endowment insurance gives you the least amount of death protection for your premium dollar.

Finding a Low Cost Policy

After you have decided which kind of life insurance fits your needs, look for a good buy. Your chances of finding a good buy are better if you use two types of index numbers that have been developed to aid in shopping for life insurance. One is called the "Surrender Cost Index" and the other is the "Net Payment Cost Index." It will be worth your time to try to understand how these indexes are used, but in any event, use them only for comparing the relative costs of similar policies. **LOOK FOR POLICIES WITH LOW COST INDEX NUMBERS.**

What is Cost?

“Cost” is the difference between what you pay and what you get back. If you pay a premium for life insurance and get nothing back, your cost for the death protection is the premium. If you pay a premium and get something back later on, such as a cash value, your cost is smaller than the premium.

The cost of some policies can also be reduced by dividends; these are called “participating” policies. Companies may tell you what their current dividends are, but the size of future dividends is unknown today and cannot be guaranteed. Dividends actually paid are set each year by the company.

Some policies do not pay dividends. These are called “guaranteed cost” or “non participating” policies. Every feature of a guaranteed cost policy is fixed so that you know in advance what your future cost will be.

The premiums and cash values of a participating policy are guaranteed, but the dividends are not. Premiums for participating policies are typically higher than for guaranteed cost policies, but the cost to you may be higher or lower, depending on the dividends actually paid.

What Are Cost Indexes?

In order to compare the cost of policies, you need to look at:

1. Premiums
2. Cash values
3. Dividends

Cost indexes use one or more of these factors to give you a convenient way to compare relative costs of similar policies. When you compare costs, an adjustment must be made to take into account that money is paid and received at different times. It is not enough to just add up the premiums you will pay and subtract the cash values and dividends you expect to get back. These indexes take care of the arithmetic for you. Instead of having to add, subtract, multiply and divide many numbers yourself, you just compare the index numbers which you can get from life insurance producers and companies:

1. **Life Insurance Surrender Cost Index.** This index is useful if you consider the level of the cash values to be of primary importance to you. It helps you compare costs if at some future point in time, such as 10 or 20 years, you were to surrender the policy and take its cash value.
Life Insurance Net Payment Cost Index. This Index is useful if your main concern is the benefits that are to be paid at your death and if the level of cash values is of secondary importance to you. It helps you compare costs at some future point in time, such as 10 or 20 years, if you continue paying premiums on your policy and do not take its cash value.

There is another number called the Equivalent Level Annual Dividend. It shows the part dividends play in determining the cost index of a participating policy. Adding a policy’s Equivalent Level Annual Dividend to its cost index allows you to compare total costs of similar policies before deducting dividends. However, if you make any cost comparisons of a participating policy with a non participating policy, remember that the total cost of the participating policy will be reduced by dividends, but the cost of the non participating policy will not change.

How Do I Use Cost Indexes?

The most important thing to remember when using cost indexes is that a policy with a small index number is generally a better buy than a comparable policy with a larger index number. The following rules are also important:

- (1) Cost comparisons should only be made between similar plans of life insurance. Similar plans are those which provide essentially the same basic benefits and require premium payments

for approximately the same period of time. The closer policies are to being identical, the more reliable the cost comparison will be.

- (2) Compare index numbers only for the kind of policy, for your age and for the amount you intend to buy. Since no one company offers the lowest cost for all types of insurance at all ages and for all amounts of insurance, it is important that you get the indexes for the actual policy, age and amount which you intend to buy. Just because a “Shopper’s Guide” tells you that one company’s policy is a good buy for a particular age and amount, you should not assume that all of that company’s policies are equally good buys.
- (3) Small differences in index numbers could be offset by other policy features, or differences in the quality of service you may expect from the company or its producer. Therefore, when you find small differences in cost indexes, your choice should be based on something other than cost.
- (4) In any event, you will need other information on which to base your purchase decision. Be sure you can afford the premiums, and that you understand its cash values, dividends and death benefits. You should also make a judgment on how well the life insurance company or producer will provide service in the future, to you as a policyholder.
- (5) These life insurance cost indexes apply to new policies and should not be used to determine whether you should drop a policy you have already owned for awhile, in favor of a new one. If such a replacement is suggested, you should ask for information from the company that issued the old policy before you take action.

Important Things To Remember – A Summary

The first decision you must make when buying a life insurance policy is choosing a policy whose benefits and premiums must closely meet your needs and ability to pay. Next, find a policy which is also a relatively good buy. If you compare Surrender Cost Indexes and Net Payment Cost Indexes of similar competing policies, your chances of finding a relatively good buy will be better than if you do not shop. **REMEMBER, LOOK FOR POLICIES WITH LOWER COST INDEX NUMBERS.** A good life insurance producer can help you to choose the amount of life insurance and kind of policy you want and will give you cost indexes so that you make cost comparisons of similar policies.

Don’t buy life insurance unless you intend to stick with it. A policy which is a good buy when held for 20 years can be very costly if you quit during the early years of the policy. If you surrender such a policy during the first few years, you may get little or nothing back and much of your premium may have been used for company expenses.

Read your new policy carefully, and ask the producer or company for an explanation of anything you do not understand. Whatever you decide now, it is important to review your life insurance program every few years to keep up with changes in your income and responsibilities.

Historical Note

Adopted effective June 13, 1977 (Supp. 77-3). R20-6-209 recodified from R4-14-209 (Supp. 95-1). Former R20-6-209 renumbered to R20-6-207; new R20-6-209 renumbered from R20-6-211 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-210. Readable and Understandable Policy: Private Passenger Automobile, Homeowner, Personal Line Dwelling, and Mobile Homeowner

A. Definitions. The following definitions apply in this Section:

Department of Insurance

1. "Readable insurance policy" means a policy that can be read and reasonably understood by a person without special knowledge or training.
 2. "Policy" means a contract or agreement for insurance, or an insurance certificate regardless of the name used, and includes all clauses, endorsements, and papers attached or incorporated.
- B.** Scope. This Section applies to private passenger motor vehicle policies, homeowner policies, personal line dwelling policies, for four family units or less, and mobile homeowner policies delivered or issued for delivery in Arizona.
- C.** Compliance.
1. An insurer shall test the readability of its policy by use of the Flesch Readability Formula as set forth in Rudolf Flesch, *The Art of Readable Writing* (1949, as revised 1974).
 2. An insurer shall not use a policy unless the policy has a total readability score of 40 or more on the Flesch scale.
 3. An insurer shall include with each policy form filing required to be filed with the Director a checklist for the line of insurance setting forth the Flesch score.
- D.** Readability guidelines.
1. General organization of text.
 - a. A policy shall be divided into logically arranged sections for ease of locating content.
 - b. Each section shall be self-contained as to provisions relating solely to that section (for example, an exclusion section shall not be mixed with other parts of a policy).
 - c. General policy provisions applying to all or several like coverages shall be located in a common area.
 - d. The policy shall not contain non-essential provisions.
 - e. Defined words and terms shall be placed in a separate section at the beginning of the policy.
 2. Visual aids to readability. The insurer shall ensure that each policy meets the following format requirements:
 - a. Type size shall be at least eight point.
 - b. The font shall be block print rather than script, and legible.
 - c. Captions and headings shall be distinguishable from the general text.
 - d. White space separating coverages, policy sections, and columns shall be sufficient to make a distinct separation.
 - e. Defined words and terms shall be distinguishable from the general text.
 3. Language usage. The insurer shall ensure that each policy:
 - a. Is written in everyday, conversational language;
 - b. Uses short, simple sentences and words in common usage;
 - c. Uses an easy-to-read style, personal pronouns, and present tense active verbs.
1. "Policy" means a contract or agreement for or effecting insurance, or a certificate of insurance, regardless of the name used, and includes all clauses, riders, endorsements, and attached papers.
 2. "Person" has the same meaning prescribed in A.R.S. § 20-105.
- B.** Scope. This Section applies to all policies delivered or issued for delivery in this state.
- C.** Prohibition. An insurer shall not engage in the following prohibited acts or practices that constitute unfair discrimination between individuals of the same class:
1. Refusal to insure or refusal to continue to insure, or limiting the amount, extent, or kind of coverage available to an individual solely because of blindness or partial blindness; or
 2. Charging an individual a different rate for the same coverage solely because of blindness or partial blindness.
- D.** In this subsection, "refusal to insure" includes denial by an insurer of disability insurance coverage on the grounds that the policy defines "disability" as being presumed if the insured loses eyesight. An insurer may exclude from coverage disabilities consisting solely of blindness or partial blindness if the insured was blind or partially blind when the policy was issued.
- E.** For all other conditions, including the underlying cause of the blindness or partial blindness, a person who is blind or partially blind is subject to the same standards of sound actuarial principles or actual or reasonably anticipated experience as a sighted person.

Historical Note

Adopted effective August 1, 1977 (Supp. 77-4).
 Amended effective March 27, 1976 (Supp. 78-2). Correction, Historical Note for Supp. 77-4 should read adopted effective January 1, 1979 filed August 1, 1977. Historical Note for Supp. 78-2 should read Appendix amended effective January 1, 1979 filed March 27, 1978 (Supp. 79-5). Editorial correction, (D)(7)(a), title now shown in italics (Supp. 81-1). R20-6-211 recodified from R4-14-211 (Supp. 95-1). Former R20-6-211 renumbered to R20-6-209; new R20-6-211 renumbered from R20-6-213 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-212. Forms for Replacement of Life Insurance Policies and Annuities

An insurer shall use the following forms of the National Association of Insurance Commissioners Model Regulations (and no future editions or amendments), which are incorporated by reference and available at the Department of Insurance, 2910 N. 44th St., Phoenix, AZ 85018 and the National Association of Insurance Commissioners, Publications Department, 2301 McGee St., Suite 800, Kansas City, MO 64108:

1. For the purpose of meeting the requirements of A.R.S. § 20-1241.03(C): Life Insurance and Annuities Replacement Model Regulation, Appendix A – Important Notice: Replacement of Life Insurance or Annuities, Volume III, pp. 613-11 through 613-12, July 2000.
2. For the purpose of meeting the requirements of A.R.S. § 20-1241.07(A): Life Insurance and Annuities Replacement Model Regulation, Appendix B – Notice Regarding Replacement: Replacing Your Life Insurance Policy or Annuity?, Volume III, pp. 613-13, July 2000.
3. For the purpose of meeting the requirements of A.R.S. § 20-1241.07(B)(2): Life Insurance and Annuities Replacement Model Regulation, Appendix C – Important Notice:

Historical Note

Adopted effective May 28, 1979 (Supp. 79-1). R20-6-210 recodified from R4-14-210 (Supp. 95-1). Former R20-6-210 renumbered to R20-6-208; new R20-6-210 renumbered from R20-6-212 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-211. Discrimination on the Basis of Blindness or Partial Blindness

A. Definitions. The following definitions apply in this Section:

Replacement of Life Insurance or Annuities, Volume III, pp. 613-14 through 613-15, 1998.

Historical Note

Adopted effective March 27, 1978 (Supp. 78-2). Editorial correction see subsection (A) citation to A.R.S. (Supp. 78-4). Editorial correction see subsections (B) and (F) citation to A.R.S. (Supp. 78-6). R20-6-212 recodified from R4-14-212 (Supp. 95-1). Former R20-6-212 renumbered to R20-6-210; new R20-6-212 renumbered from R20-6-215 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-212.01. Forms for Buyer's Guide for Annuities

An insurer shall use the following forms of the National Association of Insurance Commissioners Model Regulations (and no future editions or amendments), which are incorporated by reference and available at the Department of Insurance, 2910 N. 44th St., Phoenix, AZ 85018 and the National Association of Insurance Commissioners, Publications Department, 2301 McGee St., Suite 800, Kansas City, MO 64108:

For the purpose of meeting the requirements of A.R.S. § 20-1242.02 regarding a Buyer's Guide: Annuity Disclosure Model Regulation, Appendix - Buyer's Guide to Fixed Deferred Annuities, Volume II, pp. 245-6 through 245-13, 1999, with attached Appendix I - Equity-Indexed Annuities, Volume II, pp. 245-14 through 245-20, 1999.

Historical Note

Section R20-6-212.01 renumbered from R20-6-215.01 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-213. Life and Disability Insurance Policy Language Simplification

A. Definitions. The following definitions apply in this Section:

1. "Company" or "insurer" means any life or disability insurance company, benefit insurer, benefit stock insurer, prepaid dental plan organizations, health care service organizations, and all similar type organizations.
2. "Director" means the Director of Insurance of Arizona.
3. "Policy" or "policy form" means any policy, contract, plan or agreement of life or disability insurance, including credit life insurance and credit disability insurance, delivered or issued for delivery in the state by any company subject to this rule; and any certificate issued under a group insurance policy delivered or issued for delivery in this state.

B. Applicability.

1. This Section and R20-6-212 apply to all life and disability insurance policies delivered or issued for delivery in this state by any company but do not apply to:
 - a. Any policy that is a security subject to federal jurisdiction;
 - b. Any group policy covering a group of 1,000 or more lives at date of issue, other than a group credit life insurance policy or a group credit disability insurance policy however, this shall not exempt any certificate issued under a group policy delivered or issued for delivery in this state; or
 - c. Any group annuity contract that serves as a funding vehicle for pension, profit-sharing, or deferred compensation plans;
2. Except as provided in R20-6-210, no other rule of this state setting language simplification standards shall apply to any policy forms.

C. Minimum policy language simplification standards.

1. Except as stated in subsection (B), an insurer shall not deliver or issue for delivery a policy form that has not been approved by the Director unless:
 - a. The text achieves a minimum score of 40 on the Flesch reading ease test or an equivalent score on any other comparable test as provided in subsection (3);
 - b. It is printed, except for specification pages, schedules, and tables, in no less than 10 point type, one point leaded;
 - c. The style, arrangement and overall appearance of the policy do not give undue prominence to any portion of the text of the policy or to any endorsements or riders; and
 - d. The policy, if the policy has more than 3,000 words printed on three or fewer pages of text or if the policy has more than three pages regardless of the number of words, contains a table of contents or an index of the principal sections of the policy.
2. An insurer shall measure a Flesch reading ease test score as follows:
 - a. For policy forms containing 10,000 words or less of text, an insurer shall analyze the entire form. For policy forms containing more than 10,000 words, an insurer may analyze the readability of two, 200-word samples per page instead of the entire form. The insurer shall separate the samples by at least 20 printed lines.
 - b. The insurer shall count the number of words and sentences in the text, then divide the total number of words by the total number of sentences, then multiply that figure by a factor of 1.015.
 - c. The insurer shall count and divide the total number of syllables by the total number of words, then multiply that figure by a factor of 84.6.
 - d. The sum of the figures computed under subsections (b) and (c) subtracted from 206.835 equals the Flesch reading ease score for the policy form.
 - e. For subsections (b), (c), and (d), the insurer shall use the following procedures:
 - i. A contraction, hyphenated word, or numbers and letters, when separated by spaces, shall be counted as one word;
 - ii. A unit of words ending with a period, semicolon, or colon, but excluding headings and captions, shall be counted as a sentence; and
 - iii. A syllable means a unit of spoken language consisting of one or more letters of a word as divided by an accepted dictionary. If the dictionary shows two or more equally acceptable pronunciations of a word, the pronunciation containing fewer syllables may be used.
 - f. The term "text" as used in this subsection shall include all printed matter except the following:
 - i. The name and address of the insurer, the name, number or title of the policy, the table of contents or index, captions and subcaptions, specification pages, schedules or tables; and
 - ii. Policy language that is drafted to conform to the requirements of a federal law, regulation, or agency interpretation, policy language required by a collectively bargained agreement, medical terminology, words defined in the policy, and policy language required by law or regulation, if the insurer identifies the language or terminology excepted by this subsection and certi-

fies, in writing, that the language or terminology is entitled to be excepted by this subsection.

3. Any other reading test may be approved by the Director for use as an alternative to the Flesch reading test if it is comparable in result to the Flesch reading ease test.
4. Filings subject to this subsection shall be accompanied by a certificate signed by an officer of the insurer stating that the filing meets the minimum reading ease score on the test used or stating that the score is lower than the minimum required but should be approved under subsection (G) of this Section. To confirm the accuracy of any certification, the Director may require the submission of further information to verify the certification in question.
5. At the option of the insurer, riders, endorsements, applications and other forms made a part of the policy may be scored as separate forms or as part of the policy with which they may be used.

- D.** The Director may authorize a lower score than the Flesch reading ease score required in subsection (C)(1)(a) if a lower score:
1. Provides a more accurate reflection of readability of a policy form;
 2. Is warranted by the nature of a particular policy form or type or class of policy forms; or
 3. Is caused by certain policy language drafted to conform to the requirements of any state statute, rule, or agency interpretation of law.

Historical Note

Adopted effective November 21, 1977 (Supp. 77-6).

Amended effective March 27, 1978 (Supp. 78-2).

Amended subsection (E), deleted subsection (F) and added new subsections (F) and (G) effective December 3, 1986 (Supp. 86-6). R20-6-213 recodified from R4-14-213 (Supp. 95-1). Former R20-6-213 renumbered to R20-6-211; new R20-6-213 renumbered from R20-6-216 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2). Corrected error in R20-6-213(D) that referenced subsection (E)(1)(a), which was relabeled as (C)(1)(a) in Supp. 07-2 (Supp. 08-1).

R20-6-214. Coordination of Benefits

A. Applicability.

1. This Section applies to all:
 - a. Group disability insurance policies;
 - b. Group subscriber contracts of hospital and medical service corporations and health care services organizations;
 - c. Group disability policies of benefit insurers; and
 - d. Group-type contracts that contain a coordination of benefits provision, are not available to the general public, and can be obtained and maintained only because of the covered person's membership in or connection with a particular organization. Group-type contracts that meet this description are included regardless of whether denominated as "franchise," "blanket," or some other designation.
2. This Section does not apply to:
 - a. Individual or family policies or individual or family subscriber contracts except as provided for in subsection (A)(1);
 - b. Group or group-type hospital indemnity benefits, written on a non-expense incurred basis, of \$30 per day or less unless characterized as reimbursement-type benefits and designed or administered to give the insured the right to elect indemnity-type bene-

fits, instead of the reimbursement type benefits at the time of claim; or

- c. School accident type coverages, written on a blanket, group, or franchise basis.

B. Definitions. In this Section, the following definitions apply:

1. "Allowable expense" means any necessary, reasonable, and customary item of expense, at least a portion of which is covered under one or more of the plans covering the person for whom claim is made or service provided.
 - a. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered is deemed to be both an allowable expense and a benefit paid.
 - b. A plan that takes Medicare or similar government benefits into consideration when determining the application of its coordination of benefits provision does not expand the definition of an allowable expense.
2. "Claim determination period" means an appropriate period of time such as "calendar year" or "benefit period" as defined in the policy.
3. "Plan," within the coordination of benefits provisions of a group policy or subscriber contract, means the types of coverage that the insurer may consider in determining whether overinsurance exists with respect to a specific claim.
4. "School accident-type coverage" means coverage of grammar school and high school students for accidents only, including athletic injuries, either on a 24-hour basis or "to-and-from school," for which the parent pays the entire premium.

C. Order-of-benefit determination.

1. When a claim under a plan with a coordination of benefit provision involves another plan that also has a coordination of benefit provision, the insurer shall make the order-of-benefit determination as follows:
 - a. The plan that covers the person claiming benefits other than as a dependent shall determine benefits before those of the plan that covers the person as a dependent.
 - b. The plan of a parent whose birthday occurs earlier in a calendar year shall cover a dependent child before the benefits of a plan of a parent whose birthday occurs later in a calendar year. The word "birthday" as used in this subsection refers only to month and day in a calendar year, not the year in which the person was born.
 - c. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in the following order:
 - i. First, the plan of the parent with custody of the child;
 - ii. Then, the plan of the spouse of the parent with custody of the child; and
 - iii. Finally, the plan of the parent not having custody of the child.
 - d. Notwithstanding subsection (c), if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first.
2. The benefits of a plan that covers a person as an employee (or as that employee's dependent) are determined before those of a plan that covers that person as a

laid off or retired employee (or as that employee's dependent). If the other plan does not have this provision and if, as a result, the plans do not agree on the order of benefits, this subsection does apply.

3. If none of the provisions of subsection (C) determines the order of benefits, the benefits of the plan that covered a claimant longer are determined before those of the plan that covered that person for the shorter time.
4. If one of the plans is issued out of this state and determines the order of benefits based upon the gender of a parent and, as a result, the plans do not agree on the order of benefits, the plan with the gender rule shall determine the order of benefits.

D. Excess and other nonconforming provisions. A plan with an order of benefit determination provision that complies with this Section, a complying plan, may coordinate its benefits with a plan that is "excess" or "always secondary" or that uses an order-of-benefit determination provision that is inconsistent with this Section, a noncomplying plan, on the following basis:

1. If the complying plan is the primary plan, it shall pay or provide its benefits on a primary basis.
2. If the complying plan is the secondary plan, it shall pay or provide its benefits first, as the secondary plan. The payment shall be the limit of the complying plan's liability, except as provided in subsection (4).
3. If the noncomplying plan does not provide the information needed by the complying plan to determine its benefits within a reasonable time after it is requested to do so, the complying plan shall assume that the benefits of the noncomplying plan are identical to its own, and shall pay benefits accordingly. The complying plan shall adjust any payments it makes based on the assumption whether information becomes available as the actual benefits of the noncomplying plan.
4. If the noncomplying plan pays benefits so that the claimant receives less in benefits than the claimant would have received had the noncomplying plan paid or provided its benefits as the primary plan, the complying plan shall advance to or on behalf of the claimant an amount equal to the difference. The complying plan shall not have a right to reimbursement from the claimant.

Historical Note

Adopted effective October 26, 1979 (Supp. 79-5). R20-6-214 recodified from R4-14-214 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 491, effective September 30, 2001 (Supp. 02-1). Section R20-6-214 renumbered from R20-6-217 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-215. Renumbered

Historical Note

Adopted effective September 7, 1981 (Supp. 81-3). Amended subsections (D) thru (H), deleted Agent's Statement and Exhibit D effective March 30, 1983 (Supp. 83-2). R20-6-215 recodified from R4-14-215 (Supp. 95-1). Amended by exempt rulemaking at 9 A.A.R. 5595, effective January 1, 2004 (Supp. 03-4). Former R20-6-215 renumbered to R20-6-212 by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-215.01. Renumbered

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 5595, effective January 1, 2004 (Supp. 03-4). Former

R20-6-215.01 renumbered to R20-6-212.01 by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-216. Renumbered

Historical Note

Adopted effective as set forth in subsection (H) (Supp. 80-6). R20-6-216 recodified from R4-14-216 (Supp. 95-1). Former R20-6-216 renumbered to R20-6-213 by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-217. Renumbered

Historical Note

Adopted effective September 14, 1982 (Supp. 82-3). Amended subsections (C) and (D), deleted (F) effective January 1, 1987, filed December 16, 1986 (Supp. 86-6). R20-6-217 recodified from R4-14-217 (Supp. 95-1). Former R20-6-217 renumbered to R20-6-214 by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

Editor's Note: The following Section expired under A.R.S. § 41-1056(E) on September 30, 2001 at 8 A.A.R. 491. The Notice of Rule Expiration was not received until January 9, 2002. Therefore, the repeal of the rule noted in the Historical Note is moot (Supp. 02-1).

R20-6-218. Repealed

Historical Note

Adopted effective November 9, 1984 (Supp. 84-6). R20-6-218 recodified from R4-14-218 (Supp. 95-1). Section repealed by final rulemaking at 7 A.A.R. 5443, effective November 16, 2001 (Supp. 01-4). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 491, effective September 30, 2001 (Supp. 02-1) (see Editor's Note above).

ARTICLE 3. FINANCIAL PROVISIONS AND PROCEDURES

R20-6-301. Expired

Historical Note

Former General Rule Number 3. R20-6-301 recodified from R4-14-301 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 491, effective September 30, 2001 (Supp. 02-1).

R20-6-302. Expired

Historical Note

Former General Rule 62-11. R20-6-302 recodified from R4-14-302 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 491, effective September 30, 2001 (Supp. 02-1).

R20-6-303. Termination of Certificate of Authority and Release of Deposit

A. Domestic Insurers. To request termination of a certificate of authority and, if applicable, release of statutory deposit, a domestic insurer shall file all of the following with the director:

1. A written request for termination of certificate of authority and release of deposit;
2. The insurer's original certificate of authority or an affidavit of lost certificate of authority;
3. A statement of the insurer's financial condition as of a date within 60 days of the filing date of the request for termination that includes a written statement, signed by two officers of the insurer as authorized on the jurat page

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- of the insurer's most recent annual statement, verifying that the statement of financial condition reflects the insurer's financial position as of the date signed.
4. A plan of extinguishment for its outstanding liabilities that satisfies the requirements of subsection (C) or a sworn affidavit stating that the insurer has no outstanding liabilities to policyholders or claimants under subsection (C);
 5. A certified copy of the insurer's Board of Directors resolution or other documentation of the insurer's official action taken according to the insurer's statutorily required organizational documents approving the insurer's:
 - a. Withdrawal from the insurance business,
 - b. Dissolution of the insurer,
 - c. Merger with an insurer authorized in Arizona to transact the insurer's previously written and active lines of business of the insurer requesting termination, or
 - d. Transfer of domicile to another state or country.
 6. A copy of the insurer's Articles of Dissolution, Articles of Merger, Articles of Amendment, Articles of Redomestication, or other documentation that the insurer intends to file with the Arizona Corporation Commission after issuance of the Director's order as provided in subsection (D)(2);
 7. If requested by the director, a written agreement that guarantees payment of substantially all liabilities of the domestic insurer, other than obligations extinguished under subsection (C).
- B. Foreign and Alien Insurers.** To request termination of its certificate of authority and, if applicable, release of its deposit, a foreign or alien insurer shall file all of the following with the director:
1. A written request for termination of certificate of authority and release of deposit;
 2. The insurer's original certificate of authority or an affidavit of lost certificate of authority;
 3. A statement of the insurer's financial condition as of a date within 60 days of the filing date of the request for termination that includes a written statement, signed by two officers of the insurer as authorized on the jurat page of the insurer's most recent annual statement, verifying that the statement of financial condition reflects the insurer's financial position as of the date signed.
 4. A plan of extinguishment for its Arizona liabilities that satisfies the requirements of subsection (C) or a sworn affidavit stating that the insurer has no Arizona liabilities under subsection (C);
 5. A copy of an order issued by the insurance director or other appropriate regulatory authority in the insurer's state or country of domicile that approves or authorizes either the insurer's:
 - a. Withdrawal from the insurance business,
 - b. Dissolution of the insurer,
 - c. Merger (approval of the merger from the states of domicile of the insurers), or
 - d. Transfer of domicile, if applicable.
 6. A copy of the insurer's Articles of Dissolution, Articles of Merger, Articles of Amendment, Articles of Redomestication or other required documentation that the insurer filed in its state of domicile; and
 7. If requested by the director, a written agreement that guarantees payment of substantially all Arizona liabilities of the insurer, other than obligations extinguished under subsection (C).
- C. Insurer's Plan for Extinguishment of Liabilities.**
1. To extinguish substantially all liabilities under subsection (A)(4) or subsection (B)(4) as applicable, an insurer may:
 - a. Reinsure the insurer's business in force with another insurer by entering into an agreement of bulk reinsurance that shall be effective when filed with and approved in writing by the director.
 - i. The agreement shall provide for assumption of all policyholder claims by the reinsurer including claims incurred but unreported as of the effective date of the agreement.
 - ii. The agreement may include recapture provisions exercisable by the insurer in the event the termination of its certificate of authority is not completed.
 - iii. Unless the director otherwise approves, the agreement shall provide that the reinsurer be licensed in Arizona for the particular lines of business reinsured.
 - b. Merge with another insurer that:
 - i. Assumes the liabilities of the non-surviving insurer; and
 - ii. Is authorized in Arizona for the previously written and active lines of business assumed, unless otherwise approved by the director.
 - c. Use its deposit, any additional security deposit or both to secure payment of former policyholder, policyholder, or claimant liabilities that are not reinsured or otherwise secured.
 2. For purposes of this Section, "substantially all liabilities" under Title 20 means all policyholder and claimant obligations reported by the insurer in the statement of financial condition, whether or not liquidated in amount, and shall include former policyholder claims and rights to refunds.
- D. Consideration of the Request for Termination of Certificate of Authority and Release of Deposit under subsections (A) and (B).**
1. If the director determines that the insurer has extinguished substantially all liabilities as required under this Section and has otherwise demonstrated compliance with this Section and A.R.S. Title 20, the director shall grant the request to terminate the certificate of authority and, if appropriate, release the insurer's deposit, provided:
 - a. The insurer has no fees, taxes, assessments or filings outstanding to the Department; and
 - b. The insurer is not subject of any pending investigation or examination under Title 20 by the Department.
 2. The director's order shall condition the release of a domestic insurer's deposit upon receipt by the director of evidence of the official filing with the Arizona Corporation Commission of the documentation described in subsection (A)(6).
 3. If the director determines that the insurer is unable to extinguish substantially all liabilities as required under this Section, or otherwise has not complied with this Section or with A.R.S. Title 20, the director shall notify the insured in writing that the request has been denied and the reasons for the denial.
- E. Exclusions.** This Section does not apply to:
1. An insurer's exchange and substitution of cash or eligible securities under A.R.S. § 20-586;
 2. An insurer's withdrawal of excess deposits, either cash or eligible securities, under A.R.S. §§ 20-587 and 20-588(A)(2); or
 3. Releases of deposits made under A.R.S. § 20-588(A)(3).

Historical Note

Former General Rule 72-29. R20-6-303 recodified from R4-14-303 (Supp. 95-1). Section R20-6-303 repealed; new Section R20-6-303 made by final rulemaking at 14 A.A.R. 3432, effective October 4, 2008 (Supp 08-3).

R20-6-304. Reserved**R20-6-305. Expired****Historical Note**

Adopted effective September 13, 1978, except that it shall apply to the accounting treatment for unearned premium reserves and reinsurance premium receivables for credit life disability insurance on January 1, 1979, and all annual statements filed for periods on or after that date (Supp. 78-5). R20-6-305 recodified from R4-14-305 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 491, effective September 30, 2001 (Supp. 02-1).

R20-6-306. Reserved**R20-6-307. Life and Disability Reinsurance Agreements**

A. Scope. This rule applies to all domestic life and disability insurers and reinsurers, and to all other licensed life and disability insurers and accredited reinsurers that are not subject to a substantially similar rule in their jurisdictions of domicile. This rule applies to the disability business of licensed property and casualty insurers. This rule does not apply to assumption reinsurance, yearly renewable term reinsurance, or nonproportional stop loss or catastrophe reinsurance, or similar forms of nonproportional reinsurance.

B. Definitions

1. "Agreement" means a reinsurance agreement and any amendment to a reinsurance agreement.
2. "Credit Quality" means the risk that invested assets supporting the reinsured business will decrease in value but excludes decreases to changes in interest rate.
3. "Department" means the Arizona Department of Insurance.
4. "Director" means the Director of the Arizona Department of Insurance.
5. "Disintermediation" means the risk that interest rates will rise and policy loans and surrenders will increase or maturing contracts will not renew at anticipated rates of renewal.
6. "Lapse" means the risk that a policy will voluntarily terminate before the recoupment of a statutory surplus strain experienced at issuance of the policy.
7. "Reinvestment" means the risk that interest rates will fall and funds reinvested will therefore earn less than expected.

C. Accounting Requirements

1. Unless authorized by the director, an insurer shall not, for reinsurance ceded, reduce any liability, or establish any asset in any statutory financial statement filed with the Department if, by the terms of the agreement, or in effect, any of the following conditions exist:
 - a. Renewal expense allowances provided or to be provided to the ceding insurer by the reinsurer in any accounting period are not sufficient to cover the ceding insurer's allocable renewal expenses anticipated at the time the business is reinsured on the portion of the business reinsured, unless a liability is established for the present value of the shortfall using assumptions equal to the applicable statutory reserve basis on the business reinsured.
 - b. The ceding insurer is required to reimburse the reinsurer for negative experience under the agreement.

Neither the offset of the ceding insurer's experience refunds against current and prior years' losses, nor payment by the ceding insurer of an amount equal to the reinsurer's current and prior years' losses upon voluntary termination of in-force reinsurance by the ceding insurer, shall be considered a reimbursement to the reinsurer for negative experience.

- c. The ceding insurer may be deprived of surplus or assets at the reinsurer's option or automatically upon the occurrence of a specified event, including the insolvency of the ceding insurer. Termination of the agreement by the reinsurer for nonpayment of reinsurance premiums or other amounts due shall not be considered a deprivation of surplus or assets within the meaning of this subsection.
- d. The ceding insurer is required, at scheduled times, to terminate the agreement or recapture automatically all or part of the reinsurance ceded.
- e. The ceding insurer may be required to pay the reinsurer amounts other than from income reasonably expected from the reinsured policies.
- f. Significant risks inherent in the business reinsured are not transferred to the reinsurer. Table A identifies the risks deemed significant for representative types of business.
- g. The credit quality, reinvestment, or disintermediation risk is significant for the business reinsured and the ceding company does not transfer the underlying assets to the reinsurer, segregate the underlying assets in a trust or escrow account, or otherwise segregate the underlying assets. The assets that support the reserves for classes of business that do not have a significant credit quality, reinvestment, or disintermediation risk, or for long-term care or long-term disability insurance, traditional non-par permanent, traditional par permanent, adjustable premium permanent, indeterminate premium permanent, or universal life fixed premium with no dump-in premiums allowed, may be held by the ceding company without segregation. To determine the reserves for classes of business, the supporting assets of which may be held without being segregated, the reserve interest rate adjustment formula shall reflect the ceding company's investment earnings and incorporate all realized and unrealized gains and losses reported in the ceding insurer's statutory financial statement.
- h. Settlements are made less frequently than quarterly or payments due from the reinsurer are not made in cash within 90 days of the settlement date.
- i. The ceding insurer is required to make representations or warranties unrelated to the business reinsured.
- j. The ceding insurer is required to make representations or warranties related to future performance of the business reinsured.
2. An agreement entered into after the effective date of this rule to reinsure business issued before the effective date of the agreement shall be filed by the ceding insurer with the Director within 30 days after execution of the agreement. Each filing shall be accompanied by a description of the corresponding reduction in liabilities or other credit for reinsurance, and any other financial impact of the agreement, reported in the ceding insurer's statutory financial statements. When an increase in surplus net of federal income tax results from an agreement falling

under this subsection, the ceding insurer shall separately identify the increase as a surplus item in the aggregate write-ins for gains and losses in surplus in the Capital and Surplus account of the ceding insurer's statutory financial statement. As earnings emerge from the business reinsured, the ceding insurer shall report in its statutory financial statement recognition of surplus increase as income on a net of tax basis as reinsurance ceded.

D. Written Agreements

1. A ceding insurer shall not reduce any liability or establish any asset in any statutory financial statement filed with the Department, unless the ceding insurer and the reinsurer have executed an agreement or a binding letter of intent by the "as of" date of the statutory financial statement.

2. A ceding insurer shall not be allowed a credit for the reinsurance ceded based on a letter of intent unless the ceding insurer and the reinsurer execute an agreement within 90 days from the execution date of the letter of intent.
3. The agreement shall provide that:
 - a. The agreement constitutes the entire contract between the parties with respect to the business reinsured, and there are no understandings between the parties other than as expressed in the agreement; and
 - b. Any change or modification to the agreement shall be void unless made by written amendment signed by all parties.

Historical Note

Adopted effective February 3, 1993 (Supp. 93-1). R20-6-307 recodified from R4-14-307 (Supp. 95-1). Amended effective December 7, 1995 (Supp. 95-4).

Table A. Risk Categories

Risk Categories:

- | | |
|----------------|------------------------|
| (a). Morbidity | (d). Credit Quality |
| (b). Mortality | (e). Reinvestment |
| (c). Lapse | (f). Disintermediation |

	a	b	c	d	e	f
Disability Insurance, other than long-term care or long-term disability insurance	+	0	+	0	0	0
Long-term care or long-term disability insurance	+	0	+	+	+	0
Immediate Annuities	0	+	0	+	+	0
Single Premium Deferred Annuities	0	0	+	+	+	+
Flexible Premium Deferred Annuities	0	0	+	+	+	+
Guaranteed Interest Contracts	0	0	0	+	+	+
Other Annuity Deposit Business	0	0	+	+	+	+
Single Premium Whole Life	0	+	+	+	+	+
Traditional Non-par Permanent Life	0	+	+	+	+	+
Traditional Non-par Term Life	0	+	+	0	0	0
Traditional Par Permanent Life	0	+	+	+	+	+
Traditional Par Term Life	0	+	+	0	0	0
Adjustable Premium Permanent Life	0	+	+	+	+	+
Indeterminate Premium Permanent Life	0	+	+	+	+	+
Universal Life Flexible Premium	0	+	+	+	+	+
Universal Life Fixed Premium, with dump-in premiums allowed	0	+	+	+	+	+

+ - Significant

0 - Insignificant

Historical Note

Adopted effective December 7, 1995 (Supp. 95-4). Corrected misspelled word "adjustable" as submitted in final rule (Supp. 98-3).

R20-6-308. Determination of Insurer's Hazardous Financial Condition

- A.** The Director shall consider the following criteria, either singly or in combination, to determine whether any insurer is in such condition as to render the continuance of its business hazardous to its policyholders or the people of this state:
1. Whether any financial or market conduct examination reports, audited financial reports or the insurer's financial statement filings contain any adverse findings or information with respect to its financial condition;
 2. Whether any reports or information received from the National Association of Insurance Commissioners' Insurance Regulatory Information System are adverse to the insurer with respect to its financial condition;
 3. Whether the ratios of commission expense, general insurance expense, policy benefits and reserve increases to

annual premium and net investment income are adequate in relation to the insurer's capital and surplus;

4. Whether premium income is adequate in relation to capital and surplus;
5. Whether the insurer's assets are of sufficient fair market value, liquidity, and diversity to assure its ability to meet its outstanding obligations as they mature;
6. Whether the insurer's reinsurance provides adequate protection for the insurer's remaining surplus after taking into account the insurer's cash flow and the classes of business written as well as the financial condition of the assuming reinsurer;
7. Whether the insurer's operating loss in the last 12-month period or any shorter period of time, including but not limited to net capital gain or loss, change in non-admitted assets, and cash dividends paid to shareholders, is greater

- than 50% of such insurer's remaining surplus as regards policyholders that is in excess of the minimum required;
8. Whether asset values are attributable to investments in or transactions with parents, subsidiaries, or affiliates;
 9. Whether any affiliate, subsidiary or reinsurer of the insurer is impaired, unable to meet its obligations as they come due, or in a condition that would render the continuance of its business hazardous to the insurer's policyholders or the people of this state;
 10. Whether contingent liabilities, pledges or guaranties of the insurer, either individually or collectively, total an amount which equals or exceeds the insurer's net worth so as to jeopardize its solvency;
 11. Whether there is a substantial risk that the insurer will be called upon to meet its obligations under any contingent liability, pledge or guaranty;
 12. Whether any "controlling person" of an insurer as defined in A.R.S. § 20-481(3) is delinquent in transmitting net premiums to such insurer;
 13. Whether receivables are of doubtful collectibility;
 14. Whether all persons possessing, directly or indirectly, the power to cause the direction of the management and policies of the insurer, whether as the result of an official position or corporate office held by the person or through "control" as defined in A.R.S. § 20-481(3), are adequately competent, experienced and of good character to exercise such power;
 15. Whether an insurer has failed to fully respond to inquiries relative to the financial condition of the insurer or has furnished false or misleading information concerning such an inquiry;
 16. Whether an insurer has filed any false or misleading sworn financial statement, or has made a false or misleading entry in its financial records, or has omitted any entry from its financial records necessary to make such records truthful and accurate, or has made any misrepresentation to lending institutions or to the general public regarding its affiliations;
 17. Whether the insurer lacks adequate financial and administrative capacity to meet its obligations in a timely manner considering its growth;
 18. Whether the company has experienced cash flow or liquidity problems.
- B.** For the purpose of determining an insurer's financial condition under this rule, the Director may disregard or adjust the value of assets or increase liabilities based upon consideration of the criteria set forth in subsection (A).
- C.** If the Director determines that any insurer is in such condition as to render the continuance of its business hazardous to its policyholders or the people of this state, then, in addition to any other action authorized by A.R.S. Title 20, the Director may issue an order requiring the insurer to:
1. Reduce the total amount of present and potential retained liability for policy benefits by obtaining reinsurance;
 2. Reduce, suspend or limit the volume of insurance risk being accepted or renewed;
 3. Reduce its general insurance and commission expenses by specified methods;
 4. Increase its capital and surplus;
 5. Suspend or limit principal or interest payments on surplus notes or the declaration and payment of dividends to its stockholders or to its policyholders;
 6. File reports concerning the fair market value of its assets in accordance with A.R.S. § 20-235(C);
 7. Limit or withdraw from certain investments or discontinue certain investment practices;
 8. Establish the adequacy of premium rates in relation to the risks insured;
 9. File, in addition to regular annual statements, interim financial reports in accordance with A.R.S. § 20-235(C).
- D.** A hearing demanded by an insurer aggrieved by an order of the Director under subsection (C) shall be closed to the public, but the hearing shall be open to the public if so requested in accordance with A.R.S. § 20-164(A).
- E.** This rule shall not be interpreted to limit or supersede any provision of A.R.S. Title 20 or any other provision of law pertaining to the powers of the Director or the regulation of the financial condition of insurers transacting insurance in this state.
- Historical Note**
Adopted effective March 22, 1993 (Supp. 93-1). R20-6-308 recodified from R4-14-308 (Supp. 95-1).
- R20-6-309. Expired**
- Historical Note**
New Section adopted by final rulemaking at 6 A.A.R. 255, effective January 1, 2000 (Supp. 99-4). Section expired under A.R.S. § 41-1056(E) at 13 A.A.R. 1278, effective September 30, 2006 (Supp. 07-1).
- R20-6-309.01. Expired**
- Historical Note**
New Section adopted by final rulemaking at 6 A.A.R. 255, effective January 1, 2000 (Supp. 99-4). Section expired under A.R.S. § 41-1056(E) at 13 A.A.R. 1278, effective September 30, 2006 (Supp. 07-1).
- R20-6-309.02. Expired**
- Historical Note**
New Section adopted by final rulemaking at 6 A.A.R. 255, effective January 1, 2000 (Supp. 99-4). Section expired under A.R.S. § 41-1056(E) at 13 A.A.R. 1278, effective September 30, 2006 (Supp. 07-1).
- R20-6-309.03. Expired**
- Historical Note**
New Section adopted by final rulemaking at 6 A.A.R. 255, effective January 1, 2000 (Supp. 99-4). Section expired under A.R.S. § 41-1056(E) at 13 A.A.R. 1278, effective September 30, 2006 (Supp. 07-1).
- R20-6-309.04. Expired**
- Historical Note**
New Section adopted by final rulemaking at 6 A.A.R. 255, effective January 1, 2000 (Supp. 99-4). Section expired under A.R.S. § 41-1056(E) at 13 A.A.R. 1278, effective September 30, 2006 (Supp. 07-1).
- Appendix A. Expired**
- Table 1. Expired**
- Table 2. Expired**
- Table 3. Expired**
- Table 4. Expired**
- Table 5. Expired**
- Table 6. Expired**
- Historical Note**
Appendix A adopted by final rulemaking at 6 A.A.R. 255, effective January 1, 2000 (Supp. 99-4). Appendix A (including Tables 1 through 6) expired under A.R.S. § 41-1056(E) at 13 A.A.R. 1278, effective September 30, 2006 (Supp. 07-1).

ARTICLE 4. TYPES OF INSURANCE COMPANIES**R20-6-401. Proxies, Consents, and Authorizations of Domestic Stock Insurers**

A. The Department incorporates by reference National Association of Insurance Commissioners Model Laws, Regulations and Guidelines, Volume III, pp. 490-1 through 490-40, Regulation Regarding Proxies, Consents, and Authorizations of Domestic Stock Insurers, April 1995 (and no future editions or amendments), which is on file with the Office of the Secretary of State and available from the Department of Insurance, 2910 N. 44th St., Phoenix, AZ 85018 and the National Association of Insurance Commissioners, Publications Department, 2301 McGee St., Suite 800, Kansas City, MO 64108, modified as follows:

Section 1 A is modified to read: "No domestic stock insurer that has any class of equity securities held of record by 100 or more persons, or any director, officer or employee of that insurer, or any other person, shall solicit, or permit the use of the person's name to solicit, by mail or otherwise, any proxy, consent, or authorization in respect to any class of equity securities in contravention of this regulation and Schedules A and B, hereby made a part of this regulation."

B. Domestic stock insurance companies shall comply with this Section as required under A.R.S. § 20-143(B).

Historical Note

Former General Rule 57-3. R20-6-401 recodified from R4-14-401 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E), filed in the Office of the Secretary of State August 24, 2000 (Supp. 00-3). New Section made by final rulemaking at 9 A.A.R. 1086, effective March 6, 2003 (Supp. 03-1).

R20-6-402. Expired**Historical Note**

Former General Rule 69-19. R20-6-402 recodified from R4-14-402 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E), filed in the Office of the Secretary of State August 24, 2000 (Supp. 00-3).

Exhibit A. Expired**Historical Note**

Former General Rule 69-19. R20-6-402 recodified from R4-14-402 (Supp. 95-1). Exhibit expired under A.R.S. § 41-1056(E), filed in the Office of the Secretary of State August 24, 2000 (Supp. 00-3).

Exhibit B. Expired**Historical Note**

Former General Rule 69-19. R20-6-402 recodified from R4-14-402 (Supp. 95-1). Exhibit expired under A.R.S. § 41-1056(E), filed in the Office of the Secretary of State August 24, 2000 (Supp. 00-3).

R20-6-403. Expired**Historical Note**

Former General Rule 69-21. R20-6-403 recodified from R4-14-403 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E), filed in the Office of the Secretary of State August 24, 2000 (Supp. 00-3).

Appendix A. Expired**Historical Note**

R20-6-403, Appendix A recodified from R4-14-403, Appendix A (Supp. 95-1). Appendix expired under

A.R.S. § 41-1056(E), filed in the Office of the Secretary of State August 24, 2000 (Supp. 00-3).

Appendix B. Expired**Historical Note**

R20-6-403, Appendix B recodified from R4-14-403, Appendix B (Supp. 95-1). Appendix expired under A.R.S. § 41-1056(E), filed in the Office of the Secretary of State August 24, 2000 (Supp. 00-3).

Appendix C. Expired**Historical Note**

R20-6-403, Appendix C recodified from R4-14-403, Appendix C (Supp. 95-1). Appendix expired under A.R.S. § 41-1056(E), filed in the Office of the Secretary of State August 24, 2000 (Supp. 00-3).

R20-6-404. Repealed**Historical Note**

Former General Rule 73-31; Repealed effective January 1, 1981 (Supp. 80-6). R20-6-404 recodified from R4-14-404 (Supp. 95-1).

R20-6-405. Health Care Services Organization

A. Authority. This rule is adopted pursuant to A.R.S. §§ 20-142, 20-143, 20-106 and 20-1051 through 20-1068.

B. Purpose. The purpose of this rule is to implement the legislative intent, as expressed in Chapter 128, Laws of 1973, to regulate and control Health Care Services Organizations in the State of Arizona, (including, but not limited to Certificate of Authority, licensing, fees for licensing, disciplinary procedures for agents and control of solicitation of members and evidences of coverage).

C. Scope

1. The scope of this Rule is the scope of A.R.S. Title 20 as it relates to Insurers or Hospital or Medical Service Corporations. As it relates to Health Care Services Organizations, the scope of this rule is the scope of Title 20, Chapter 1 and Title 20, Chapter 4, Article 9, as provided in A.R.S. § 20-1068. This rule is applicable to agents of persons, and persons operating or proposing to operate Health Care Services Organizations in the State of Arizona.

2. The statutory authority for this rule, A.R.S. Title 20, Chapter 4, Article 9, does not provide for exemptions therefrom for persons or agents of persons subject thereto, and no such exemption is intended or should be presumed by this rule or any provision thereof.

D. Repeal. This rule does not repeal any known prior rule, memorandum, bulletin, directive or opinion on this subject matter. If such prior rule or directive exists and is in conflict herewith, the same is repealed hereby.

E. Definitions. As used in this rule, unless the context otherwise requires:

1. "Agent" has the meaning of A.R.S. § 20-282.
2. "Basic Health Care Services" has the meaning of A.R.S. § 20-1051.
3. "Certificate of Authority" means a Certificate authorizing operation of a Health Care Services Organization.
4. "Director" means the Director of Insurance of the State of Arizona.
5. "Enrollee" has the meaning of A.R.S. § 20-1051.
6. "Evidence of coverage" has the meaning of A.R.S. § 20-1051.
7. "Health Care Plan" has the meaning of A.R.S. § 20-1051.

8. "Health Care Services" has the meaning of A.R.S. § 20-1051.
 9. "Health Care Services Organizations" has the meaning of A.R.S. § 20-1051.
 10. "Hospital Service Corporation" has the meaning of A.R.S. § 20-822.
 11. "Insurer" has the meaning of A.R.S. § 20-106(C).
 12. "License" means the authority to act as an agent of a Health Care Services Organization.
 13. "Medical Service Corporation" has the meaning of A.R.S. § 20-822.
 14. "Net charges" means the total of all sums prepaid by or for all enrollees, less approved refunds, adjustments and deductions, as consideration for Health Care Services of a Health Care Plan under an Evidence of Coverage.
 15. "Person" has the meaning of A.R.S. § 20-1051.
 16. "Physician and patient relationship" has the meaning of A.R.S. § 20-833.
 17. "Prepaid Health Plans" means any Health Care Plan to pay or make reimbursement for Health Care Services on a prepaid basis other than insured plans otherwise authorized and approved under A.R.S. Title 20.
 18. "Prepaid Group Practice Plan" means a person authorized and approved under A.R.S. Title 20.
 19. "Provider" has the meaning of A.R.S. § 20-1051.
 20. "Transact" has the meaning of A.R.S. § 20-106(A) and (B).
 21. "Unqualified agent" means a person directly or indirectly representing or acting for a Health Care Services Organization and not qualified as an agent thereof.
- F. Certificate of Authority**
1. Policy. Persons and agents of persons operating Health Care Services Organizations as of May 7, 1973, shall comply with the application requirements of A.R.S. § 20-1052 on or before August 7, 1973.
 2. A Certificate of Authority shall not be granted until the Director is satisfied that the requirements of A.R.S. §§ 20-1052, 20-1053 and 20-1054 are met and will continue to be met.
 3. An examination of an applicant at the expense of the applicant for a Certificate of Authority may be ordered to be made if the applicant is not a resident, is controlled by a non-resident, or maintains a head or principal office out of its service area, and will be ordered to be made if the applicant contracts with providers, or for services outside a reasonable area, or has contract obligations under its evidence of coverage that are, or appear to be, inequitable or unreasonable as to the enrollees.
- G. Certificate of Authority – Application**
1. A person required to be qualified to do business in this State as a Health Care Services Organization, pursuant to A.R.S. § 20-1052 shall file an application for Certificate of Authority on Department Form E-104.
 2. Applications failing to comply with the requirements of A.R.S. § 20-1053 will be denied without prejudice to the filing of an application complying with such requirements.
 3. Health Care Services Organizations operating in this State as of May 7, 1973, and having submitted a sufficient application for Certificate of Authority as required by this rule, including the disclosure filings of paragraph (7) of this subsection, may continue to operate as an organization until the Director acts upon the application.
 4. The application for Certificate of Authority shall be verified by an authorized and qualified officer of the Health Care Services Organization.
5. The application for Certificate of Authority shall be accompanied by the fees required for a hospital or medical service corporation by A.R.S. § 20-167 and a tax return or returns on Department Form E-162, for the calendar year previous to the calendar year of application during which the applicant has done business in this State as a Health Care Services Organization, and the amount of tax due thereon after the effective date hereof, if any, as provided by A.R.S. § 20-1060. The filing of such returns or payment of such tax may be adjusted or waived by the Director upon application and affirmative showing in writing therefor justifying the adjustment or waiver.
 6. The Director may, upon written request accompanied by supporting documentation justifying the request, authorize the substitution of public information filed by an applicant under similar statutes or regulations in another state, or under federal requirements, or may waive such information or additional information.
 7. Pursuant to the authority of A.R.S. § 20-1053(13), the Director finds that biographical information disclosing the past activities, employment and financial transactions or principals, principal officers, controlling persons, and agents of applicant Health Care Services Organizations is necessary for the protection of residents of this State.
 8. Pursuant to the authority of A.R.S. § 20-1053(13), the Director finds that records of fingerprints of principal officers and agents of applicant Health Care Services Organizations may be necessary for the protection of citizens of this state and may be required prior to licensing or approval of a Certificate of Authority.
- H. Certificate of Authority – Application. The application for Certificate of Authority shall be accompanied by a power of attorney as required by A.R.S. § 20-1053(A)(10) on Department Form E-128.**
- I. Certificate of Authority – Grounds for denial**
1. Policy. A Certificate of Authority to operate a Health Care Services Organization shall not be granted until the Director is satisfied by the affirmative showing, verified by the applicant, that all of the requirements of A.R.S. §§ 20-1052, 20-1053 and 20-1054 are met and will continue to be met.
 2. Guidelines. The guidelines and standards for determination of appropriate mechanisms to achieve an effective Health Care Plan include, but are not limited to the following:
 - a. Ability to provide basic Health Care Services without undue restrictions, limitations, discrimination, unreasonable fee schedules, or unreasonable administrative costs; an affirmative showing that the form of organization does not evidence any coercion, duress or other compulsion over members;
 - b. The form of organization does not lend itself to practices prohibited by A.R.S. §§ 20-441 through 20-459, and
 - c. The evidence of coverage does not contain provisions or statements which are unjust, inequitable, misleading, deceptive or untrue or encourage misrepresentation.
 3. Failure to pay obligations. Applications for a Certificate of Authority to operate a Health Care Services Organization may be denied or rejected if the applicant has failed after 30 days from the entry of final judgment, to pay obligations within the provisions of an evidence of coverage issued by such applicant. The provisions of this Section may be waived by the Director upon a clear affirmative showing that the applicant is defending an

action or appealing a judgment at law or equity in a court of this state, or is required to obtain a Certificate of Authority so as to maintain such action.

4. Unauthorized agents. Applications for a Certificate of Authority to operate a Health Care Services Organization may be denied or rejected, after stated cause and opportunity to answer, if the applicant has, 90 days after the effective date, permitted transactions by an unauthorized agent.

J. Solicitation requirements

1. Forms for evidences of coverage, advertising matter, sales material and amendments thereto, will not be approved until the Director is satisfied by filing of Department Form P-107 accompanying the filing of such form and the payment of necessary fees, that the requirements of A.R.S. §§ 20-1057, 20-1054(2), and 20-1061 have been met and will continue to be met.
2. Each Health Care Services Organization shall maintain at its home or principal office a complete file containing every printed, published or prepared advertisement brochure, form letter of solicitation, evidence of coverage, certificate, agreement or contract, and a copy of all radio and television forms of the above hereafter disseminated in this or any other State with a notation attached to each such solicitation or inducement to indicate the manner and extent of distribution and the date of approval by the Department of such solicitation. Such advertising file shall be maintained for a period of not less than three years.

K. Annual report. Each Health Care Services Organization required to file an annual statement, shall, on or before March 1 of each year, file with the Director, together with its annual statement on Department Form E-13, a certificate executed by an authorized officer of the Health Care Services Organization stating that to the best of his knowledge, information and belief, all written solicitations disseminated during the preceding statement year complied or were made to comply with the provisions of Title 20, Chapter 4, Article 9, and this rule, and that no forms of solicitation were disseminated without the prior approval of the Director.

L. Taxes

1. All Health Care Services Organizations operating and transacting business in the State of Arizona shall on or before March 1 and with the filing of the Annual Report, file a tax return on Department Form E-162, and pay the tax due on such return pursuant to A.R.S. § 20-1060.
2. A tax return required to be filed and filed with an application for Certificate of Authority may cover a period of time of less than a calendar year as specified in the return and approved by the Director. Annual tax returns required to be filed coincident with the annual report shall be for the full calendar year next preceding the date of filing the annual report.
3. Net charges, as in this rule defined, shall represent the net charges received during the calendar year next preceding the date of filing the annual report and tax return.

M. Deposit requirements

1. In the event a Health Care Services Organization determines to maintain statutory deposits by a surety bond, such surety bond shall be in form as approved by the Director guaranteeing the payment of Health Care Services furnished to enrollees, and shall be deposited with the State Treasurer.
2. In the event a Health Care Services Organization determines to maintain the deposit requirements by filing securities with the State Treasurer, a full and complete

statement of the securities proposed to be deposited, together with sufficient information to permit a determination of eligibility of such securities shall be filed with the Director on Department Form E-123, and such securities shall not be deposited until such securities are approved by the Director in writing.

3. No securities deposited as herein provided shall be exchanged or substituted for similar securities, except upon the prior written approval of the Director.
4. Health Care Services Organizations claiming to be exempt from the deposit requirement, pursuant to A.R.S. § 20-1055(f) shall submit to the Director an affirmative showing or certification executed by an authorized federal, state or municipal government or political subdivision thereof, demonstrating operational commitments equivalent to the statutory deposit requirements.
5. Statutory deposits shall not be withdrawn or a surety bond cancelled until all contingent and perfected liens, including judgments, debts, and other liabilities for payment of Health Care Services to which the enrollee is entitled under the evidence of coverage shall have been paid and the Director has given his authority in writing to withdraw such deposits or cancel such bonds.

N. Reserve requirements. Reserves required by A.R.S. § 20-1056 shall be deposited or maintained as cash, as Certificates of Deposit, or as securities eligible for investment of the capital of domestic insurers, pursuant to A.R.S. §§ 20-537 and 20-538.

O. Insurers and hospital and medical service corporations – Certificate of Authority

1. Insurers, Hospital Service Corporation, Medical Service Corporations, and Hospital and Medical Service Corporations, holding current Certificates of Authority to do business in this state may organize and operate Health Care Services Organizations jointly or severally without compliance with the deposit and reserve requirements of the statute, if the application contains an affirmative showing that the applicant organization has complied with comparable provisions of Title 20, and is an appropriate mechanism to achieve an effective Health Care Plan.
2. The provisions of statute and this rule applying to Certificates of Authority and Application therefor, shall apply to all insurers, Hospital Service Corporations, Medical Service Corporations, and Hospital and Medical Service Corporations doing business in this state.
3. Organizations claiming exemption or partial exemption pursuant to A.R.S. § 20-1063(c) shall file with the Director simultaneously with the application for Certificate of Authority, a statement affirmatively showing that the applicant has complied with provisions of Title 20 A.R.S. comparable to or more restrictive than the provisions of Title 20, Chapter 4, Article 9, and shall have received the written approval of the Director for such exemption or partial exemption.

P. Application, examination and licensing of agents

1. No agent of a Health Care Services Organization shall be eligible for transactions of a Health Care Services Organization, unless, prior to making any solicitation or transaction, he has been appointed agent by a Health Care Services Organization holding a current valid Certificate of Authority and has been licensed as herein provided. Persons directly or indirectly representing or acting for a Health Care Services Organization and not licensed as herein provided, or otherwise qualified under A.R.S. Title 20, shall be an unqualified agent.

2. Any person applying for a license as an agent of a Health Care Services Organization shall do so by filing with the Department of Insurance the following:
 - a. An application for such license on a form approved by the Director of the Department of Insurance;
 - b. The required fees for such license;
 - c. Such additional information as the Director may deem necessary.
 3. The licensing of an agent of a Health Care Services Organization shall not become effective until such applicant shall have satisfactorily passed a written examination in accordance with A.R.S. § 20-292 as supplemented by A.R.S. § 20-167.
 4. The examination shall be given in such places and at such times as the Director shall from time to time designate.
 5. The form of examination and the manual may be altered and amended from time to time, so as to represent a fair test of the applicant's qualifications.
 6. Every applicant for license shall satisfactorily complete the examination given with a grade of at least 70%, or such other percentage as may be fixed from time to time by the Director prior to the examination commensurate with the nature of the examination given.
 7. License and examination fees shall be in accordance with A.R.S. § 20-167.
 8. Report of the results of any examination given pursuant to this rule shall be mailed to the applicant and to the applicant's Health Care Services Organization at the address shown on the application.
 9. Except as modified by this rule, the provisions for examination, licensing, annual fees and disciplinary procedures of Chapter 2, Article 3 of Title 20, shall apply.
 10. Any agent licensed in this state shall immediately report to the Director any judgment or injunction entered against him on the basis of conduct deemed to have involved fraud, deceit, misrepresentation, or other violation affecting his license and all complaints or charges of misconduct lodged with his employer, any public agency of the state, or another state.
 11. The Director may reject any application or suspend or revoke, or refuse to renew any agent's license for inducements or statements which are unjust, unfair, inequitable, misleading or deceptive, or which encourage misrepresentation, or are untrue or misleading.
 12. The rules, standards and guidelines governing any proceeding relating to the suspension or revocation of the license of a life insurance agent, where applicable, shall also govern any proceedings for suspension or revocation of the license of an agent of a Health Care Services Organization.
 13. Renewal of a license of an agent shall follow the same procedure as heretofore established for renewal of insurance agents' licenses in this state.
 14. Renewal of a license of an agent shall follow the same procedure as heretofore established for renewal of insurance agents' licenses in this state.
- Q. Forms**
1. The forms prescribed by this rule and the instructions applicable thereto are adopted as requirements of the Director and necessary for the protection of citizens of this state. Such forms, instructions, manuals or examinations are those currently in use, but the same may be amended without reference to this rule and when approved as amended are incorporated in this rule by reference. The form of manual or examination of agents, or any form adopted by the Director may be reproduced for the purpose of reporting or for other purposes.
 2. For good cause shown, the Director may authorize the filing of forms and reports on dates other than required by this rule, if applied for in writing not less than 10 days prior to the due date of such report and statement, exhibit, return or accounting.
- R. Severability.** In any provision of this rule or the forms, statements, returns or reports made part of this rule, or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect the provisions of applications of this rule, which can be given effect without the invalid provision or application, and to this end the provisions of this rule are declared to be severable.
- S. Effective date.** This rule became effective on the 7th day of May, 1973. Amendments to this rule shall become effective upon filing with the Secretary of State.
- Historical Note**
- Former General Rule 73-33; Amended subsections (E), (P), (R), (S), and (T) effective August 12, 1981 (Supp. 81-4). R20-6-405 recodified from R4-14-405 (Supp. 95-1).
- R20-6-406. Expired**
- Historical Note**
- Adopted effective May 18, 1978 (Supp. 78-3). R20-6-406 recodified from R4-14-406 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E), filed in the Office of the Secretary of State August 24, 2000 (Supp. 00-3).
- R20-6-407. Service Companies**
- A. Scope.** This rule shall apply to all service companies except those which are exempt under A.R.S. § 20-1095.02.
- B. Definitions.**
1. "Gray Market" auto means an imported motor vehicle which has not been certified for all safety, emission, and other federal and state standards prior to the arrival of the vehicle into the United States.
 2. "Service" within the meaning of Article 11, Chapter 4, Title 20 includes reimbursement for towing, car rental, lodging or travel breakdown expenses.
 3. The "Contract Holder" means the consumer as defined in A.R.S. § 20-1095(1).
- C. Application for service company permit.**
1. The application for a service company permit under this rule shall be on the form designated by the director which shall contain the following information:
 - a. The name of applicant;
 - b. Arizona address of applicant;
 - c. The home office address of applicant;
 - d. Type of entity (e.g. corporation, partnership);
 - e. Type of equipment to be serviced;
 - f. Fiscal year of applicant;
 - g. A list of suspensions, revocations or other disciplinary or rehabilitative actions against the service company in this or any other jurisdiction. The application form shall be signed under oath and acknowledged by the chief executive officer, chairman of the board of directors, or other person having power of attorney, in which case the power of attorney shall be attached.
 2. The following items shall be attached to the application form and shall complete the application:
 - a. A copy of the service company's most recent financial statement, sworn to and certified by the owner, duly elected officers, or a certified public accountant.

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- b. Evidence of having deposited cash or acceptable securities pursuant to A.R.S. § 20-1095.04.
 - c. Surety bond in lieu of deposit under subparagraph (b) on a form acceptable to the Director.
 - d. Initial nonrefundable permit fee of \$100 with each new application.
 - e. A biographical affidavit, on a form approved by the director, for each officer, director, manager or person owning 25% or more of the service company, and for each officer, director, manager or person owning 25% or more of an entity which owns the service company.
 - f. A copy of the service company's service contract, application, claim forms, brochures, and other forms used in connection with the sale.
- D.** Deposit. A service company providing a deposit of cash or alternatives to cash pursuant to A.R.S. § 20-1095.04 shall maintain the deposit in the amount required and such deposit shall not be encumbered. The deposit shall not be released except pursuant to one of the following:
- 1. The service company provides a bond or mechanical reimbursement policy which covers the outstanding service contract liabilities.
 - 2. All outstanding service contracts and liabilities thereunder have been assumed by a service company, in good standing, with the approval of the director, acknowledged by the assuming service company's administrator and acknowledged by endorsement by the mechanical reimbursement insurer or surety.
 - 3. Evidence satisfactory to the director that:
 - a. All outstanding service contracts and liabilities have expired or been cancelled in accordance with the service contract terms,
 - b. That all claims have been settled,
 - c. That there is no reason to believe there are any unreported claims, and
 - d. That the service company is financially able and agrees to be financially responsible for any valid unreported claims.
- E.** The service contract, approval of forms.
- 1. Each service company holding a service company permit or applying for such permit shall submit all contract, claim and application forms, brochures and other advertising material to the Director for approval not less than 30 days prior to the proposed effective date thereof. No form, brochure or other printed material may be used until approved by the Director or has been on file with the Director more than 30 days.
 - 2. No service contract shall be approved unless it contains a provision permitting the cancellation of the contract. The cancellation provision shall provide for a pro rata refund after deducting for administrative expenses associated with the cancellation. No claim incurred or paid shall be deducted from the amount to be returned. The cancellation provision shall not contain both cancellation penalty and a cancellation fee.
 - 3. No service contract or application shall be approved unless it:
 - a. Is written in nontechnical, readily understood language, using words with common everyday meanings;
 - b. Provides for the performance of services within a reasonable period of time of the request for such services by the holder of the contract;
 - c. Discloses on the face of the application and the contract:
 - i. The name, address and telephone number of the service company;
 - ii. The name, address and telephone number of the service contract administrator, if any;
 - iii. The name of the individual who sold the service contract.
- d. Clearly, conspicuously and plainly states:
- i. The services to be performed by the service company and the terms and conditions of such performance;
 - ii. The service fee or deductible charge, if any, to be charged, or applied, for service calls and/or each covered repair.
 - iii. Each of the systems, products, appliances and components covered by the contract;
 - iv. The period during which the contract will remain in effect;
 - v. All limitations respecting the performance of services, including any restrictions as to time periods when services may be required or will be performed;
 - vi. The cost of the service contract;
 - vii. Those specific items or components which are excluded from coverage in large bold type;
 - viii. The conditions, if any, under which the service contract or coverage may be reinstated after coverage has been voided by acts or omissions by the service contract holder;
 - ix. The material acts or omissions by the contract holder which cancel or void coverage;
4. No service contract shall be approved if:
- a. The coverage may be cancelled or voided due to acts or omissions of the service company, its assignees or subcontractors for their failure to provide correct information of their failure to perform the services or repairs provided in a timely, competent, workmanlike manner;
 - b. Parts or components repaired or replaced under the service contract are excluded;
 - c. The contract can be cancelled or voided by the service company or its representatives for the following reasons including but not limited to:
 - i. Pre-existing conditions;
 - ii. Prior use or unlawful acts relating to the product;
 - iii. Misrepresentation by either the service company or its subcontractors;
 - iv. Ineligibility for the program, including gray market, high performance and GM diesel autos.
- F.** Disapproval of contracts, applications or advertising. The director may disapprove any service contract, application or advertising material that is in violation of this rule by issuing an order specifying in what respect the service contract, application or advertising material violates this rule. Any person aggrieved by such an order can demand a hearing thereon in accordance with A.R.S. § 20-1095.09.
- G.** Permit expiration; renewal.
- 1. Each permit issued pursuant to this rule shall expire at midnight on the last day of the service company's fiscal year. Thereafter, the service company shall have 90 days in which to file its completed renewal application including its certified financial statement and pay the renewal fee of \$100. A permit shall remain in effect upon the service company's timely payment of the renewal fee, timely filing of its annual financial statement and com-

- pleted renewal application. An incomplete application will not be considered received until it is complete.
2. Any late filing of the renewal application, financial report or late payment of the renewal fee shall be subject to a late fee of \$25 per day. Such late fee shall not release the service company of liability for other violations of these rules or other laws.

Historical Note

Adopted effective April 30, 1981 (Supp. 81-2). Former Section R4-14-407 repealed and a new Section R4-14-407 adopted effective July 2, 1987 (Supp. 87-3). R20-6-407 recodified from R4-14-407 (Supp. 95-1).

R20-6-408. Motor Vehicle Service Contract Program

- A. Scope. This rule shall apply to all motor vehicle service contract programs as defined in A.R.S. § 20-1095(5).
- B. Definitions.
 1. "Gray Market" auto means an automobile which has not been certified for all safety, emission, and other federal and state standards prior to the arrival of the vehicle into the United States.
 2. "Service" within the meaning of Article 11, Chapter 4, Title 20 includes reimbursement for towing, car rental, lodging or travel breakdown expenses.
 3. The "Contract Holder" means the consumer as defined in A.R.S. § 20-1095(1).
- C. Application for motor vehicle service contract program.
 1. The application for approval of a motor vehicle service contract program under this rule shall be on the form designated by the director which shall contain the following information:
 - a. Name of administrator;
 - b. Arizona address of administrator;
 - c. Home office of administrator;
 - d. The type of entity (e.g. corporation, partnership);
 - e. Whether the administrator is an insurer;
 - f. The name of the program. The application form shall be signed under oath and acknowledged by the chief executive officer, chairman of the board of directors, or other natural person having power of attorney to represent the entity, in which case the power of attorney shall be attached to the application.
 2. The following items shall be attached to the application form and shall complete the application:
 - a. Mechanical reimbursement insurance policy with an Arizona endorsement on a form acceptable to the Director, or an Arizona bond on a form acceptable to the Director which will be issued to each dealer or cash or securities deposited with the state treasurer through the Director's office in lieu of the policy or bond.
 - b. Initial nonrefundable permit fee of \$100 with each application. A separate and complete application and fee must be submitted for each service contract form.
 - c. A list of the dealers who propose to sell the motor vehicle service contract program, if known.
 - d. The service contract program, including all contract forms, claims forms, applications, brochures, and other forms used in connection with the sale.
 - e. Biographical affidavits, on a form approved by the Director, for each person owning 25% or more of the administrator or insurer.
 - f. The name and address of its statutory agent in Arizona for the purpose of service of process.

3. If the administrator or insurer elects to use a mechanical reimbursement insurance policy, then the following applies to meet the requirements of A.R.S. § 20-1095.06(B):
 - a. An application shall not be submitted before an insurance company has had its rules, rates and forms approved. The insurance company must file the mechanical reimbursement policy forms, rules and rates for approval.
 - b. The cancellation procedure in the mechanical reimbursement policy, any procedure manual and the service contract shall be consistent.
 - c. The insurance company shall give insureds 30 days prior notice of any rate revisions to take effect.
 - d. Mechanical reimbursement policies which void coverage if the dealer, its own authorized repair facility, or its subcontractor provide incorrect or unverifiable information shall not be approved.
 - e. A mechanical reimbursement policy must be issued by the insurance company to each dealer selling a service contract program.
4. An administrator or an insurer applying for approval pursuant to A.R.S. § 20-1095.06 of a motor vehicle service contract program, which is insured by a mechanical reimbursement policy or surety bond, shall certify that the policy or surety bond is effective prior to the sale of contracts by the dealer.
5. In the event that a surety bond, cash or securities are used to meet the requirements of A.R.S. § 20-1095.06(B), the administrator or insurer shall file with the Director within 90 days after the end of the motor vehicle dealer's accounting year a report stating the number of contracts in force at the end of the year and that the surety bond, cash or securities has been increased as required by A.R.S. § 20-1095.06.
- D. Approval of forms.
 1. Each administrator or insurer applying for approval of its motor vehicle service contract program, or amendment thereof, shall submit all contract, claim, and application forms, brochures and other advertising material to the Director for approval not less than 30 days prior to the proposed effective date thereof. No form, brochure or other printed material may be used until approved by the Director or has been on file with the Director more than 30 days.
 2. No service contract shall be approved unless it contains a provision permitting the cancellation of the contract. The cancellation provision shall provide for a pro rata refund after deducting for administrative expenses associated with the cancellation. No claim incurred or paid shall be deducted from the amount to be returned. The cancellation provision shall not contain both a cancellation penalty and a cancellation fee.
 3. No service contract or application shall be approved unless it:
 - a. Is written in nontechnical, readily understood language, using words with common everyday meanings;
 - b. Provides for the performance of services within a reasonable period of time of the request for such services by the holder of the contract;
 - c. Discloses on the face of the application and the contract:
 - i. The name, address and telephone number of the motor vehicle dealer, if any;

- ii. The name, address and telephone number of the contract administrator, if any;
 - iii. The name of the individual who sold the service contract.
- d. Clearly, conspicuously and plainly states:
 - i. The services to be performed by the motor vehicle dealer and the terms and conditions of such performance;
 - ii. The service fee or deductible charge, if any, to be charged, or applied, for each covered repair;
 - iii. Each of the systems and components covered by the contract;
 - iv. The period during which the contract will remain in effect;
 - v. All limitations respecting the performance of services, including any restrictions as to time periods when services may be required or will be performed;
 - vi. The cost of the service contract;
 - vii. Those specific items or components which are excluded from coverage in large bold type;
 - viii. The conditions, if any, under which the service contract or coverage may be reinstated after coverage has been voided by acts or omissions by the service contract holder;
 - ix. The material acts or omissions by the contract holder which cancel or void coverage;
- 4. No service contract shall be approved if:
 - a. The coverage may be cancelled or voided due to acts or omissions of the motor vehicle dealer, its assignees or subcontractors for their failure to provide correct information or their failure to perform the services or repairs promised in a timely, competent, and workmanlike manner;
 - b. Parts or components repaired or replaced under the service contract are excluded;
 - c. The contract can be cancelled or voided by the administrator, insurer or its representatives for reasons which are within the knowledge and/or control of the motor vehicle dealer including but not limited to:
 - i. Pre-existing conditions;
 - ii. Prior use or the odometer has been tampered with prior to purchase;
 - iii. Misrepresentation by either the motor vehicle dealer or its subcontractors;
 - iv. Ineligibility for the program, including gray market, high performance and GM diesel autos.
- E. Disapproval of contracts, applications or advertising. The director may refuse to approve or disapprove program or advertising material that is in violation of this Rule by issuing an order specifying in what respect the motor vehicle service contract program or advertising material violates this Rule. Any person aggrieved by such an order can demand a hearing thereon in accordance with A.R.S. § 20-1095.09.
- F. Motor vehicle dealer's notice of intent. The motor vehicle dealer's notice of intent required by A.R.S. § 20-1095.07(B) shall be certified by an individual having authority to represent the dealer and shall include the following information:
 - 1. The dealer's name, address and dealer's license number;
 - 2. The name of the administrator;
 - 3. The name or other identification of each motor vehicle service contract program which it intends to sell;
 - 4. The name of the insurer(s), the policy number(s) and the expiration date(s) of its mechanical reimbursement policy or bond;
- 5. Confirmation that the dealer will notify the director by certified mail prior to effecting any change in the information provided in its notice of intent. The notice of intent shall be continuous until withdrawn or amended by the motor vehicle dealer.

Historical Note

Former Section R4-14-408 renumbered as Section R4-14-409; a new Section R4-14-408 adopted effective July 15, 1987 (Supp. 87-3). R20-6-408 recodified from R4-14-408 (Supp. 95-1).

R20-6-409. Hospital, Medical, Dental, and Optometric Service Corporations

- A. Applicability. This rule applies to all subscription contracts issued by hospital, medical, dental and optometric service corporations.
- B. Subscription contract provision. Subscription contracts of hospital, medical, dental and optometric service corporations subject to the provisions of Article 3, Chapter 4 of Title 20, A.R.S., shall meet the requirements of the following rules:
 - 1. R20-6-201. Advertisements of disability insurance.
 - 2. R20-6-209. Unfair sex discrimination.
 - 3. R20-6-210. Group coverage discontinuance and replacement.
 - 4. R20-6-213. Unfair discrimination on the basis of blindness, partial blindness, or physical disability.
 - 5. R20-6-216. Life and disability insurance policy language simplification.
 - 6. R20-6-302. Valuation of reserves for disability policies.
 - 7. R20-6-606. Medicare supplement insurance disclosure and minimum standards.
 - 8. R20-6-607. Reasonableness of benefits in relation to premium charged.
- C. Severability. If any provision of this rule or the application thereof to any person or circumstance is for any reason held invalid, the remainder of the rule and the application of such provision to other persons or circumstances shall not be affected thereby.

Historical Note

Adopted effective July 9, 1982 (Supp. 82-4). Former Section R4-14-408 renumbered without change as Section R4-14-409 effective July 15, 1987 (Supp. 87-3). R20-6-409 recodified from R4-14-409 (Supp. 95-1).

ARTICLE 5. THE INSURANCE CONTRACT

R20-6-501. Ten-day Period to Examine Disability Insurance Policy

For the purpose of implementing A.R.S. §§ 20-442, 20-443, 20-826, 20-1111 and 20-1113 and to make more specific the regulation therein provided relative to policies of individual disability insurance (accident and sickness, hospitalization, medical, surgical and loss of time) issued in the State of Arizona and further to provide satisfactory public remedy against the hazards of misunderstanding by an applicant, of deception and coercion by an agent and of certain policy exclusions and limitations that cheapen the value of coverage, the Insurance Department of Arizona adopts the following rule:

- 1. Each policy of individual disability insurance, except one for which no provision for renewal is made, issued for delivery in the State of Arizona on or after October 1, 1961, by an insurance company or by a hospital or medical service corporation shall have printed on the first page thereof or attached thereto or endorsed thereupon in prominent style a notice declaring that, during a period of 10 days (or, at the insurer's option, a longer period) from the date of delivery to the policyholder, such policy may

be returned for cancellation to the insurer at its home office (or, at the insurer's option, to its branch office or to the agent through whom it was purchased) and declaring further that in the event of such return the insurer will refund the entirety of any premium paid therefor, including any policy fees or other charges, and that the policy shall be deemed void from the beginning and that the par-

ties shall be returned to their original position as if no policy had been issued.

2. The Insurance Department does not specify the particular language the notice shall contain but prefers usage of a phraseology approximately along the lines of either the longer (Form A) or shorter (Form B) sample below:

Sample Form A

NOTICE OF TEN-DAY RIGHT TO EXAMINE POLICY

The _____ Insurance Company urges you to read this policy carefully and trusts that upon doing so you will fully understand, and will be pleased with, its coverage. If, however, questions arise or information is desired, do not hesitate to consult the selling agent. In addition, should the policy for any reason be unsatisfactory, by surrendering it within ten days following receipt to our office at _____ or to the selling agent, immediately full premium will be refunded and the policy will be cancelled and deemed void and as never in force and effect.

Sample Form B

IMPORTANT NOTICE

If for any reason this policy is unsatisfactory, it may be returned for cancellation within ten days following receipt – in which case the entire premium will be refunded.

Historical Note

Former General Rule 61-7. R20-6-501 recodified from R4-14-501 (Supp. 95-1).

ARTICLE 6. TYPES OF INSURANCE CONTRACTS

R20-6-601. Regulations Governing Bail Transactions

A. General provisions

1. Effective date
 - a. These regulations are effective November 1, 1960. On and after date, no bail transaction or severable portion thereof shall be conducted, directly or indirectly except in full conformity herewith.
 - b. No surety insurer shall furnish for use and no bail bond agent shall use any forms or documents which contain any provisions contrary to these regulations on or after the effective date hereof.
2. Authority. Authority for these regulations is A.R.S. §§ 20-142, 20-143 and 20-257 and A.R.S. Chapter 2, Article 3.
3. Public interest served. These regulations serve the public interest by prohibiting inequities in bail transactions and by establishing standards of licensing and conduct for bail bond agents.
4. Regulations as severable. These regulations shall be construed as severable, such that, where one or more Sections are held invalid, such remaining Sections will not be adversely affected.
5. Penalty. Violation of these regulations will subject the guilty party to the penalties of A.R.S. §§ 20-114, 20-220 and 20-316 and to the enforcement procedures of A.R.S. §§ 20-152 and 20-160 through 20-166.

B. Definitions

1. "Bail transaction" defined. As used in these regulations, the term "bail transaction" includes solicitation and inducement, preliminary negotiation and effectuation of a contract of surety insurance and the transaction of matters subsequent thereto and arising therefrom – all in connection with the release of persons arrested or confined.
2. "Bail bond agent" defined. As used in these regulations, the term "bail bond agent" means any person who engages in a bail transaction on behalf of a surety insurer or representative thereof.

3. "Arrestee" defined. As used in these regulations, the term "arrestee" means any person arrested or detained whose release on bail is solicited or procured or concerning whose release negotiations are commenced.
4. "Director" defined. As used in these regulations, the term "Director" means the Director of Insurance of the state.

C. Licensing

1. Application for license. Each application for original or renewal license as a bail bond agent shall be on a form furnished by the Director, and each applicant for such license shall furnish such supplementary information and supporting statements as the Director may require.
2. Prohibited associations. A bail bond license shall not be issued to, renewed for or maintained by any person who associates regularly with criminals, gamblers or persons of poor repute – except to the extent such association is required by business or professional duty and responsibility.
3. Transactions by unlicensed persons prohibited. No bail bond agent shall directly or indirectly permit any person on his behalf to solicit or negotiate bail transactions unless such person is duly licensed by the Director.
4. Employees. Employees of bail bond agents performing only clerical duties need not be licensed hereunder and shall be deemed not engaged in bail transactions.

D. Conduct of bail bond agents

1. Disclosure of business. Every bail bond agent shall conduct his business in such a manner that the public and those dealing with him shall be aware of the capacity in which he is acting.
2. Control of employees. A bail bond agent shall exercise direct supervision over his employees and keep informed of their actions as his employees.
3. Prohibited employees. No bail bond agent shall have in his employ at any time any criminal, gambler or person of poor repute.
4. Acting for attorney. No bail bond agent shall receive, or collect for an attorney any money or other item of value

for attorney's fee, costs or any other purpose on behalf of an arrestee, unless a receipt is given therefor.

5. Informants prohibited. No bail bond agent shall for any purpose, directly or indirectly, enter into an arrangement of any kind or have an understanding with a law enforcement officer, with a newspaper employee, with a messenger service or employee thereof, with a trusty in a jail, with other person incarcerated in a jail, or with any person whatever, to inform or notify any bail bond agent directly or indirectly of:
 - a. The existence of a criminal complaint;
 - b. The fact of an arrest; or
 - c. The fact that an arrest of any person is pending or contemplated; or
 - d. Any information pertaining to matters set forth in (a), (b), and (c) hereof or to the persons involved therewith.
6. Compliance with rules of public authority. No bail bond agent shall solicit any person in a bail transaction in a prison or jail or other place of detention, court or public institution connected with the administration of justice unless said bail bond agent has fully complied with every rule, regulation and ordinance issued by each public authority governing the conduct of persons in or about said premises.
7. Representations to public authority
 - a. No bail bond agent shall make any misleading or untrue representation to a court or to a public official with respect to a bail transaction, nor for the purpose of avoiding or preventing a forfeiture of bail or of having set aside a forfeiture which has occurred.
 - b. Every bail bond agent shall truthfully and fully answer every question asked him by the Director or his representative respecting his bail transactions and matters relating to the conduct of his bail business. Any bail bond agent may have his attorney present when he answers any such question.
8. Maintenance of records. Every bail bond agent shall keep complete records of all business done under authority of his license. Such records shall be open to inspection or examination by the Director or his representatives at all reasonable times at the principal place of business of the bail bond agent as designated in his license.

E. Charges, collateral, refunds and rebates

1. Rates
 - a. No bail bond agent shall issue or deliver a bail bond except at the premium rates most recently filed and approved by the Director in accordance with A.R.S. § 20-357.
 - b. Every bail bond agent shall post the premium rates of the surety insurer he represents in a conspicuous manner at his place of business.
2. Charges permitted. No bail bond agent shall, in any bail transaction or in connection therewith, directly or indirectly, charge or collect money or other valuable consideration from any person except for the following purposes:
 - a. To pay the premium at the rates established by the surety insurer and approved by the Director.
 - b. To provide collateral.
 - c. To reimburse himself for actual and reasonable expenses incurred in connection with the individual bail transaction, including:
 - i. Guard fees after the first 12 hours following release of an arrestee on bail;

- ii. Notary fees, recording fees, necessary long distance telephone expenses, telegram charges, and travel expenses for other than local community travel.
- iii. Any other actual expenditure necessary to the bail transaction which is not usually and customarily incurred in connection with the ordinary operation and conduct of bail transactions.

3. Delivery of documents to arrestee

- a. Every bail bond agent shall, at the time of obtaining the release of an arrestee on bail or immediately thereafter, deliver to such arrestee or to the principal person with whom negotiations were made, if other than the arrestee, a copy of the bail bond premium agreement, which shall include:
 - i. The name of the surety insurer and the name and business address of the bail bond agent.
 - ii. The amount of bail and the premium thereof.
- b. The bail bond agent shall also deliver at such time a statement detailing all charges in addition to the premium, the amount received on account, the unpaid balance if any, and a description of and a receipt for any collateral received.

4. Collateral

- a. Any bail bond agent who receives collateral in connection with a bail transaction shall do so in a fiduciary capacity and, prior to any forfeiture of bail, shall keep such collateral separate and apart from any other funds, assets or property of such bail bond agent.
- b. Any collateral received shall be returned to the person who deposited it with the bail bond agent or any assignee as soon as the obligation, the satisfaction of which was secured by the collateral, is discharged. Where such collateral has been deposited to secure the obligation of a bond, it shall be returned immediately upon the entry of any order by an authorized official by virtue of which liability under the bond is terminated, or, if any bail bond agent fails to cooperate fully with any authorized official to secure the termination of such liability, immediately upon the accrual of any right to secure an order of termination of liability.
- c. When such collateral has been deposited as security for unpaid premium or charges and, if such premium or charges remained unpaid at the time of exoneration and after demand therefor has thereafter been made by the bail bond agent, collateral other than cash may be levied upon in the manner provided by law and cash collateral up to the amount of such unpaid premium on charges may be applied in payment thereof.
- d. If collateral received by a bail bond agent is in excess of the bail forfeited, such excess shall be returned to the depositor immediately upon application of the collateral to the forfeiture subject, however, to any claim of the bail bond agent for unpaid premium or charges as provided in subparagraph (c) of paragraph (4) of subsection (E), or as agreed to in writing by the bail bond agent and arrestee or his indemnitor.

5. Premium refund upon surrender of arrestee. No bail bond agent shall surrender an arrestee to custody prior to the time specified in the bail bond for the appearance of the arrestee, or prior to any other occasion when the presence of the arrestee in court is lawfully required, without

returning all premium paid therefor, unless as a result of judicial action, or material misrepresentation by the arrestee or his indemnitor with respect to the execution of the bail bond agreement, or a material and substantial increase in the hazard assumed. Failure of the arrestee to pay the premium, or charges permitted under these regulations or any part thereof, and failure to furnish collateral required by the bail bond agent, shall not be considered a material and substantial increase in the hazard assumed.

6. Rebating prohibited. No bail bond agent shall pay or allow in any manner, directly or indirectly, to any person who is not also a bail bond agent any commission or valuable consideration on or in connection with a bail transaction. This Section shall not prohibit payments by a bail bond agent to an unlicensed person of charges by such persons for services of the kind specified in paragraph (2) subsection (E) of this Section.

Historical Note

Former General Rule 60-5. R20-6-601 recodified from R4-14-601 (Supp. 95-1).

R20-6-602. Nationwide Inland Marine Definition

- A. Applicability. This rule applies to risks and coverages which may be classified or identified as Marine, Inland Marine or Transportation insurance but shall not be construed to mean that the kinds of risks and coverages are solely Marine, Inland Marine or Transportation insurance in all instances. This rule shall not be construed to restrict or limit in any way the exercise of any insuring powers granted under charters and license whether used separately, in combination or otherwise.
- B. Marine and/or transportation policies may cover under the following conditions:
 1. Imports.
 - a. Imports may be covered wherever the property may be and without restriction as to time, provided the coverage of the issuing companies includes hazards of transportation.
 - b. An import, as a proper subject of marine or transportation insurance, shall be deemed to maintain its character as such so long as the property remains segregated in such a way that it can be identified and has not become incorporated and mixed with the general mass of property in the United States, and shall be deemed to have been completed when such property has been:
 - i. Sold and delivered by the importer, factor or consignee; or
 - ii. Removed from place of storage and placed on sale as part of the importer's stock in trade at a point of sale or distribution; or
 - iii. Delivered for manufacture, processing or change in form to premises of the importer or of another for any such purposes.
 2. Exports.
 - a. Exports may be covered wherever the property may be located without restriction as to time, provided the coverage of each issuing company includes hazards of transportation.
 - b. An export, as a proper subject of marine or transportation insurance, shall be deemed to acquire its character as such when designated or while being prepared for export and retain that character unless diverted for domestic trade, and when so diverted, the provisions of this rule respecting domestic shipments shall apply, provided, however, that this pro-

vision shall not apply to long established methods of insuring certain commodities, e.g., cotton.

3. Domestic shipments.
 - a. Domestic shipments on consignment, for sale or distribution, exhibit, or trial, or approval or auction, while in transit, while in the custody of others and while being returned, provided the coverage of each issuing company includes hazards of transportation, and further provided that in no event shall the policy cover domestic shipments on consignment on premises owned, leased or operated by the consignor.
 - b. Domestic shipments not on consignment, provided the coverage of the issuing companies includes hazards of transportation, beginning and ending within the United States, and further provided that such shipments shall not be covered at manufacturing premises nor after arrival at premises owned, leased or operated by assured or purchaser.
4. Bridges, tunnels and other instrumentalities of transportation and communication excluding buildings, their improvements and betterments, their furniture and furnishings, fixed contents and supplies held in storage. The foregoing includes:
 - a. Bridges, tunnels, other similar instrumentalities, including auxiliary facilities and equipment attendant thereto.
 - b. Piers, wharves, docks, slips, dry docks and marine railways.
 - c. Pipelines, including on-line propulsion, regulating and other equipment appurtenant to such pipelines, but excluding all property at manufacturing, producing, refining, converting, treating or conditioning plants.
 - d. Power transmission and telephone and telegraph lines, excluding all property at generating, converting or transforming stations, substations and exchanges.
 - e. Radio and television communication equipment in use as such including towers and antennae with auxiliary equipment, and appurtenant electrical operating and control apparatus.
 - f. Outdoor cranes, loading bridges and similar equipment used to load, unload and transport.
5. Personal Property Floater Risks covering individuals and/or generally
 - a. Personal Effects Floater Policies
 - b. The Personal Property Floater
 - c. Government Service Floater
 - d. Personal Fur Floaters
 - e. Personal Jewelry Floaters
 - f. Wedding Present Floaters for not exceeding 90 days after the date of the wedding.
 - g. Silverware Floaters.
 - h. Fine Arts Floaters, covering paintings, etchings, pictures, tapestries, art glass windows, and other bona fide works of art of rarity, historical value or artistic merit.
 - i. Stamp and Coin Floaters.
 - j. Musical Instrument Floaters. Radios, televisions, record players and combinations thereof are not deemed musical instruments.
 - k. Mobile Articles, Machinery and Equipment Floaters, excluding vehicles designed for highway use and auto homes, trailers and semi-trailers except when hauled by tractors not designed for highway use, covering identified property of a mobile or

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- floating nature pertaining to or usual to a household. Such policies shall not cover furniture and fixtures not customarily used away from premises where such property is usually kept.
- l. Installment Sales and Leased Property Policies covering property pertaining to a household and sold under conditional contract of sale, partial payment contract or installment sales contract or leased, but excluding motor vehicles designed for highway use. Such policies must cover in transit but shall not extend beyond the termination of the seller's or lessor's interest.
 - m. Live Animal Floaters.
6. Commercial Property Floater Risks covering property pertaining to a business, profession or occupation.
 - a. Radium Floaters.
 - b. Physicians' and Surgeons Instrument Floaters. Such policies may include coverage of such furniture, fixtures and tenant assured's interest in such improvements and betterments of buildings as are located in that portion of the premises occupied by the assured in the practice of his profession.
 - c. Pattern and Die Floaters.
 - d. Theatrical Floaters, excluding buildings and their improvements and betterments, and furniture and fixtures that do not travel about with theatrical troupes.
 - e. Film Floaters, including builders' risk during the production and coverage on completed negatives and positives and sound records.
 - f. Salesmen's Samples Floaters.
 - g. Exhibition Policies on property while on exhibition and in transit to or from such exhibitions.
 - h. Live Animal Floaters.
 - i. Builders Risks and/or Installation Risks covering interest of owner, seller or contractor, against loss or damage to machinery, equipment, building materials or supplies, being used with and during the course of installation, testing, building, renovating or repairing. Such policies may cover at points or places where work is being performed, while in transit and during temporary storage or deposit, of property designated for and awaiting specific installation, building, renovating or repairing.
 - i. Such coverage shall be limited to Builders Risks or Installation Risks where Perils in addition to Fire and Extended Coverage are to be insured.
 - ii. If written for account of owner, the coverage shall cease upon completion and acceptance thereof; or if written for account of a seller or contractor the coverage shall terminate when the interest of the seller or contractor ceases.
 - j. Mobile Articles, Machinery and Equipment Floaters, excluding motor vehicles designed for highway use and auto homes, trailers and semi-trailers except when hauled by tractors not designed for highway use and snow plows constructed exclusively for highway use covering identified property of a mobile or floating nature, not on sale or consignment, or in course of manufacture, which has come into the custody or control of parties who intend to use such property for the purpose for which it was manufactured or created. Such policies shall not cover furniture and fixtures not customarily used away from premises where such property is usually kept.
 - k. Property in transit to and from and in custody of bailees not owned, controlled or operated by the bailor. Such policies shall not cover bailee's property at his premises.
 - l. Installment sales and leased property. Policies covering property sold under conditional contract of sale, partial payment contract, installment sales contract, or leased but excluding motor vehicles designed for highway use. Such policies must cover in transit but shall not extend beyond the termination of the seller's or lessor's interest. This Section is not intended to include machinery and equipment under certain "lease-back" contracts.
 - m. Garment Contractors Floaters.
 - n. Furriers or Fur Storer's Customer's Policies, i.e., policies under which certificates or receipt are issued by furriers or fur storers covering specified articles the property of customers.
 - o. Accounts Receivable Policies, Valuable Papers and Records Policies.
 - p. Floor Plan Policies, covering property for sale while in possession of dealers under a Floor Plan or any similar plan under which the dealer borrows money from a bank or lending institution with which to pay the manufacturer, provided:
 - i. Such merchandise is specifically identifiable as encumbered to the bank or lending institution.
 - ii. The dealer's right to sell or otherwise dispose of such merchandise is conditioned upon its being released from encumbrance by the bank or lending institution.
 - iii. That such policies cover in transit and do not extend beyond the termination of the dealer's interest.
 - iv. That such policies shall not cover automobiles or motor vehicles; merchandise for which the dealer's collateral is the stock or inventory as distinguished from merchandise specifically identifiable as encumbered to the lending institution.
 - q. Sign and Street Clock Policies, including neon signs, automatic or mechanical signs, street clocks, while in use as such.
 - r. Fine Arts Policies covering paintings, etchings, pictures, tapestries, art glass windows, and other bona fide works of art of rarity, historical value or artistic merit, for account of museums, galleries, universities, businesses, municipalities and other similar interests.
 - s. Policies covering personal property which, when sold to the ultimate purchaser, may be covered specifically, by the owner, under Inland Marine Policies including:
 - i. Musical Instrument Dealers Policies, covering property consisting principally of musical instruments and their accessories. Radios, televisions, record players and combinations thereof are not deemed musical instruments.
 - ii. Camera Dealers Policies, covering property consisting principally of cameras and their accessories.
 - iii. Furrier's Dealers Policies, covering property consisting principally of furs and fur garments.

- iv. Equipment Dealers Policies, covering mobile equipment consisting of binders, reapers, tractors, harvesters, harrows, tedders and other similar agricultural equipment and accessories therefor; construction equipment consisting of bulldozers, road scrapers, tractors, compressors, pneumatic tools, and similar equipment and accessories therefor; but excluding motor vehicles designed for highway use.
 - v. Stamp and Coin Dealers covering property of philatelic and numismatic nature.
 - vi. Jewelers' Block Policies.
 - vii. Fine Arts Dealers.
Such policies may include coverage of money in locked safes or vaults on the Assured's premises. Such policies also may include coverage of furniture, fixtures, tools, machinery, patterns, molds, dies and tenant insureds interest in improvements of buildings.
 - t. Wool Growers Floaters.
 - u. Domestic Bulk Liquids Policies, covering tanks and domestic bulk liquids stored therein.
 - v. Difference in Conditions Coverage excluding fire and extended coverage perils.
 - w. Electronic Data Processing Policies.
- C.** Unless otherwise permitted, nothing in the foregoing shall be construed to permit MARINE OR TRANSPORTATION POLICIES TO COVER:
1. Storage of assured's merchandise, except as hereinbefore provided.
 2. Merchandise in course of manufacture, the property of and on the premises of the manufacturer.
 3. Furniture and fixtures and improvements and betterments to buildings.
 4. Monies and/or securities in safes, vaults, safety deposit vaults, bank or assured's premises, except while in course of transportation.

Historical Note

Former General Rule 59-4; Amended effective August 30, 1985 (Supp. 85-4). R20-6-602 recodified from R4-14-602 (Supp. 95-1).

R20-6-603. Repealed**Historical Note**

Former General Rule 69-18; Repealed effective July 27, 1981 (Supp. 81-4). R20-6-603 recodified from R4-14-603 (Supp. 95-1).

R20-6-604. Definitions

The definitions in A.R.S. § 20-1603 and this Section apply to R20-6-604 through R20-6-604.10.

"Actual loss ratio" means incurred claims divided by earned premiums at rates in use.

"Actuarially equivalent" means of equal actuarial present value determined as of a given date with each value based on the same set of actuarial assumptions. When used in this Article in reference to rates and coverage, "actuarially equivalent" means a rate or coverage that is actuarially determined to yield loss ratios of 50% for credit life insurance and 60% for credit disability insurance.

"Credit insurance" means credit life insurance, credit disability insurance, or both, but does not include any insurance for which there is no identifiable charge.

"Earned premiums" means earned premiums at prima facie rates and earned premiums at rates in use.

"Earned premiums at prima facie rates" means an insurer's actual earned premiums, adjusted to the amount that the insurer would have earned if the insurer's premium rates had equaled the prima facie rates in effect during the experience period.

"Earned premiums at rates in use" means the premiums that an insurer actually earns on the premium rates the insurer charges during an experience period.

"Evidence of individual insurability" means information about a debtor's health status or medical history that a debtor provides as a condition of credit insurance becoming effective.

"Experience" means an insurer's earned premiums and incurred claims during an experience period.

"Experience period" means a period of time for which an insurer reports income and expense information on the insurer's credit insurance business.

"Final adjusted rates" means the prima facie rates referred to in R20-6-604.04 and R20-6-604.05, subject to any deviations approved under R20-6-604.08.

"Gross debt" means the sum of the remaining payments that a debtor owes a creditor.

"Identifiable charge" means a charge for credit insurance that is imposed on a debtor with credit insurance but not on a debtor without credit insurance, and includes a charge for insurance that is disclosed in the credit or other financial instrument furnished to the debtor, which sets forth the financial elements of a credit transaction, and any difference in finance, interest, service charges, or other similar charges made to a debtor in like circumstances except for the debtor's status as insured or noninsured.

"Incurred claims" means the total claims an insurer pays during an experience period, adjusted for the change in the claim reserves.

"Net debt" means the amount necessary to liquidate a debt in a single lump-sum payment excluding unearned interest and other unearned finance charges.

"Plan of credit insurance" means an insurance plan based on one of the following rate and coverage categories:

Credit life insurance, other than on revolving accounts, including joint and single life coverage, decreasing and level insurance, and outstanding balance and single premium;

Credit life insurance on revolving accounts;

Credit life insurance on an age-graded basis;

Credit disability insurance, other than on revolving accounts, including outstanding balance and single premium, and each combination of waiting period and retroactive or non-retroactive benefits;

Credit disability insurance on revolving accounts, including each combination of waiting period and retroactive or non-retroactive benefits.

"Preexisting condition" means a condition:

For which a debtor received medical advice, consultation, or treatment within six months before the effective date of credit insurance coverage; and

From which the debtor dies, in the case of life insurance, or becomes disabled, in the case of disability insurance, within six months after the effective date of coverage.

“Prima facie adjusted loss ratio” means incurred claims divided by earned premiums at prima facie rates.

“Prima facie rates” means the rates established by the Director as prescribed in R20-6-604.03.

“Reasonableness standard” means the requirement in A.R.S. § 20-1610(B) that an insurer’s premiums for credit insurance shall not be excessive in relation to the benefits provided under the policy.

“Rule of Anticipation” means the product of the gross single premium per \$100 of indebtedness for a debtor’s remaining term of indebtedness, times the number of hundreds of dollars of remaining indebtedness.

Historical Note

Former General Rule 70-22; Correction, original publication did not include Exhibit C (Supp. 76-1). Amended effective January 8, 1980 (Supp. 80-1). Former Section R4-14-604 repealed, new Section R4-14-604 adopted effective April 1, 1982. See subsection (N) for further detail (Supp. 82-2). Amended subsection (N) and Exhibit A effective March 30, 1983 (Supp. 83-2). R20-6-604 recodified from R4-14-604 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2725, effective June 7, 2002 (Supp. 02-2).

Exhibit A. Repealed

Historical Note

Former General Rule 70-22; Correction, original publication did not include Exhibit C (Supp. 76-1). Amended effective January 8, 1980 (Supp. 80-1). Former Section R4-14-604 repealed, new Section R4-14-604 adopted effective April 1, 1982. See subsection (N) for further detail (Supp. 82-2). Amended subsection (N) and Exhibit A effective March 30, 1983 (Supp. 83-2). R20-6-604 recodified from R4-14-604 (Supp. 95-1). Section repealed by final rulemaking at 8 A.A.R. 2725, effective June 7, 2002 (Supp. 02-2).

R20-6-604.01. Rights and Treatment of Debtors

A. Creditor Obligations.

1. Multiple plans of insurance. If a creditor makes more than one plan of credit insurance available to debtors, the creditor shall inform each debtor of each plan for which the debtor is eligible and of the premium and charges for each plan.
2. Substitution. If a creditor requires a debtor to have credit insurance as additional security for a debt, the creditor shall inform the debtor in writing of the debtor’s right to obtain alternative coverage as prescribed in A.R.S. § 20-1614 before the loan transaction is completed.
3. Remittance of premiums. If a creditor adds an insurance charge or premium to a debt, the creditor shall remit the insurance charge or premium to the insurer within 60 days after it is added to the debt.

B. Creditor and insurer obligations regarding insurance on refinanced debt.

1. If a debt is discharged because the debtor refinances the debt before the scheduled maturity date, the creditor shall notify the insurer that issued the credit insurance on the discharged debt.

2. An insurer shall not issue any credit insurance that covers the refinanced debt with an effective date preceding the termination date of the insurance on the original debt.
3. The insurer issuing the coverage on the discharged debt shall refund to or credit the debtor with all unearned insurance charges or premium according to R20-6-604.06.
4. If a debt is refinanced, the effective date of the policy provisions in any new insurance covering the refinanced debt shall be the first date on which the debtor became insured under the previous policy. An insurer may apply any new exclusion period or preexisting condition limitation only to the portion of the new loan that exceeds the previous loan.

C. Required policy provisions.

1. Termination provisions for group policies. A group credit insurance policy shall provide for continued coverage of debtors covered under the policy if the policy terminates, as follows:
 - a. For a policy with a single premium payment, or any other payment method that prepays coverage for more than one month, a provision requiring continued insurance coverage for the entire period for which the premium has been paid; and
 - b. For a policy with a monthly premium payment, a provision requiring the insurer to send the debtor a termination notice at least 30 days before the effective date of termination, unless an insurer is issuing replacement coverage in at least the same amount, without lapse of coverage.
2. Maximum aggregate provisions. A provision in an individual policy or group certificate that sets a maximum limit on total claim payments shall apply only to that individual policy or group certificate.

D. Creditor and insurer obligations when debtor prepays debt.

1. Except as provided in subsection (D)(2), if a debtor prepays a debt in full, any credit insurance covering the debt shall terminate on the date of prepayment. The creditor and insurer shall refund to or credit the debtor with any unearned premium according to R20-6-604.06.
2. If a debt is fully prepaid because of the debtor’s death or any other lump-sum credit insurance payment, a creditor or insurer is not required to refund premium for the coverage under which the lump sum was paid.
3. If a claim under credit disability coverage is in progress at the time of prepayment, the insurer:
 - a. May calculate the refund as if the prepayment did not occur until the end of the period for payment of benefits, and
 - b. Is not required to refund premiums for any period for which credit disability benefits are payable.

E. Benefits payable on revolving account. If a debtor is paying for credit insurance coverage on a revolving account and dies, the insurer shall pay a benefit amount equal to the amount of indebtedness outstanding on the date of death. The insurer may exclude preexisting conditions occurring within six months of any advance on the revolving account, running separately for each advance or charge.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 2725, effective June 7, 2002 (Supp. 02-2).

R20-6-604.02. Satisfying the Reasonableness Standard

- ##### A.
1. An insurer shall comply with all requirements of A.R.S. § 20-1610 regarding premium and insurance charges.

- B. An insurer may satisfy the reasonableness standard in A.R.S. § 20-1610(B) if the insurer's premium rate develops a loss ratio of not less than 50% for credit life insurance and not less than 60% for credit disability insurance.
- C. While in effect, the rates described in R20-6-604.04 and R20-6-604.05, subject to any deviations approved under R20-6-604.08 are conclusively presumed to develop the loss ratios described in subsection (B). For purposes of prospective effect, the Department may rebut this presumption by disproving or withdrawing approval for the rates as prescribed in A.R.S. § 20-1610.
- D. An insurer may provide coverage other than the standard coverage described in R20-6-604.04 and R20-6-604.05. An insurer that wishes to provide nonstandard coverage shall:
 1. File the nonstandard coverage policy information as prescribed in A.R.S. § 20-1609, and
 2. Demonstrate that the rates for the coverage are reasonably expected to develop a loss ratio of not less than 50% for credit life insurance and not less than 60% for credit disability insurance.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 2725, effective June 7, 2002 (Supp. 02-2).

R20-6-604.03. Determination of Prima Facie Rates

- A. The Director shall, by order, establish prima facie rates as prescribed in this Section.
- B. At least once every three years, the Director shall:
 1. Determine the rate of expected claims on a statewide basis;
 2. Compare the rate of expected claims with the rate of actual claims for the past three years determined from the incurred claims and earned premiums at prima facie rates; and
 3. If the Director determines that the prima facie rates require adjustment, issue a notice of hearing and proposed order adjusting the actual statewide prima facie rates. The hearing date on the proposed order shall be no earlier than 45 days from the date of the notice.
- C. The Director shall mail a copy of the notice and proposed order to:
 1. Each insurer that reported transaction of credit insurance on its annual statement immediately preceding the date of the notice, and
 2. Any other person who sends the Director a written request for notice of proceedings to adjust the prima facie rates.
- D. Any person may submit written comments to the Director or appear at the hearing and provide oral comments on the record. Written comments shall be received no later than the close of record date specified in the notice of hearing.
- E. The Director shall:
 1. Consider written and oral comments; and
 2. Issue a final order setting prima facie rates no later than 30 days after the close of record date specified in the notice of hearing.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 2725, effective June 7, 2002 (Supp. 02-2).

R20-6-604.04. Credit Life Insurance Rates and Provisions

- A. Under the process prescribed in R20-6-604.03, the Director shall issue an order establishing prima facie rates for credit life insurance.
- B. The Department shall presume that an insurer meets the loss ratios prescribed in R20-6-604.02(B) if the insurer uses the

prima facie rates, subject to the requirements in this Section and R20-6-604.08. An insurer may use the prima facie rates without filing additional actuarial support.

- C. A credit life insurance policy shall meet the requirements listed in this Section. The policy shall:
 1. Provide coverage for death, by whatever means caused, to all eligible debtors, with or without evidence of individual insurability for debtors that purchase coverage within 30 days of being eligible;
 2. Have no exclusions other than for:
 - a. Suicide within six months after the effective date of coverage, or
 - b. A preexisting condition;
 3. Have no age restrictions, except the following permissible exclusions:
 - a. An age restriction providing that no insurance will become effective on a debtor on or after the attainment of age 70 and that all insurance shall terminate on a debtor attaining age 70; and
 - b. An age restriction for a revolving credit life insurance policy that:
 - i. Excludes a class of debtors determined by age, or
 - ii. Provides for termination of insurance or reduction in the amount of insurance when a debtor reaches age 70; and
 4. For insurance on revolving accounts, have the date on which an advance or charge occurs as the effective date of coverage for each part of the insurance attributable to a different advance or a charge to the plan account. Any exclusion period or preexisting condition limitation shall run separately for each advance or charge.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 2725, effective June 7, 2002 (Supp. 02-2).

R20-6-604.05. Credit Disability Insurance Rates and Provisions

- A. Under the process prescribed in R20-6-604.03, the Director shall issue an order establishing prima facie rates for credit disability insurance.
- B. The Department shall presume that an insurer meets the loss ratios prescribed in R20-6-604.02(B) if the insurer uses the prima facie rates, subject to the requirements in this Section and R20-6-604.08. An insurer may use the prima facie rates without filing additional actuarial support.
- C. A credit disability insurance policy shall meet the requirements listed in this Section. The policy shall:
 1. Provide coverage for disability, by whatever means caused, to all eligible debtors, with or without evidence of individual insurability for debtors that purchase coverage within 30 days of becoming eligible;
 2. Include a definition of disability that is no more restrictive than the following:
 - a. For the first 12 months of disability, the inability of the insured to perform the essential functions of the insured's occupation; and
 - b. After the first 12 months of disability, the inability of the insured to perform the essential functions of any occupation for which the insured is reasonably suited by virtue of education, training, or experience;
 3. Not include any employment requirement that a debtor be employed more than full-time on the effective date of coverage, with a definition of "full-time" as a regular work week of at least 30 hours;

4. Have no exclusions other than for disabilities resulting from:
 - a. Normal pregnancy,
 - b. Intentionally self-inflicted injury, or
 - c. A preexisting condition;
5. For insurance on revolving accounts, have the date on which an advance or charge occurs as the effective date of coverage for each part of the insurance attributable to a different advance or a charge to the plan account. Any exclusion period or preexisting condition limitation shall run separately for each advance or charge;
6. Have no age restrictions, except the following permissible exclusion:
An age restriction providing that no insurance will become effective on a debtor on or after the attainment of age 65 and that all insurance shall terminate on a debtor attaining age 66; and
7. Include a provision for a daily benefit of not less than one-thirtieth of the monthly benefit payable under the policy.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 2725, effective June 7, 2002 (Supp. 02-2).

R20-6-604.06. Refund Methods

- A. When refunding premiums as prescribed in A.R.S. § 20-1611, an insurer shall use the following methods:
 1. For insurance paid by a single premium, the Rule of Anticipation method; and
 2. For insurance paid by other than a single premium, a method that refunds at least the pro rata gross unearned amount charged to the debtor.
- B. The Director may approve other refund methods similar to those described in subsection (A), that are actuarially equivalent to the type of coverage the debtor purchased.
- C. An insurer's refund method may recognize adjustments to a daily basis for interest or payments if the adjustments are consistent with the underlying credit transaction.
- D. An insurer is not required to refund any amount less than \$5.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 2725, effective June 7, 2002 (Supp. 02-2).

R20-6-604.07. Experience Reports

- A. By April 1 of each year, an insurer that transacts credit insurance in this state shall file with the Director an experience report, on a form specified by the Director, for each class of business that the insurer transacts as provided in this Section.
 1. In this Section, a "class of business" means:
 - a. Credit unions;
 - b. Banks, savings and loan institutions, and mortgage companies;
 - c. Finance companies, small loan companies, and consumer lenders defined in A.R.S. § 6-601(5);
 - d. Dealers, including auto, truck, and boat dealers, retail stores, and other persons selling financed goods; and
 - e. All other persons selling credit insurance not specifically listed in subsection (A)(1)(a) through (d).
 2. The report shall include the following information:
 - a. Mode of premium payment,
 - b. Plan of benefits description,
 - c. Earned premiums,
 - d. Incurred claims,
 - e. Loss ratios, and
 - f. For credit life insurance, mean insurance in force.

- B. For each day a report is late, the Director may assess a penalty as prescribed in A.R.S. § 20-223.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 2725, effective June 7, 2002 (Supp. 02-2).

R20-6-604.08. Use of Prima Facie Rates; Rate Deviations

- A. Use of rates greater than prima facie rates. An insurer may file for approval and use of any deviated rates that are higher than the prima facie rates referred to in R20-6-604.04 and R20-6-604.05 as prescribed in A.R.S. § 20-1610.
 1. The deviated rates shall meet the minimum loss ratio standards and other requirements prescribed by R20-6-604.02.
 2. The filing shall specify the accounts to which the rates apply.
 3. The rates may be:
 - a. Applied uniformly to all accounts of the insurer; or
 - b. Applied on an equitable basis approved by the Director to accounts of the insurer for which the insurer's experience has been less favorable than expected.
- B. Approval period of deviated rates. An insurer may use a deviated rate for the same period of time as the experience period used to establish the rate, not to exceed a period of three years from the date of approval. An insurer may file for a new deviated rate before the end of the approval period, but not more often than once in any 12 month period.
- C. Approval is non-transferable. The Director's approval of a deviated rate is not transferable to another insurer. If an insurer acquires an account for which another insurer obtained a deviated rate, the successor insurer may not charge the deviated rate without obtaining approval for the deviated rate as prescribed in subsection (B).
- D. Use of rates lower than filed rates. An insurer may use a rate that is less than its filed rate without notice to the Director.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 2725, effective June 7, 2002 (Supp. 02-2).

R20-6-604.09. Supervision of Consumer Credit Insurance Operations

- A. At least once every three years, an insurer transacting credit insurance in Arizona shall review the credit insurance operations of each creditor with whom the insurer does business to ensure that each creditor is complying with applicable credit insurance laws. The insurer shall review the following:
 1. The creditor does not charge rates in excess of the prima facie rates or any deviated rates for which the insurer obtains approval;
 2. The creditor makes benefit payments as prescribed in the policy; and
 3. The creditor refunds unearned premiums as prescribed in R20-6-604.06.
- B. The insurer shall maintain for the Director's inspection a written record of each review and action the insurer takes to address any creditor noncompliance found by the insurer, for at least three years following the end of the review.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 2725, effective June 7, 2002 (Supp. 02-2).

R20-6-604.10. Prohibited Transactions

- A. The practices listed in this Section are deemed unfair trade practices under A.R.S. § 20-442. An insurer that commits any

of the following practices is subject to penalties as prescribed in A.R.S. § 20-456:

1. Offering or providing a creditor with any special advantage or any service not set out in either the group insurance contract or in the agency contract, other than payment of commissions;
 2. Agreeing to deposit with a bank or financial institution, the insurer's money or securities as a substitute for a deposit of money or securities that the financial institution would otherwise require from the creditor as a compensating balance or deposit offset for a loan or other advancement; or
 3. Depositing money or securities without interest or at a lesser rate of interest than the creditor, bank, or financial institution is currently paying on other similar deposits.
- B.** This Section does not prohibit an insurer from maintaining demand deposits or premium deposit accounts that are reasonably necessary for use in the ordinary course of the insurer's business.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 2725, effective June 7, 2002 (Supp. 02-2).

R20-6-605. Emergency Expired

Historical Note

Former General Rule 72-26. Repealed effective December 4, 1986 (Supp. 86-6). Adopted as an emergency effective January 9, 1990, pursuant to A.R.S. § 41-1026 valid for only 90 days; re-adopted as an emergency with changes effective March 26, 1990, pursuant to A.R.S. § 41-1026 valid for only 90 days (Supp. 90-1). Re-adopted as an emergency without change effective June 20, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-2). Emergency expired. R20-6-605 recodified from R4-14-605 (Supp. 95-1).

R20-6-606. Repealed

Historical Note

Adopted effective July 1, 1980 (Supp. 80-3). Amended effective June 1, 1981. See also subsection (G) (Supp. 81-1). Amended subsections (D), (E)(3)(a), (F)(2)(b), (3)(a), (4)(e), (G), and (H) effective January 11, 1982 (Supp. 82-1). Amended subsections (G) and (H) as an emergency effective August 1, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-3). Emergency expired.

Amended and readopted as an emergency effective November 18, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Corrected and readopted as an emergency effective February 10, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Amended effective August 4, 1989 (Supp. 89-3). Amended and adopted as an emergency effective September 13, 1989 (Supp. 89-3). Emergency expired (Supp. 89-4). Amended effective November 19, 1990 (Supp. 90-4). Repealed by emergency action effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Repealed again by emergency action effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Repealed effective May 28, 1992 (Supp. 92-2). R20-6-606 recodified from R4-14-606 (Supp. 95-1).

R20-6-607. Reasonableness of Benefits in Relation to Premium Charged

- A.** Applicability. This rule shall apply to individual disability insurance (as defined in A.R.S. § 20-253) policy forms and rates.
- B.** When rate filing is required. Every individual policy form, rider or endorsement form affecting benefits which is submitted for approval shall be accompanied by a rate filing unless such rider or endorsement form does not require a change in the rate. Any subsequent addition to or change in rates applicable to such policy, rider or endorsement form shall also be filed.
- C.** General contents of all rate filings. Each rate submission shall include an actuarial memorandum describing the basis on which rates were determined and shall indicate and describe the calculation of the ratio, hereinafter called "anticipated loss ratio," of the present value of the expected benefits to the present value of the expected premiums over the entire period for which rates are computed to provide coverage. Each rate submission must also include a certification by a qualified actuary that to the best of the actuary's knowledge and judgment, the rate filing is in compliance with applicable laws and regulations of this state and that the benefits are reasonable in relation to the premiums.
- D.** Previously approved forms. Filings of rate revisions for a previously approved policy, rider or endorsement form shall also include the following:
 1. A statement of the scope and reason for the revision, and an estimate of the expected average effect on premiums including the anticipated loss ratio for the form.
 2. A statement as to whether the filing applies only to new business, only to in-force business, or both, and the reasons therefor.
 3. A history of the experience under existing rates, including at least the data indicated in subsection (D). The history may also include, if available and appropriate, the ratios of actual claims to the claims expected according to the assumptions underlying the existing rates. Additional data might include: substitution of actual claim run-offs for claim reserves and liabilities; determination of loss ratios with the increase in policy reserves (other than unearned premium reserves) added to benefits rather than subtracted from premiums; accumulations of experience funds; substitution of net level policy reserves for preliminary term policy reserves; adjustment of premiums to an annual mode basis; or other adjustments or schedules suited to the form and to the records of the company. All additional data must be reconciled, as appropriate, to the required data.
 4. The date and magnitude of each previous rate change, if any.
- E.** Experience records. Insurers shall maintain records of earned premiums and incurred benefits for each calendar year for each policy form, including data for rider and endorsement forms which are used with the policy form, on the same basis, including all reserves, as required for the Accident and Health Policy Experience Exhibit to the NAIC annual statement convention blank. Separate data may be maintained for each rider or endorsement form to the extent appropriate. Experience under forms which provide substantially similar coverage may be combined. The data shall be for all years of issue combined, for each calendar year of experience since the year the form was first issued, except the data for calendar years prior to the most recent five years may be combined.

- F.** Evaluation experience data. In determining the credibility and appropriateness of experience data, due consideration must be given to all relevant factors, such as:
1. Statistical credibility of premiums and benefits, e.g., low exposure, low loss frequency.
 2. Experienced and projected trends relative to the kind of coverage, e.g., inflation in medical expenses, economic cycles affecting disability income experience.
 3. The concentration of experience at early policy durations where select morbidity and preliminary term reserves are applicable and where loss ratios are expected to be substantially lower than at later policy durations.
 4. The mix of business by risk classification.
- G.** Anticipated loss ratio standard. With respect to a new form or a currently approved form, except currently approved non-cancelable policy forms, under which the average annual premium (as defined below) is expected to be at least \$200, benefits shall be deemed reasonable in relation to premiums provided the anticipated loss ratio is at least as great as shown in the following table:

Type of Coverage	Renewal Clause			
	OR	CR	GR	NC
Medical expense	60%	55%	55%	50%
Loss of income and other	60%	55%	50%	45%

For a policy form including riders and endorsements, under which the expected average annual premium per policy is \$100 or more but less than \$200, subtract 5 percentage points from the numbers in the table above, or if less than \$100, subtract 10 percentage points.

The average annual premium per policy shall be computed by the insurer based on an anticipated distribution of business by all applicable criteria having a price difference, such as age, sex, amount, dependent status, rider frequency, etc., except assuming an annual mode for all policies (i.e., the fractional premium loading shall not affect the average annual premium or anticipated loss ratio calculation).

The above anticipated loss ratio standards do not apply to a class of business which is regulated by specific statutes or regulations mandating loss ratios for such business, e.g., Medicare Supplement and Credit Life and Disability.

Definitions of Renewal Clause

OR – Optionally Renewable: renewal is at the option of the insurance company.

CR – Conditionally Renewable: renewal can be declined by the insurance company only for stated reasons other than deterioration of health.

GR – Guaranteed Renewable: renewal cannot be declined by the insurance company for any reason, but the insurance company can revise rates on a class basis.

NC – Non-Cancelable: renewal cannot be declined nor can rates be revised by the insurance company.

- H.** Rate revisions. With respect to filings of rate revisions for a previously approved form, benefits shall be deemed reasonable in relation to premiums provided both the following loss ratios meet the standards in subsection (F) above.
1. The anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage;
 2. The anticipated loss ratio derived by dividing (a) by (b) where

- a. Is the sum of the accumulated benefits, from the original effective date of the form or the effective date of this regulation, whichever is later, to the effective date of the revision, and the present value of future benefits, and
- b. Is the sum of the accumulated premiums from the original effective date of the form or the effective date of the regulation, whichever is later, to the effective date of the revision, and the present value of future premiums.

Such present values shall be taken over the entire period for which the revised rates are computed to provide coverage, and such accumulated benefits and premiums to include an explicit estimate of the actual benefits and premiums from the last date as of which an accounting has been made to the effective date of the revision. Interest shall be used in the calculation of these accumulated benefits and premiums and present values only if it is a significant factor in the calculation of this loss ratio.

- I.** Anticipated loss ratios lower than those indicated in subsections (H) and (I) will require justification based on the special circumstances that may be applicable.
1. Examples of coverages requiring special consideration are as follows:
 - a. Accident only;
 - b. Short term nonrenewable, e.g., airline trip, student accident;
 - c. Specified peril, e.g., common carrier;
 - d. Other special risks.
 2. Examples of other factors requiring special consideration are as follows:
 - a. Marketing methods, giving due consideration to acquisition and administration costs and to premium mode;
 - b. Extraordinary expenses;
 - c. High risk of claim fluctuation because of the low loss frequency of the catastrophic, or experimental nature of the coverage;
 - d. Product features such as long elimination periods, high deductibles and high maximum limits;
 - e. The industrial or debit method of distribution;
 - f. Forms issued prior to the effective date of this rule. Companies are urged to review their experience periodically and to file rate revisions, as appropriate, in a timely manner to avoid the necessity of later filing of exceptionally large rate increases.
 3. Notwithstanding the foregoing paragraphs to the contrary, hospital indemnity and cancer and other dread diseases policies shall develop the loss ratios pursuant to subsection (G).
- J.** Severability provision. If any provision of this rule or the application thereof to any person or circumstances is held invalid, the remainder of the rule and the application of such provision to other persons or circumstances shall not be affected thereby.
- K.** Effective date. This rule shall become effective upon filing with the Secretary of State and shall apply to all individual disability policy form and rate filings submitted on and after said date.

Historical Note

Adopted effective July 14, 1981 (Supp. 81-1). R20-6-607
recodified from R4-14-607 (Supp. 95-1).

ARTICLE 7. LICENSING PROVISIONS AND PROCEDURES

R20-6-701. Repealed

Historical Note

Former General Rule 56-1; Repealed effective January 1, 1981 (Supp. 80-6). R20-6-701 recodified from R4-14-701 (Supp. 95-1).

R20-6-702. Expired

Historical Note

Former General Rule 56-2. R20-6-702 recodified from R4-14-702 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 9 A.A.R. 2115, effective April 30, 2003 (Supp. 03-2).

R20-6-703. Expired

Historical Note

Former General Rule 61-6. R20-6-703 recodified from R4-14-703 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 9 A.A.R. 2115, effective April 30, 2003 (Supp. 03-2).

R20-6-704. Expired

Historical Note

Former General Rule 6-19. R20-6-704 recodified from R4-14-704 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 9 A.A.R. 2115, effective April 30, 2003 (Supp. 03-2).

R20-6-705. Expired

Historical Note

Former General Rule 66-13. R20-6-705 recodified from R4-14-705 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 9 A.A.R. 2115, effective April 30, 2003 (Supp. 03-2).

R20-6-706. Expired

Historical Note

Former General Rule 69-15; Repealed effective February 22, 1977 (Supp. 77-1). New Section R4-14-706 adopted effective November 5, 1980 (Supp. 80-5). R20-6-706 recodified from R4-14-706 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 9 A.A.R. 2115, effective April 30, 2003 (Supp. 03-2).

R20-6-707. Expired

Historical Note

Former General Rule 69-18; Amended effective March 17, 1981 (Supp. 81-2). R20-6-707 recodified from R4-14-707 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 9 A.A.R. 2115, effective April 30, 2003 (Supp. 03-2).

R20-6-708. Licensing Time-frames

A. Definitions. The definitions listed below apply in this Section.

1. "Administrative completeness review time frame" means the number of days from the Department's receipt of an application for a license until the Department determines that the application contains all components required by statute or rule, including all information required to be submitted by other government agencies A.R.S. § 41-1072 (1).
2. "License" has the meaning prescribed in A.R.S. § 41-1001(10).
3. "Overall time frame" means the number of days after the Department's receipt of an application for a license

during which the Department determines whether to grant or deny a license. The overall time frame consists of both the administrative completeness review time frame and the substantive review time frame A.R.S. § 41-1072 (2).

4. "Substantive review time frame" means the number of days after the completion of the administrative completeness review time frame during which the Department determines whether an application or applicant for a license meets all substantive criteria required by state or rule A.R.S. § 41-1072(3).
- B.** The time-frames listed in Table A apply to licenses issued by the Department. The licensing time-frames consist of an administrative completeness review, a substantive review, and an overall review.
- C.** Within the time-frame for the administrative completeness review set forth in Table A, the Department shall notify the applicant in writing of whether the application is complete or incomplete. If the application is incomplete, the Department shall issue a notice of deficiency to the applicant specifying what information or component is required to make the application administratively complete.
1. If the Department determines that an application for a license is not administratively complete, the Department shall include a comprehensive list of the specific deficiencies in the written notice provided under subsection (C). If the Department issues a written notice of deficiency within the administrative completeness review time-frame, the administrative completeness review time-frame and the overall review time-frame are suspended from the date the notice is issued until the date that the Department receives the missing information from the applicant.
 2. If an applicant does not make some response to each specific deficiency in a notice of deficiency issued during an administrative completeness review, the Department may issue a notice to the applicant within 10 days after receipt of the applicant's response, stating that the response is inadequate. The notice of inadequate response shall identify each specified deficiency to which the applicant did not make some response.
 - a. If the Department issues a notice of inadequate response under this subsection, the suspension of the administrative completeness review time-frame and the overall time-frame is not terminated.
 - b. If the Department does not issue a notice of inadequate response under this subsection, the Department is not precluded from issuing additional notices of deficiency during an administrative completeness review.
 3. If an applicant does not make some response to each specified deficiency in a notice of deficiency issued under subsection (C)(2) within 60 days after the date of a notice of deficiency or within 60 days after a notice of inadequate response issued under subsection (C)(2), the application is deemed withdrawn, and the Department is not required to take further action with respect to the application.
- D.** Within the time-frame for the substantive review set forth in Table A, the Department may issue one comprehensive written request for additional information to the applicant specifying each component or item of information required.
1. If the Department issues a comprehensive written request for additional information within the substantive review time-frame, the substantive review time-frame and the overall time-frame are suspended from the date the writ-

ten request is issued until the date that the Department receives the additional information from the applicant.

2. If an applicant does not make some response to each component or item of information requested in a comprehensive written request for additional information, the Department may issue a notice to the applicant within 10 days after receipt of the applicant's response stating that the response is inadequate. The notice of inadequate response shall identify each component or item of information required, to which the applicant did make some response.
 - a. If the Department issues a notice of inadequate response under this subsection, the suspension of the substantive review time-frame and overall time-frame is not terminated.
 - b. If the Department does not issue a notice of inadequate response under this subsection, the Department is not precluded from later issuing supplemental requests by mutual agreement for additional information, during the substantive review.
3. If an applicant does not make some response to each component or item of information required in a comprehensive written request or a supplemental request for additional information, within 60 days after the date of a comprehensive written request or within 60 days after the date of the supplemental request, the application is

deemed withdrawn, and the Department is not required to take further action with respect to the application.

- E. Within the overall time-frames set forth in Table A, unless extended by mutual agreement under A.R.S. § 41-1075, the Department shall notify the applicant in writing that the application is granted or denied. If the application is denied, the Department shall provide written justification for the denial and a written explanation of the applicant's right to a hearing or the applicant's right to appeal.
- F. In computing the time periods prescribed in these time-frame rules, the last day of a notice period is included in the computation, unless it is a Saturday, Sunday, or legal holiday.
- G. This rule applies to applications filed on or after January 1, 1999.

Historical Note

Former General Rule 70-22; Correction, original publication did not include Exhibit C. (Supp. 76-1). Repealed effective January 8, 1980 (Supp. 80-1). R20-6-708 recodified from R4-14-708 (Supp. 95-1). Amended effective January 1, 1999; filed in the Office of the Secretary of State December 4, 1998 (Supp. 98-4).

R20-6-709. Repealed

Historical Note

Former General Rule 71-23; Repealed effective January 1, 1981 (Supp. 80-6). R20-6-709 recodified from R4-14-709 (Supp. 95-1).

Table A. Licensing Time-frames Table

License	Relevant A.R.S.	Administrative Completeness	Substantive Review	Overall Time-frame
Certificate of Authority*	§ 20-216	210	90	300
Certificate of Exemption	§ 20-401.05	92	30	122
Reinsurance Intermediary	§ 20-486.01	120	60	180
Hospital, Medical, Dental, and Optometric Service Corporation	§ 20-825	210	90	300
Prepaid Dental Plan Organization	§ 20-1004	210	90	300
Life Care Provider Permit*	§ 20-1803	60	30	90
Health Care Services Organization	§ 20-1052	210	90	300
Mechanical Reimbursement Reinsurer	§ 20-1096.04	210	90	300
Prepaid Legal Insurer*	§ 20-1097.02	45	15	60
Service Representative	§ 20-285	120	60	180
Managing General Agent-Firm	§ 20-284	120	60	180
Managing General Agent-Individual	§ 20-288	120	60	180
Risk Management Consultant	§ 20-289	120	60	180
Agent, Broker and Solicitor	§ 20-291	120	60	180
Nonresident Agent and Broker	§ 20-303	120	60	180
Vending Machine	§ 20-306	120	60	180
Limited Travel Agent	§ 20-306.01	120	60	180
Adjuster	§ 20-312	120	60	180
Bail Bond Agent	§ 20-319	120	60	180
Surplus Lines Broker	§ 20-411	120	60	180
Title Insurance Agent	§ 20-1580	120	60	180
Credit Life and Disability Agents	§ 20-1612	120	60	180
Variable Contract Agent	§ 20-2662	120	60	180
Utilization Review Agent	§ 20-2505	30	90	120
Rating Organization*	§ 20-361	30	30	60
Rate Service Organization	§ 20-389	60	60	120
Qualifying Surplus Lines Insurer	§ 20-413	45	30	75
Third Party Administrator	§ 20-485.12	45	45	90
Service Companies	§ 20-1095.01	30	30	60
Risk Retention Group (Foreign)*	§ 20-2403	60	0	60
Risk Purchasing Groups	§ 20-2407	30	30	60

* Statutory time-frames

Historical Note

Table 1 adopted effective January 1, 1999; filed in the Office of the Secretary of State December 4, 1998 (Supp. 98-4).

ARTICLE 8. PROHIBITED PRACTICES, PENALTIES**R20-6-801. Unfair Claims Settlement Practices**

- A.** Applicability. This rule applies to all persons and to all insurance policies, insurance contracts and subscription contracts except policies of Worker's Compensation and title insurance. This rule is not exclusive, and other acts not herein specified, may also be deemed to be a violation of A.R.S. § 20-461, The Unfair Claims Settlement Practices Act.
- B.** Definitions

1. "Agent" means any individual, corporation, association, partnership or other legal entity authorized to represent an insurer with respect to a claim.
2. "Claimant" means either a first party claimant, a third party claimant, or both and includes such claimant's designated legal representative and includes a member of the claimant's immediate family designated by the claimant.
3. "Director" means the Director of Insurance of the State of Arizona.

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4. "First party claimant" means an individual, corporation, association, partnership or other legal entity asserting a right to payment under an insurance policy or insurance contract arising out of the occurrence of the contingency of loss covered by such policy or contract.
 5. "Insurance policy or insurance contract" has the meaning of A.R.S. § 20-103.
 6. "Insurer" has the meaning of A.R.S. § 20-106(C).
 7. "Investigation" means all activities of an insurer directly or indirectly related to the determination of liabilities under coverages afforded by an insurance policy or insurance contract.
 8. "Notification of claim" means any notification, whether in writing or other means, acceptable under the terms of any insurance policy or insurance contract, to an insurer or its agent, by a claimant, which reasonably apprises the insurer of the facts pertinent to a claim.
 9. "Person" has the meaning of A.R.S. § 20-105.
 10. "Third party claimant" means any individual, corporation, association, partnership or other legal entity asserting a claim against any individual, corporation, association, partnership or other legal entity insured under an insurance policy or insurance contract of an insurer.
 11. "Worker's compensation" includes, but is not limited to, Longshoremen's and Harbor Worker's Compensation.
- C.** File and record documentation. The insurer's claim files shall be subject to examination by the Director or by his duly appointed designees. Such files shall contain all notes and work papers pertaining to the claim in such detail that pertinent events and the dates of such events can be reconstructed.
- D.** Misrepresentation of policy provisions
1. No insurer shall fail to fully disclose to first party claimants all pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented.
 2. No agent shall conceal from first party claimants benefits, coverages or other provisions of any insurance policy or insurance contract when such benefits, coverages or other provisions are pertinent to a claim.
 3. No insurer shall deny a claim on the basis that the claimant has failed to exhibit the damaged property to the insurer, unless the insurer has requested the claimant to exhibit the property and the claimant has refused without a sound basis therefor.
 4. No insurer shall, except where there is a time limit specified in the policy, make statements, written or otherwise, requiring a claimant to give written notice of loss or proof of loss within a specified time limit and which seek to relieve the company of its obligations if such a time limit is not complied with unless the failure to comply with such time limit prejudices the insurer's rights.
 5. No insurer shall request a first party claimant to sign a release that extends beyond the subject matter that gave rise to the claim payment.
 6. No insurer shall issue checks or drafts in partial settlement of a loss or claim under a specific coverage which contain language that releases the insurer or its insured from its total liability.
- E.** Failure to acknowledge pertinent communications
1. Every insurer, upon receiving notification of a claim shall, within 10 working days, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgment is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated.
- Notification given to an agent of an insurer shall be notification to the insurer.
2. Every insurer, upon receipt of any inquiry from the Department of Insurance respecting a claim shall, within fifteen working days of receipt of such inquiry, furnish the Department with an adequate response to the inquiry.
 3. An appropriate reply shall be made within 10 working days on all other pertinent communications from a claimant which reasonably suggest that a response is expected.
 4. Every insurer, upon receiving notification of claim, shall promptly provide necessary claim forms, instructions, and reasonable assistance so that first party claimants can comply with the policy conditions and the insurer's reasonable requirements. Compliance with this paragraph within 10 working days of notification of a claim shall constitute compliance with paragraph (1) of this subsection.
- F.** Standards for prompt investigation of claims. Every insurer shall complete investigation of a claim within 30 days after notification of claim, unless such investigation cannot reasonably be completed within such time.
- G.** Standards for prompt, fair and equitable settlements applicable to all insurers
1. Notice of acceptance or denial of claim.
 - a. Within fifteen working days after receipt by the insurer of properly executed proofs of loss, the first party claimant shall be advised of the acceptance or denial of the claim by the insurer. No insurer shall deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to such provision, condition or exclusion is included in the denial. The denial must be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial.
 - b. If the insurer needs more time to determine whether a first party claim should be accepted or denied, it shall also notify the first party claimant within fifteen working days after receipt of the proofs of loss, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 45 days from the date of the initial notification and every 45 days thereafter, send to such claimant a letter setting forth the reasons additional time is needed for investigation.
 - c. Where there is a reasonable basis supported by specific information available for review by the Director for suspecting that the first party claimant has fraudulently caused or contributed to the loss by arson, the insurer is relieved from the requirements of subparagraphs (a) and (b) above. Provided, however, that the claimant shall be advised of the acceptance or denial of the claim by the insurer within a reasonable time for full investigation after receipt by the insurer of a properly executed proof of loss.
 2. If a claim is denied for reasons other than those described in subparagraph (a) above, and is made by any other means than writing, an appropriate notation shall be made in the claim file of the insurer.
 3. Insurers shall not fail to settle first party claims on the basis that responsibility for payment should be assumed by others, except as may otherwise be provided by policy provisions.
 4. Insurers shall not continue negotiations for settlement of a claim directly with a claimant who is neither an attorney nor represented by an attorney until the claimant's rights may be affected by a statute of limitations or a policy or

contract time limit, without giving the claimant written notice that the time limit may be expiring and may affect the claimant's right. Such notice shall be given to first party claimants 30 days and to third party claimants 60 days before the date on which such time limit may expire.

5. No insurer shall make statements which indicate that the rights of a third party claimant may be impaired if a form or release is not completed within a given period of time unless the statement is given for the purpose of notifying the third party claimant of the provision of a statute of limitations.

H. Standards for prompt, fair and equitable settlements applicable to automobile insurance

1. When the insurance policy provides for the adjustment and settlement of first party automobile total losses on the basis of actual cash value or replacement with another of like kind and quality, one of the following methods must apply:
 - a. The insurer may elect to offer a replacement automobile which is a specific comparable automobile available to the insured, with all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of the automobile paid, at no cost other than any deductible provided in the policy. The offer and any rejection thereof must be documented in the claim file.
 - b. The insurer may elect a cash settlement based upon the actual cost, less any deductible provided in the policy, to purchase a comparable automobile including all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of a comparable automobile. Such cost may be determined by:
 - i. The cost of a comparable automobile in the local market area when a comparable automobile is available in the local market area.
 - ii. One of two or more quotations obtained by the insurer from two or more qualified dealers located within the local market area when a comparable automobile is not available in the local market area.
 - c. When a first party automobile total loss is settled on a basis which deviates from the methods described in subparagraphs (a) and (b) above, the deviation must be supported by documentation giving particulars of the automobile condition. Any deductions from such cost, including deduction for salvage, must be measurable, discernible, itemized and specified as to dollar amount and shall be appropriate in amount. The basis for such settlement shall be fully explained to the first party claimant.
2. Where liability and damages are reasonably clear, insurers shall not recommend that third party claimants make claim under their own policies solely to avoid paying claims under such insurer's policy or insurance contract.
3. Insurers shall not require a claimant to travel unreasonably either to inspect a replacement automobile, to obtain a repair estimate or to have the automobile repaired at a specific repair shop.
4. Insurers shall, upon the claimant's request, include the first party claimant's deductible, if any, in subrogation demands. Subrogation recoveries shall be shared on a proportionate basis with the first party claimant, unless the deductible amount has been otherwise recovered. No deduction for expenses can be made from the deductible recovery unless an outside attorney is retained to collect

such recovery. The deduction may then be for only a pro rata share of the allocated loss adjustment expense.

5. If an insurer prepares an estimate of the cost of automobile repairs, such estimate shall be in an amount for which it may be reasonably expected the damage can be satisfactorily repaired. The insurer shall give a copy of the estimate to the claimant and may furnish to the claimant the names of one or more conveniently located repair shops.
6. When the amount claimed is reduced because of betterment or depreciation all information for such reduction shall be contained in the claim file. Such deductions shall be itemized and specified as to dollar amount and shall be appropriate for the amount of deductions.
7. When the insurer elects to repair and designates a specific repair shop for automobile repairs, the insurer shall cause the damaged automobile to be restored to its condition prior to the loss at no additional cost to the claimant other than as stated in the policy and within a reasonable period of time.
8. The insurer shall not use as a basis for cash settlement with a first party claimant an amount which is less than the amount which the insurer would pay if the repairs were made, other than in total loss situations, unless such amount is agreed to by the insured.
- I. Severability. If any provision of this rule or the application thereof to any person or circumstances is held invalid, the remainder of the rule and the application of such provision to other persons and circumstances shall not be affected.
- J. Effective date. This rule shall become effective 90 days from the date of filing with the Secretary of State.

Historical Note

Adopted effective January 12, 1982 (Supp. 81-5). R20-6-801 recodified from R4-14-801 (Supp. 95-1).

R20-6-802. Emergency Expired

Historical Note

Emergency rule adopted effective May 31, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Emergency expired. Emergency rule readopted without change effective September 5, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-3). Emergency expired. R20-6-802 recodified from R4-14-802 (Supp. 95-1).

ARTICLE 9. TERMINATION OR DISSOLUTION

R20-6-901. Reserved

ARTICLE 10. LONG-TERM CARE INSURANCE

R20-6-1001. Applicability and Scope

Except as otherwise specifically provided, this Article applies to all long-term care insurance policies delivered or issued for delivery in this state.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1001 recodified from R4-14-1001 (Supp. 95-1). Amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4).

R20-6-1002. Definitions

The definitions in A.R.S. § 20-1691 and the following definitions apply in this Article.

1. "Incidental" means that the value of the long-term care benefits provided is less than 10% of the total value of the benefits provided over the life of the policy, with value measured as of the date of issue.

2. "Long-term care benefit classification" means one of the following:
 - a. Institutional long-term care – benefits only;
 - b. Non-institutional long-term care – benefits only; or
 - c. Comprehensive long-term care benefits.
3. "Managed care plan" means a health care or assisted living agreement designed to coordinate patient care or control costs through utilization review, case management, use of specific provider networks, or a combination of these methods.
4. "Personal information" has the same meaning prescribed in A.R.S. § 20-2102(19).
5. "Privileged information" has the same meaning prescribed in A.R.S. § 20-2102(22).
6. "Qualified actuary" means a member in good standing of the American Academy of Actuaries.
7. "Similar policy forms" means all long-term care insurance policies and certificates that are issued by a particular insurer and that have the same long-term care benefit classification as a policy form being reviewed.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1002 recodified from R4-14-1002 (Supp. 95-1).

Amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4).

R20-6-1003. Policy Terms

A. A long-term care insurance policy delivered or issued for delivery in this state shall not use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements:

1. "Activities of daily living" means eating, toileting, transferring, bathing, dressing, or continence.
2. "Acute condition" means that an individual is medically unstable and requires frequent monitoring by medical professionals, such as physicians and registered nurses, to maintain the individual's health status.
3. "Adult day care" means a program of social and health-related services for six or more individuals, that is provided during the day in a community group setting, for the purpose of supporting frail, impaired, elderly, or other disabled adults who can benefit from the services and care in a setting outside the home.
4. "Agent" means an insurance producer as defined in A.R.S. § 20-281(5).
5. "Bathing" means washing oneself by sponge bath, or in a tub or shower, and includes the act of getting in and out of the tub or shower.
6. "Cognitive impairment" means a deficiency in a person's:
 - a. Short or long-term memory;
 - b. Orientation as to person, place, or time;
 - c. Deductive or abstract reasoning; or
 - d. Judgment as it relates to safety awareness.
7. "Continence" means the ability to maintain control of bowel and bladder function, or when unable to maintain control, the ability to perform associated personal hygiene, such as caring for a catheter or colostomy bag.
8. "Dressing" means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
9. "Eating" means feeding oneself by getting food into the body from a receptacle such as a plate, cup, or table, or by a feeding tube or intravenously.
10. "Guaranteed renewable" means the insured has the right to continue a long-term-care insurance policy in force by the timely payment of premiums and the insurer has no

unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that the insurer may revise rates on a class basis.

11. "Hands-on assistance" means physical help to an individual who could not perform an activity of daily living without help from another individual, and includes minimal, moderate, or maximal help.
12. "Home health services" means the services described A.R.S. § 36-151.
13. "Level premium" means that an insurer does not have any right to change the premium, even at renewal.
14. "Medicare" means "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.
15. "Noncancellable" means the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally cancel or make any change in any provision of the insurance or in the premium rate.
16. "Personal care" means the provision of hands-on assistance to help an individual with activities of daily living in relation to the level of skill required, the nature of the care, and the setting in which the care must be delivered.
17. "Toileting" means getting to and from the toilet, getting on and off the toilet, and performing tasks associated with personal hygiene.
18. "Transferring" means moving into or out of a bed, chair, or wheelchair.

B. Any long-term care policy delivered or issued for delivery in this state shall include the following policy terms and provisions as specified in this subsection:

1. "Home care" shall be defined in relation to the level of skill required, the nature of the care, and the setting in which the care must be delivered.
2. "Intermediate care" shall be defined in relation to the level of skill required, the nature of the care, and the setting in which the care must be delivered.
3. "Mental or nervous disorder" shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.
4. "Skilled nursing care," shall be defined in relation to the level of skill required, the nature of the care and the setting in which care is delivered.
5. Service providers, including "skilled nursing facility," "extended care facility," "intermediate care facility," "convalescent nursing home," "personal care facility," and "home care agency" shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services and may require that the provider be appropriately licensed or certified.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1003 recodified from R4-14-1003 (Supp. 95-1).

Amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4).

R20-6-1004. Required Policy Provisions

A. Renewability

1. An individual long-term care insurance policy shall contain a renewability provision, which shall be either "guaranteed renewable" or "noncancellable." The renewability provision shall be appropriately captioned, shall appear on the first page of the policy, and shall state that the coverage is guaranteed renewable or noncancellable. This requirement does not apply to a long-term care insurance policy that is part of or combined with a life insurance policy that does not contain a renewability provision and that reserves the right not to renew solely to the policyholder.
 2. An insurer shall not use the terms "guaranteed renewable" and "noncancellable" in any individual long-term care insurance policy without further explanatory language according to the disclosure requirements of this Article.
 3. A qualified long-term care insurance policy shall have the guaranteed renewability provisions specified in Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986 in the policy.
 4. A long-term care insurance policy or certificate shall include a statement that premium rates are subject to change, unless the policy does not afford the insurer the right to raise premiums.
- B. Limitations and Exclusions**
1. If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Preexisting Condition Limitations."
 2. A long-term care insurance policy or certificate containing any limitations or conditions for eligibility not prohibited by A.R.S. §§ 20-1691.03 and 20-1691.05 shall describe the limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label the paragraph "Limitations or Conditions on Eligibility for Benefits."
 3. A policy shall not be delivered or issued for delivery in this state as long-term care insurance if the policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows:
 - a. Preexisting conditions or disease;
 - b. Mental or nervous disorders; however, this shall not permit exclusion or limitation of the benefits on the basis of Alzheimer's Disease;
 - c. Alcoholism and drug addiction;
 - d. Illness, treatment or medical condition arising out of:
 - i. War, declared or undeclared, or act of war;
 - ii. Participation in a felony, riot or insurrection;
 - iii. Service in the armed forces or auxiliary units;
 - iv. Suicide, attempted suicide, or intentionally self-inflicted injury; or
 - v. Aviation, if non-fare-paying passenger.
 - e. Treatment provided in a government facility, unless otherwise required by law;
 - f. Services for which benefits are available under Medicare or other governmental program, except Medicaid;
 - g. Any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law;
 - h. Services provided by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance;
 - i. Expenses for services or items available or paid under another long-term care insurance or health insurance policy; or
 - j. In the case of a qualified long-term care insurance policy, expenses for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act or would be reimbursable but for the application of a deductible or coinsurance amount;
 4. Subsection (B)(2) does not prohibit exclusions and limitations by type of provider or territorial limitations.
- C. Extension of benefits.** A long-term care insurance policy shall provide that termination of long-term care insurance is without prejudice to any benefits payable for institutionalization if the institutionalization began while the long-term care insurance was in force and continues without interruption after termination. An insurer may limit this extension of benefits period to the duration of the benefit period, if any, or to payment of the maximum benefits and the insurer may still apply any policy waiting period and all other applicable provisions of the policy.
- D. Reinstatement.** A long-term care insurance policy shall include a provision for reinstatement of coverage if a lapse occurs if the insurer receives proof that the insured was cognitively impaired or had a loss of functional capacity before expiration of the grace period in the policy. The option to reinstate shall be available to the insured for at least five months after the date of termination and shall allow for the collection of past due premiums, as appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria for these conditions set forth in the original long-term care policy.
- E. Continuation or conversion**
1. A group long-term care insurance policy shall provide covered individuals with a basis for continuation or conversion of coverage as specified in this subsection.
 2. The policy shall include a provision that maintains coverage under the existing group policy when the coverage would otherwise terminate, subject only to the continued timely payment of premiums when due. A group policy that restricts provision of benefits and services to, or has incentives to use certain providers or facilities, may provide continuation benefits that are substantially equivalent to the benefits of the existing group policy. The Director shall make a determination as to the substantial equivalency of benefits and, in doing so, shall take into consideration the differences between managed care and non-managed care plans, including provider system arrangements, service availability, benefit levels and administrative complexity.
 3. The policy shall include a provision that an individual, whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuation of the group policy in its entirety or with respect to an insured class, who has been insured under the group policy (and any group policy which it replaced), is entitled to the issuance of a converted policy by the insurer under whose group policy the individual is covered, without evidence of insurability.
 4. A converted policy shall be an individual policy of long-term care insurance providing benefits identical to or benefits that the Director determines to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incen-

- tives to use certain providers or facilities, the Director, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and non-managed care plans provider system arrangements, service availability, benefit levels and administrative complexity, and other plan elements.
5. An insurer may require an individual seeking a conversion policy to make a written application for the converted policy and pay the first premium due, if any, as directed by the insurer not later than 31 days after termination of coverage under the group policy. The insurer shall issue the converted policy effective on the day following the termination of coverage under the group policy. The converted policy shall be renewable annually.
 6. Unless the group policy from which conversion is made replaced previous group coverage, the insurer shall calculate the premium for the converted policy on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. If the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.
 7. An insurer is required to provide continuation of coverage or issuance of a converted policy as provided in this subsection, unless:
 - a. Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or
 - b. The terminating coverage is replaced not later than 31 days after termination, by group coverage that
 - i. Is effective on the day following the termination of coverage;
 - ii. Provides benefits identical to or benefits the Director determines to be substantially equivalent to or in excess of those provided by the terminating coverage; and
 - iii. Has a premium calculated in a manner consistent with the requirements of subsection (E)(6).
 8. Notwithstanding any other provision of this Section, a converted policy that an insurer issues to an individual who at the time of conversion is covered by another long-term care insurance policy providing benefits on the basis of incurred expenses, may contain a provision that reduces benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100% of incurred expenses. An insurer may include this provision in the converted policy only if the converted policy also provides for a premium decrease or refund that reflects the reduction in payable benefits.
 9. The converted policy that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group remained in force and effect.
 10. Notwithstanding any other provision of this Section, any insured individual whose eligibility for group long-term care coverage is based upon the individual's relationship to another person, is entitled to continuation of coverage under the group policy upon if the qualifying relationship terminates by death or dissolution of marriage.
- F. Discontinuance and replacement. If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy:
 1. Shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced; and
 2. Shall not vary or otherwise depend on the individual's health or disability status, claim experience, or use of long-term care services.
 - G. Premium Increases
 1. An insurer shall not increase the premium charged to an insured because of:
 - a. The insured aging beyond age 65; or
 - b. The duration of coverage under the policy.
 2. Purchase of additional coverage is not considered a premium rate increase, however, for the calculation required under R20-6-1019, an insurer shall add to and consider the portion of the premium attributable to the additional coverage as part of the initial annual premium.
 3. A reduction in benefits is not considered a premium change, however, for the calculation required under R20-6-1019, an insurer shall base the initial annual premium on the reduced benefits.
 - H. Electronic enrollment for group policies
 1. For coverage offered to a group defined in A.R.S. § 20-1691(5)(a), any requirement that an insurer or insurance producer obtain an insured's signature is satisfied if:
 - a. The group policyholder or insurer obtains the insured's consent by telephonic or electronic enrollment, and provides the enrollee with verification of enrollment information within five business days of enrollment; and
 - b. The telephonic or electronic enrollment process has safeguards to assure the accuracy, retention, and prompt retrieval of records, and the confidentiality of personal and privileged information.
 2. If the Director requests, the insurer shall make available records showing the insurer's ability to confirm enrollment and coverage amounts.
 - I. Minimum standards for home health care benefits.
 1. If an insurer issues a long-term care insurance policy or certificate that provides benefits for home-health care, the policy or certificate shall not, limit or exclude benefits by any of the following:
 - a. Requiring that the insured would need skilled care in a skilled nursing facility if home health services are not provided;
 - b. Requiring that the insured first or simultaneously receive nursing or therapeutic services in a home or community setting before home health services are covered;
 - c. Requiring that eligible services be provided by a registered nurse or licensed practical nurse;
 - d. Requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide or other licensed or certified home care worker acting within the scope of licensure or certification;
 - e. Requiring that the insured have an acute condition before home health services are covered;
 - f. Limiting benefits to services provided by Medicare-certified agencies or providers;

- g. Excluding coverage for personal care services provided by a home health aide;
 - h. Requiring that home health care services be provided at a level of certification or licensure greater than that required by the eligible service; or
 - i. Excluding coverage for adult day care services.
2. An insurer may apply home health care coverage to non-home health care benefits in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.
- J.** Appeals. Policy shall include a clear description of the process for appealing and resolving benefit determinations.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1004 recodified from R4-14-1004 (Supp. 95-1).

Amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4).

R20-6-1005. Unintentional Lapse

- A.** An insured may designate in writing at least one person to receive notice of lapse and termination of a long-term care insurance policy for nonpayment of premium, in addition to the insured. Designation shall not constitute acceptance of any liability by the third-party notice recipient for services provided to the insured.
- B.** An insurer shall not issue a long-term care insurance policy until the applicant has provided either a written designation of at least one person in addition to the applicant, who shall receive notice of lapse or termination, with the person's full name and home address, or the applicant's written waiver, dated and signed, indicating that the applicant chooses not to designate a notice recipient.
- C.** The insurer shall use a form for written designation or waiver that provides space clearly delineated for the designation. The insurer shall include the following language on the form for waiver of the right to name a designated recipient: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that this notice will not be given until 30 days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice."
- D.** At least once every two years, an insurer shall notify the insured of the right to change the person designated to receive notice in subsection (A). An insured may add, delete, or change a designated recipient or change a designated recipient at any time by notifying the insurer in writing, and providing the name and home address for the new designated recipient or the designated recipient to be deleted.
- E.** If the insured pays premiums for the long-term care insurance policy through a payroll or pension deduction plan, the insurer is not required to comply with the requirements in subsections (A) through (D) until 60 days after the insured is no longer on the payment plan.
- F.** An individual long-term care insurance policy shall not lapse or be terminated for nonpayment of premium unless the insurer gives the insured and any recipient designated under subsections (A) through (D) written notice at least 30 days before the effective date of termination or lapse, by first class mail, postage prepaid. An insurer shall not give notice until 30 days after the date on which a premium is due and unpaid. Notice is deemed given five days after the date of mailing.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1005 recodified from R4-14-1005 (Supp. 95-1). Section

R20-6-1005 renumbered to R20-6-1006; new Section R20-6-1005 made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4).

R20-6-1006. Inflation Protection

- A.** An insurer shall not offer a long-term care insurance policy unless the insurer offers, at the time of purchase, in addition to any other inflation protection, the option to purchase a policy with an inflation protection provision to address the reduction or limitation on the value of benefits that may result from inflation over time. The terms of the required provision shall be no less favorable than the following:
1. A provision that provides for increases in benefit levels compounding annually at a rate of no less than 5%;
 2. A provision that allows an insured to periodically increase benefit levels without providing evidence of insurability or health status, if the insured did not decline the option for the previous period. The increased benefit shall be no less than the difference between the existing benefit and that benefit compounded annually at a rate of no less than 5% from the purchase of the existing benefit until the year in which the offer is made; or
 3. A provision for coverage of a specified percentage of actual or reasonable charges that is not subject to a maximum indemnity amount or limit.
- B.** If the policy is issued to a group, the insurer shall extend the offer required by subsection (A) to the group policyholder; except, if the policy is issued under A.R.S. § 20-1691.04(C) to a group, other than to a continuing care retirement community, the insurer shall make the offer to each proposed certificateholder.
- C.** An insurer is not required to make the offer in subsection (A) for life insurance policies or riders with accelerated long-term care benefits.
- D.** An insurer shall include the information listed in this subsection in or with the outline of coverage.
1. A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a 20-year period.
 2. Any expected premium increases or additional premiums to pay for automatic or optional benefit increases. If premium increases or additional premiums will be based on the attained age of the applicant at the time of the increase, the insurer shall provide a revised schedule of attained-age premiums. An insurer may use a hypothetical or a graphic demonstration for this disclosure.
- E.** Inflation-protection benefit increases shall continue without regard to an insured's age, claim status, claim history, or length of time insured under the policy.
- F.** An insurer's offer of inflation protection that provides for automatic benefit increases shall include an offer of a premium that the insurer expects to remain constant. The insurer shall disclose in the offer in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.
- G.** An insurer shall include in a long-term care insurance policy inflation protection as provided in subsection (A)(1) unless an insurer obtains a rejection of inflation protection signed by the insured as required in subsection (H). The rejection may be either on the application form or on a separate form.
- H.** A rejection of inflation protection is deemed part of an application and shall state: "I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I

reviewed Plans [insert description of plans], and I reject inflation protection.”

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1006 recodified from R4-14-1006 (Supp. 95-1). R20-6-1006 renumbered to R20-6-1007; new Section R20-5-1006 renumbered from R20-6-1005 and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4).

R20-6-1007. Required Disclosure Provisions

- A.** Riders and endorsements. Except for riders or endorsements by which an insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, if an insurer adds a rider or endorsement to an individual long-term care insurance policy after date of issue or at reinstatement or renewal that reduces or eliminates benefits or coverage in the policy, the insurer shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term shall require the signed written agreement of the insured unless the increased benefits or coverage are required by law. If the insurer charges a separate additional premium for benefits provided in connection with riders or endorsements, premium charge shall be set forth in the policy, rider, or endorsement.
- B.** Payment of Benefits. A long-term care insurance policy that provides for the payment of benefits based on standards described as “usual and customary,” “reasonable and customary” or words of similar import shall define the terms and explain them in its accompanying outline of coverage.
- C.** Disclosure of tax consequences. For life insurance policies that provide an accelerated benefit for long-term care, an insurer shall provide a disclosure statement at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted, that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax adviser. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents.
- D.** Benefit triggers. A long-term care insurance policy shall use activities of daily living and cognitive impairment to measure an insured’s need for long-term care. The long-term care insurance policy or certificate shall describe these terms and provisions in a separate paragraph in the policy or certificate labeled “Eligibility for the Payment of Benefits” that includes and explains:
 1. Any additional benefit triggers;
 2. Benefit triggers that result in payment of different benefit levels;
 3. Any requirement that an attending physician or other specified person certify a certain level of functional dependency for the insured to be eligible for benefits.
- E.** A long-term care insurance policy or certificate shall contain a disclosure statement in the policy and in the outline of coverage indicating whether it is intended to be a qualified long-term care insurance contract as specified in the outline of coverage in Appendix J, paragraph 3.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1007 recodified from R4-14-1007 (Supp. 95-1). Former Section R20-6-1007 renumbered to R20-6-1010; new Section R20-6-1007 renumbered from R20-6-1006 and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4).

R20-6-1008. Required Disclosure of Rating Practices to Consumers

- A.** This Section applies as follows:
 1. Except as provided in subsection (A)(2), this Section applies to any long-term care policy or certificate issued in this state on or after May 10, 2005.
 2. For certificates issued under an in-force, long-term care insurance policy issued to a group as defined in A.R.S. § 20-1691(5)(a), the provisions of this Section apply on the first policy anniversary that occurs on or after November 10, 2005.
- B.** Unless a policy is one for which an insurer can not increase the applicable premium rate or rate schedule, the insurer shall provide the information listed in this subsection to the applicant at the time of application or enrollment. If the method of application does not allow for delivery at that time, the insurer shall provide the information to the applicant no later than at the time of delivery of the policy or certificate.
 1. A statement that the policy may be subject to rate increases in the future.
 2. An explanation of potential future premium rate revisions, and the policyholder’s or certificateholder’s option if a premium rate revision occurs.
 3. The premium rate or rate schedules applicable to the applicant that will be in effect until the insurer makes a request for an increase.
 4. A general explanation for applying premium rate or rate schedule adjustments that includes:
 - a. A description of when premium rate or rate-schedule adjustments will be effective (e.g., next anniversary date, next billing date); and
 - b. The insurer’s right to a revised premium rate or rate schedule as provided in subsection (B)(3) if the premium rate or rate schedule is changed.
 5. Information regarding each premium rate increase on this policy form or similar policy form over the past 10 years for this state or any other state, that, at a minimum, identifies:
 - a. The policy forms for which premium rates have been increased;
 - b. The calendar years when the form was available for purchase; and
 - c. The amount or percent of each increase, which may be expressed as a percentage of the premium rate before the increase, or as minimum and maximum percentages if the rate increase is variable by rating characteristics.
 6. The insurer may, in a fair manner, provide explanatory information related to the rate increases in addition to the information required under subsection (B)(5).
- C.** An insurer may exclude from the disclosure required under subsection (B)(5), premium rate increases applicable to:
 1. Blocks of business acquired from other nonaffiliated insurers; and
 2. Policies acquired from other nonaffiliated insurers if the increases occurred before the acquisition.
- D.** If an acquiring insurer files for a rate increase on a long-term care insurance policy form or a block of policy forms acquired from a nonaffiliated insurer on or before the later of the January 10, 2005, or the end of a 24-month period following the acquisition of the policies or block of policies, the acquiring insurer may exclude that rate increase from the disclosure required under subsection (B)(5). However, the nonaffiliated insurer that sells the policy form or a block of policy forms shall include that rate increase in the disclosure required under subsection (B)(5). If the acquiring insurer files for a subse-

quent rate increase, even within the 24-month period, on the same policy form acquired from a nonaffiliated insurer or block of policy forms acquired from nonaffiliated insurers, the acquiring insurer shall make all disclosures required by subsection (B)(5), including disclosure of the earlier rate increase.

- E. Unless the method of application does not allow an insured to sign an acknowledgement that the insurer made the disclosures required under subsection (B) at the time of application, the applicant shall sign an acknowledgement of disclosure at that time. Otherwise, the applicant shall sign a disclosure acknowledgement no later than at the time of delivery of the policy or certificate.
- F. An insurer shall use the forms in Appendix A and Appendix B to comply with the requirements of subsections (B) through (E). The text and format of an insurer's forms shall be substantially similar to the text and format of Appendices A and B.
- G. An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificateholders, if applicable, at least 45 days before the effective date of the increase. The notice shall include the information required by subsection (B).

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1008 recodified from R4-14-1008 (Supp. 95-1). Former Section R20-6-1008 renumbered to R20-6-1011; new Section R20-6-1008 made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4).

R20-6-1009. Initial Filing Requirements

- A. This Section applies to any long-term care policy issued in this state on or after May 10, 2005.
- B. At the time of making a filing under A.R.S. § 20-1691.08, an insurer shall provide the Director a copy of the disclosure documents required under R20-6-1008 and an actuarial certification that includes the following:
 - 1. The initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;
 - 2. The policy design and coverage provided have been reviewed and taken into consideration;
 - 3. The underwriting and claims adjudication processes have been reviewed and taken into consideration;
 - 4. A complete description of the basis for contract reserves that are anticipated to be held under the form, to include:
 - a. Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held;
 - b. A statement that the assumptions used for reserves contain reasonable margins for adverse experience;
 - c. A statement that the net valuation premium for renewal years does not increase (except for attained-age rating where permitted); and
 - d. A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur;
 - i. An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship;
 - ii. If the gross premiums for certain age groups appear to be inconsistent with this requirement,

the Director may request a demonstration under subsection (C) based on a standard age distribution; and

- 5. A statement that the premium rate schedule:
 - a. Is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or
 - b. A comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences.
- C. The Director may require an insurer to provide an actuarial demonstration that benefits provided under a long-term care policy are reasonable in relation to premiums charged. The actuarial demonstration shall include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other studies, or both.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1009 recodified from R4-14-1009 (Supp. 95-1). Section R20-6-1009 renumbered to R20-6-1012; new Section R20-6-1009 made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4).

R20-6-1010. Requirements for Application Forms and Replacement Coverage

- A. An insurer's application form for a long-term care insurance policy shall include the questions listed in this Section to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other health or long-term care policy or certificate presently in force. An insurer may include the questions in a supplementary application or other form to be signed by the applicant and insurance producer, except where the coverage is sold without an insurance producer. For a replacement policy issued to a group as defined in A.R.S. § 20-1691(5)(a), the insurer may modify the questions only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced if the certificate holder has been notified of the replacement.
 - 1. Do you have another long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract)?
 - 2. Did you have another long-term care insurance policy or certificate in force during the last 12 months?
 - a. If so, with which company?
 - b. If that policy lapsed, when did it lapse?
 - 3. Are you covered by Medicaid?
 - 4. Do you intend to replace any of your medical or health insurance coverage with this policy or certificate?
- B. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan the applicant selects.
- C. An insurance producer shall list any other health insurance policies the insurance producer has sold to the applicant, including:
 - 1. Policies that are still in force.
 - 2. Policies sold in the past five years that are no longer in force.
- D. On determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its insurance producer shall furnish the applicant, before issuing or delivering of the individual long-term care

insurance policy, a notice that substantially conforms to the form prescribed in Appendix C regarding replacement of health or long-term care coverage. The insurer shall:

1. Give one copy of the notice to the applicant; and
 2. Keep an additional copy signed by the applicant.
- E.** Insurers using direct response solicitation methods shall deliver a notice regarding replacement of health or long-term care coverage to the applicant upon issuance of the policy.
- F.** If replacement is intended, the replacing insurer shall send the existing insurer written notice of the proposed replacement within five working days from the date the replacing insurer receives the application or issues the policy, whichever is sooner. The notice shall identify the existing policy by name of the insurer and the insured, and policy number or insured's address including zip code.
- G.** A life insurance policy that accelerate benefits for long-term care shall comply with this Section if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply with the replacement requirements of Title 20, Chapter 6, Article 1.1. If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer shall comply with the requirements of this Section and with Title 20, Chapter 6, Article 1.1.
- H.** If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions and probationary periods in the new long-term care policy for similar benefits if similar exclusions are satisfied under the original policy.
- I.** Reporting requirements
1. An insurer shall maintain the following records for each insurance producer:
 - a. The amount of the insurance producer's replacement sales as a percent of the insurance producer's total annual sales; and
 - b. The amount of lapses of long-term care insurance policies sold by the insurance producer as a percent of the insurance producer's total annual sales.
 2. No later than June 30 of each year, on the forms specified in Appendix E and Appendix F, an insurer shall report the following information for the preceding calendar year to the Department:
 - a. The 10% of its insurance producers licensed in Arizona with the greatest percentages of lapses and replacements as measured by subsection (H)(1); and
 - b. The number of lapsed policies as a percent of the total annual sales and as a percent of the insurer's total number of policies in force as of the end of the preceding calendar year.
 - c. The number of replacement policies sold as a percent of the insurer's total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year; and
 - d. For qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied.
- J.** In subsection (I),
1. "Claim" means a request for payment of benefits under an in-force policy, regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met;
 2. "Denied" means the insurer refuses to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition;

3. "Policy" means only long-term care insurance; and
4. "Report" means on a statewide basis.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1010 recodified from R4-14-1010 (Supp. 95-1). R20-6-1010 renumbered to R20-6-1013; new Section R20-6-1010 renumbered from R20-6-1007 and amended by final by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4).

R20-6-1011. Prohibition Against Post-claims Underwriting

- A.** An application for a long-term care insurance policy or certificate that is not guaranteed issue shall meet the requirements of this Section.
1. The application shall contain clear and unambiguous questions designed to ascertain the applicant's health condition.
 - a. If the application has a question asking whether the applicant has had medication prescribed by a physician, the application shall also ask the applicant to list the prescribed medication.
 - b. If the insurer knew or reasonably should have known that the medications listed in the application are related to a medical condition for which coverage would otherwise be denied, the insurer shall not rescind the policy or certificate for that condition.
 2. The application shall include the following language which shall be set out conspicuously and in close conjunction with the applicant's signature block: "Caution: If your answers on this application are incorrect or untrue, [company] has the right to deny benefits or rescind your policy."
 3. The policy or certificate shall contain the following language, or language substantially similar to the following, set out conspicuously: "Caution: The issuance of this long-term care insurance [policy] [certificate] is based on your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]."
- B.** Before issuing a long-term care insurance policy or certificate that is not guaranteed issue to an applicant age 80 or older, the insurer shall obtain one of the following:
- a. A report of a physical examination;
 - b. An assessment of functional capacity;
 - c. An attending physician's statement; or
 - d. Copies of medical records.
- C.** The insurer or its insurance producer shall deliver a copy of the completed application or enrollment form, as applicable to the insured no later than at the time of delivery of the policy or certificate unless the insurer gave a copy to the applicant it at the time of application.
- D.** An insurer selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state- and country-wide, except those which the insured voluntarily effectuated.
- E.** On or before March 31 of each year, an insurer shall report the following information to the Director for the preceding calendar year, using the form prescribed in Appendix G:
1. Insurer name, address, phone number;

2. As to each rescission except those voluntarily effectuated by the insured:
 - a. Policy form number;
 - b. Policy and certificate number;
 - c. Name of the insured;
 - d. Date of policy issuance;
 - e. Date claim submitted;
 - f. Date of rescission; and
 - g. Detailed reason for rescission.
3. Signature, name and title of the preparer, and date prepared.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1011 recodified from R4-14-1011 (Supp. 95-1). R20-6-1011 renumbered to R20-6-1014; new Section R20-6-1011 renumbered from R20-6-1008 and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4).

R20-6-1012. Discretionary Powers of Director

The Director may, on written request and after an administrative hearing, issue an order to modify or suspend a specific provision or provision of this Article with respect to a specific long-term care insurance policy or certificate upon a written finding that:

1. The modification or suspension would be in the best interest of the insureds; and
2. The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and
 - a. The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care; or
 - b. The policy or certificate is to be issued to residents of a life-care or continuing-care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or
 - c. The modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1012 recodified from R4-14-1012 (Supp. 95-1). R20-6-1012 renumbered to R20-6-1016; new Section R20-6-1012 renumbered from R20-6-1009 and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4).

R20-6-1013. Reserve Standards

- A. If long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders an insurer shall determine, policy reserves for long-time care benefits are determined under A.R.S. § 20-510. An insurer shall establish claim reserves shall be established for a policy or rider in claim status.
- B. An insurer shall base reserves for policies and riders under subsection (A) on the multiple decrement model using all relevant decrements except for voluntary termination rates. An insurer may use single decrement approximations if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The insurer, when calculating reserves, may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. The insurer shall not set the reserves for the long-term care benefit and the life insurance benefit be less

than the reserves for the life insurance benefit assuming no long-term care benefit.

- C. In the development and calculation of reserves for policies and riders subject to this Section, an insurer shall give due regard to the applicable policy provisions, marketing methods, administrative procedures and all other considerations which impact projected claim costs including the following:
 1. Definition of insured events;
 2. Covered long-term care facilities;
 3. Existence of home convalescence care coverage;
 4. Definition of facilities;
 5. Existence or absence of barriers to eligibility;
 6. Premium waiver provision;
 7. Renewability;
 8. Ability to raise premiums;
 9. Marketing method;
 10. Underwriting procedures;
 11. Claims adjustment procedures;
 12. Waiting period;
 13. Maximum benefit;
 14. Availability of eligible facilities;
 15. Margins in claim costs;
 16. Optional nature of benefit;
 17. Delay in eligibility for benefit;
 18. Inflation protection provisions;
 19. Guaranteed insurability option; and
 20. Other similar or comparable factors affecting risk.
- D. A member of the American Academy of Actuaries shall certify an insurer's use of any applicable valuation morbidity table as appropriate as a statutory valuation table.
- E. When long-term care benefits are provided other than as described in subsection (A), an insurer shall determine reserves under A.R.S. § 20-508.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1013 recodified from R4-14-1013 (Supp. 95-1). Section R20-6-1013 renumbered to R20-6-1017; new Section R20-6-1013 renumbered from R20-6-1010 and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4).

R20-6-1014. Loss Ratio

- A. This Section applies to policies and certificates issued any time prior to May 10, 2005.
- B. Benefits under an individual long-term care insurance policy is deemed reasonable in relation to premiums if the expected loss ratio is at least 60% calculated in a manner that provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, the director shall consider to all relevant factors, including:
 1. Statistical credibility of incurred claims experience and earned premiums;
 2. The period for which rates are computed to provide coverage;
 3. Experienced and projected trends;
 4. Concentration of experience within early policy duration;
 5. Expected claim fluctuation;
 6. Experience refunds, adjustments, or dividends;
 7. Renewability features;
 8. All appropriate expense factors;
 9. Interest;
 10. Experimental nature of the coverage;
 11. Policy reserves;
 12. Mix of business by risk classification; and
 13. Product features such as long elimination periods, high deductibles, and high maximum limits.

- C. Subsection (B) does not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is deemed to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following:
1. The interest credited internally to determine cash value accumulations, including long-term care, if any, is guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy.
 2. The portion of the policy that provides life insurance benefits complies with the nonforfeiture requirements of A.R.S. § 20-1231;
 3. The policy complies with the disclosure requirements of A.R.S. § 20-1691.06(A) through (E);
 4. At the time of making a filing under A.R.S. § 20-1691.08, the insurer files an actuarial memorandum that includes the following information:
 - a. A description of the basis on which the long-term care rates were determined;
 - b. A description of the basis for the reserves;
 - c. A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;
 - d. A description and a table of each actuarial assumption used; for expenses, an insurer shall include percent of premium dollars per policy and dollars per unit of benefits, if any;
 - e. A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;
 - f. The estimated average annual premium per policy and the average issue age;
 - g. A statement as to whether underwriting is performed, including:
 - i. Time of underwriting;
 - ii. A description of the type of underwriting used, such as medical underwriting or functional assessment underwriting; and
 - iii. For a group policy, whether an enrollee's dependents are subject to underwriting; and
 - h. A description of the effect of the long-term care policy provisions on the required premiums, nonforfeiture values, and reserves on the underlying life insurance policy, both for active lives and those in long-term care status.
- C. An insurer shall notify the Director of a proposed premium rate schedule increase, including an exceptional increase, at least 30 days before issuing notice to its policyholders. The notice to the Director shall include:
1. Information required by R20-6-1008;
 2. Certification by a qualified actuary that:
 - a. If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated;
 - b. The premium rate filing complies with the provisions of this Section;
 3. An actuarial memorandum justifying the rate schedule change request that includes:
 - a. Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase and the method and assumptions used in determining the projected values, including the following:
 - i. Any assumptions that deviate from those used for pricing other forms currently available for sale;
 - ii. Annual values for the five years preceding and the three years following the valuation date, provided separately,
 - iii. Development of the lifetime loss ratio, unless the rate increase is an exceptional increase;
 - iv. A demonstration of compliance with subsection (D); and
 - b. For exceptional increases, the actuarial memorandum shall also include:
 - i. The projected experience that is limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and
 - ii. If the Director determines under subsection (A) that offsets may exist, the insurer shall use appropriate net projected experience;
 - c. Disclosure of how reserves have been incorporated in this rate increase when the rate increase will trigger contingent benefit upon lapse;
 - d. Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and any other actions of the insurer on which the actuary has relied;
 - e. A statement that the actuary has considered policy design, underwriting, and claims adjudication practices; and
 4. A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless the insurer provides the Director with documentation justifying the greater rate; and
 5. Upon the Director's request, other similar and related information the Director may require to evaluate the premium rate schedule increase.
- D. The following requirements apply to all premium rate schedule increases:
1. The insurer shall return 70% of the present value of projected additional premiums from an exceptional increase to policyholders in benefits;
 2. The sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1014 recodified from R4-14-1014 (Supp. 95-1). Section repealed; R20-6-1014 renumbered from R20-6-1011 and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4).

R20-6-1015. Premium Rate Schedule Increase

- A. In this Section, "exceptional increase" means a rate increase that an insurer has filed and that the Director has determined is justified because of changes in laws applicable to long-term care insurance, or increased and unexpected utilization that affects the majority of insurers of similar products. The Director may request independent actuarial review on the issue of whether an increase should be deemed an exceptional increase. The Director may also determine whether there are any potential offsets to higher claims costs.
- B. This Section applies to any individual long-term care policy or certificate issued in this state on or after May 10, 2005.

- inclusion of active life reserves, shall not be less than the sum of the following:
- a. The accumulated value of the initial earned premium times 58%;
 - b. 85% of the accumulated value of prior premium rate schedule increases on an earned basis;
 - c. The present value of future projected initial earned premiums times 58%; and
 - d. 85% of the present value of future projected premiums not in subsection(D)(2)(c) on an earned basis;
3. If a policy form has both exceptional and other increases, the values in subsection (D)(2)(b) and (D)(2)(d) shall also include 70% for exceptional rate increase amounts; and
 4. All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as specified in the NAIC Accounting Practices and Procedures Manual to which insurers are subject under A.R.S. § 20-223. The actuary shall disclose the use of any appropriate averages in the actuarial memorandum required under subsection (B)(3).
- E.** For each rate increase that is implemented, the insurer shall file for approval by the Director updated projections, as defined in subsection (C)(3)(a), annually for the next three years and shall include a comparison of actual results to projected values. The Director may extend the reporting period beyond three years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in subsection (K), the insurer shall provide the projections required by this subsection to the policyholder instead of filing with the Director.
- F.** If any premium rate in the revised premium rate schedule is greater than 200 percent of the comparable rate in the initial premium schedule, the insurer shall file lifetime projections, as defined in subsection (C)(3)(a), for the Director's approval every five years following the end of the required period in subsection (E). For group insurance policies that meet the conditions in subsection (L), the insurer shall provide the projections required by this subsection to the policyholder instead of filing with the Director.
- G.** If the Director finds that the actual experience following a rate increase does not match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in subsection (D), the Director may require the insurer to implement premium rate schedule adjustments or other measures to reduce the difference between the projected and actual experience. In determining whether the actual experience matches the projected experience, the Director shall consider subsection (C)(3)(e), if applicable.
- H.** If the majority of the policies to which the increase applies are eligible for the contingent benefit upon lapse, the insurer shall file:
1. A plan, subject to Director approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form experience requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the Director may impose the condition in subsections (I) through (K); and
 2. The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to subsection (D) had the greater of the original anticipated lifetime loss ratio or 58% has been used in the calculations described in subsection (D)(2)(a) and (D)(2)(c).
- I.** For a rate increase filing that meets the criteria listed in this subsection, the Director shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the 12 months following each increase to determine if lapsation in excess of projected lapsation has occurred or is anticipated:
1. The rate increase is not the first rate increase requested for the specific policy form or forms;
 2. The rate increase is not an exceptional increase; and
 3. The majority of the policies or certificates to which the increase applies are eligible for the contingent benefit upon lapse.
- J.** If the Director finds excess lapsation under subsection (I), the Director may find that a rate spiral exists and may require the insurer to offer, without underwriting, to all in-force insureds subject to the rate increase, the option to replace existing information communicating the offer are subject to the Director's approval. The offer shall:
1. Be based on actuarially sound principles, but not on attained age; and
 2. Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy; and
 3. Allow the insured the option of retaining the existing coverage.
- K.** The insurer shall maintain the experience of the insureds whose coverage was replaced under subsection (J) separate from the experience of insureds originally issued the policy forms. If the insurer requests a rate increase on the policy form, the rate increase shall be limited to the lesser of:
1. The maximum rate increase determined based on the combined experience; and
 2. The maximum rate increase determined based only on the experience of the insureds originally issued the form, plus ten percent.
- L.** If the Director finds that an insurer has exhibited a history or pattern of filing inadequate initial premium rates for long-term care insurance, after considering the total number of policies filed over a period of time and the percentage of policies with inadequate rates, the Director may, in addition to remedies available under subsections (I) through (K), prohibit the insurer from the following:
1. Filing and marketing comparable coverage for a period of up to five years; and
 2. Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.
- M.** Subsections (B) through (L) shall not apply to a policy for which long-term care benefits provided by the policy are incidental, as provided under subsection (A), if the policy complies with all of the following provisions:
1. The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;
 2. The portion of the policy that provides insurance benefits other than long-term care coverage meets the applicable nonforfeiture requirements under state law, including A.R.S. §§ 20-1231, 20-1232 and 20-2636;
 3. The policy meets the disclosure requirements of A.R.S. § 20-1691.06;
 4. The portion of the policy that provides insurance benefits other than long-term care coverage meets the disclosure requirements as applicable in the following:
 - a. Title 20, Chapter 6, Article 1.2; and

- b. Title 20, Chapter 16, Article 2.
- 5. At the time of making a filing under A.R.S. § 20-1691.08, the insurer files an actuarial memorandum that includes:
 - a. Description of the bases on which the actuary determined the long-term care rates and the reserves;
 - b. A summary of the type of policy, benefits, renewability provisions, general marketing method, and limits on ages of issuance;
 - c. A description and a table of each actuarial assumption used, with the percent of premium dollars per policy and dollars per unit of benefits, if any, for expenses;
 - d. A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;
 - e. The estimated average annual premium per policy and the average issue age;
 - f. A statement as to whether the insurer performs underwriting at the time of application with an explanation of the following:
 - i. Whether underwriting is used, and, if used, a description of the type of underwriting, such as medical underwriting or functional assessment underwriting; and
 - ii. For a group policy, whether the enrollee or any dependent will be underwritten and when underwriting occurs; and
 - g. A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values, and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1015 recodified from R4-14-1015 (Supp. 95-1). Section R20-6-1015 renumbered to R20-6-1022; new Section R20-6-1015 made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4).

R20-6-1016. Filing Requirements for Group Policies

- A. Out-of-State Policies. Before an insurer or similar organization may offer group long-term care insurance to a resident of this state under A.R.S. § 20-1691.02(D), the insurer or organization shall file with the Director evidence that a state with statutory or regulatory long-term care insurance requirements substantially similar to those of this state has approved the group policy or certificate for use in that state.
- B. Associations. For long-term policies marketed or issued to associations, the insurer or organization shall file with the insurance department the policy, certificate, and corresponding outline of coverage.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1016 recodified from R4-14-1016 (Supp. 95-1). Section R20-6-1016 renumbered to R20-6-1023; new Section R20-6-1016 renumbered from R20-6-1012 and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4).

R20-6-1017. Standards for Marketing

- A. Every insurer marketing long-term care insurance coverage in this state, directly or through an insurance producer shall:
 - 1. Establish marketing procedures to assure that any comparison of policies by its insurance producers is fair and accurate, and that excessive insurance is not sold or issued.

- 2. Display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy, the following language: "Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."
- 3. Provide the applicant with copies of the disclosure forms in Appendices A and B.
- 4. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has health or long-term care insurance and the types and amounts of any such insurance.
- 5. Provide an explanation of contingent benefit upon lapse as provided for in R20-6-1019(E).
- 6. Provide written notice to an applicant or prospective policyholder or certificateholder advising of this state's senior insurance counseling program (SHIP), and the name, address, and phone number for the SHIP, at the time of solicitation.
- 7. Establish auditable procedures for verifying compliance with this Section (A).

- B. In addition to the practices prohibited in A.R.S. § 20-441 et seq., the following acts and practices are prohibited:

- 1. Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.
- 2. High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.
- 3. Cold lead advertising. Making use directly or indirectly or any method of marketing that fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance producer or insurance company.
- 4. Misrepresentation. Misrepresenting a fact in selling or offering to sell a long-term care insurance policy.

- C. An insurer shall not market or issue a long-term care policy or certificate to an association unless the insurer files the information required under R20-6-1016(B) and annually certifies that the association has complied with the requirements of this Section.

Historical Note

New section R20-5-1017 renumbered from R20-6-1013 and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4).

R20-6-1018. Suitability

- A. This Section does not apply to life insurance policies that accelerate benefits for long-term care.
- B. Every insurer or other person marketing long-term care insurance, including an insurance producer or managing general agent, (the "issuer") shall:
 - 1. Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;
 - 2. Train its insurance producers in the use of its suitability standards; and

3. Maintain a copy of its suitability standards and make them available for inspection upon the Director's request.
- C. To determine whether an applicant meets an issuer's suitability standards, the insurance producer and issuer shall develop procedures that take the following into consideration:
 1. The applicant's ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;
 2. The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and
 3. The values, benefits, and costs of the applicant's existing insurance, if any, when compared to the values, benefits, and costs of the recommended purchase or replacement.
- D. The issuer shall make reasonable efforts to obtain the information set out in subsection (C)(1), including giving the applicant the "Long-Term Care Insurance Personal Worksheet" prescribed in Appendix A, to complete before or at the time of application. The issuer shall use a personal worksheet that contains, at a minimum, the information contained in Appendix A, in substantially the same text and format, in not less than 12 point type. The issuer may ask the applicant to provide additional information to comply with its suitability standards. An issuer shall file a copy of its personal worksheet with the Director.
- E. An issuer shall not consider an applicant for coverage until the issuer has received the applicant's completed personal worksheet, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses.
- F. No one shall sell or disseminate information obtained through the personal worksheet outside the issuer that obtains the worksheet.
- G. The issuer shall use its suitability standards to determine whether issuance of long-term care insurance coverage to a particular applicant is appropriate.
- H. An insurance producer shall use the suitability standards developed by the issuer in marketing long-term care insurance.
- I. When giving an applicant a personal worksheet, the issuer shall also provide the applicant with a disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance." The form shall be in substantially the same format and text contained in Appendix H, in not less than 12 point type.
- J. If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. In the alternative, the issuer shall send the applicant a letter that is substantially similar to Appendix I. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent to purchase the long-term care policy. The issuer shall have either the applicant's returned Appendix I letter or a record of the alternative method of verification as part of the applicant's file.
- K. The issuer shall report annually to the Director the total number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of those who chose to confirm after receiving a suitability letter as prescribed in subsection (J).

Historical Note

New Section made by final rulemaking at 10 A.A.R.
4661, effective January 3, 2005 (Supp. 04-4).

R20-6-1019. Nonforfeiture Benefit Requirement

- A. This Section does not apply to life insurance policies or riders containing accelerated long-term care benefits.
- B. To comply with the requirement to offer a nonforfeiture benefit pursuant to the provisions of A.R.S. § 20-1691.11, an insurer shall meet the following requirements:
 1. A policy or certificate offered with nonforfeiture benefits shall have the same coverage elements, eligibility, benefit triggers and benefit length as a policy or certificate issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefit described in subsection (I).
 2. The offer shall be in writing if the nonforfeiture benefit is not otherwise described in the Outline of Coverage or other materials given to the prospective policyholder.
- C. If the offer required to be made under A.R.S. § 20-1691.11 is rejected, the insurer shall provide the contingent benefit upon lapse described in this Section.
- D. If a prospective policyholder rejects the offer of a nonforfeiture benefit, the insurer shall provide the contingent benefit upon lapse described in this Section for individual and group policies without the nonforfeiture benefit, issued after January 10, 2005.
- E. If a group policyholder elects to make the nonforfeiture benefit an option to a certificateholder, the certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.
- F. The contingent benefit on lapse is triggered when:
 1. An insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth in the chart below, based on the insured's issue age; and
 2. The policy or certificate lapses within 120 days of the due date of the increased premium.

Triggers for a Substantial Premium Increase		
Issue Age		Percent Increase Over Initial Premium
29 and under		200%
30-34		190%
35-39		170%
40-44		150%
45-49		130%
50-54		110%
55-59		90%
60		70%
61		66%
62		62%
63		58%
64		54%
65		50%
66		48%
67		46%
68		44%
69		42%
70		40%
71		38%
72		36%

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73		34%
74		32%
75		30%
76		28%
77		26%
78		24%
79		22%
80		20%
81		19%
82		18%
83		17%
84		16%
85		15%
86		14%
87		13%
88		12%
89		11%
90 and over		10%

G. Unless otherwise required, an insurer shall notify policyholders at least 30 days before the due date of the premium reflecting the rate increase.

H. On or before the effective date of a substantial premium increase as defined in subsection (F), an insurer shall:

1. Offer the insured the option of reducing policy benefits under the current coverage without additional underwriting so that required premium payments are not increased;
2. Offer to convert the coverage to a paid-up status with a shortened benefit period according to the terms of subsection (I), which the insured may elect at any time during the 120-day period referenced in subsection (F)(2); and
3. Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in subsection (F)(2) is deemed to be the election of the offer to convert under subsection (H)(2).

I. In this Section, "benefits continued as nonforfeiture benefits," including contingent benefits upon lapse, mean any of the following:

1. Attained age rating is defined as a schedule of premiums starting from the issue date that increases age at least one percent per year before age 50, and at least three percent per year beyond age 50.
2. The nonforfeiture benefit shall be of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in subsection (I)(3).
3. The standard nonforfeiture credit equals 100% of the sum of all premiums paid, including the premiums paid before any change in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. The minimum nonforfeiture credit shall not be less than 30 times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of subsection (J).
4. The nonforfeiture benefit shall begin not later than the end of the third year following the policy or certificate

issue date. The contingent benefit upon lapse shall be effective during the first three years, and thereafter.

5. Notwithstanding subsection (I)(4), for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:

- a. The end of the tenth year following the policy or certificate issue date; or
- b. The end of the second year following the date the policy or certificate is no longer subject to attained age rating.

6. Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

J. All benefits paid by the insurer while the policy or certificate is in premium-paying status and in the paid-up status shall not exceed the maximum benefits that would be payable if the policy or certificate had remained in premium-paying status.

K. There shall be no difference in the minimum nonforfeiture benefits for group and individual policies.

L. The requirements in this Section are effective on or after November 10, 2005 and shall apply as follows:

1. Except as provided in subsection (L)(2), this Section applies to any long-term care policy issued in this state on or after January 10, 2005.
2. The provisions of this Section do not apply to certificates issued on or after January 10, 2005, under a group long-term care insurance policy as defined in A.R.S. § 20-1691(5)(a), that was in force on January 10, 2005.

M. Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse shall be subject to the loss ratio requirements of R20-6-1014, treating the policy as a whole.

N. To determine whether contingent nonforfeiture upon lapse provisions are triggered under subsection (F), a replacing insurer that purchased or otherwise assumed a block of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium the insured paid when first buying the policy from the original insurer.

O. An insurer shall offer a nonforfeiture benefit for a qualified long-term care insurance contract that is a level premium contract and the benefit shall meet the following requirements:

1. The nonforfeiture provision shall be separately captioned using the term "nonforfeiture benefit" or a substantially similar caption.
2. The nonforfeiture provision shall provide a benefit available in the event of a default in the payment of any premiums and shall state that the insurer may adjust the amount of the benefit initially granted only as needed to reflect changes in claims, persistency, and interest as reflected in changes in rates for premium paying contracts approved by the Director under to A.R.S. § 20-1691.08 for the same contract form; and
3. The nonforfeiture provision shall provide at least one of the following:
 - a. Reduced paid-up premiums,
 - b. Extended term insurance,
 - c. Shortened benefit period; or
 - d. Other similar offerings that the Director has approved.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4).

R20-6-1020. Standards for Benefit Triggers

- A.** A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Except as otherwise provided in R20-6-1021, eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three of the activities of daily living or the presence of cognitive impairment.
- B.** Activities of daily living shall include at least the following as defined in R20-6-1003 and in the policy:
 1. Bathing;
 2. Continence;
 3. Dressing;
 4. Eating;
 5. Toileting; and
 6. Transferring;
- C.** An insurer may use additional activities of daily living to trigger covered benefits if the activities are defined in the policy.
- D.** An insurer may use additional provisions to determine when benefits are payable under a policy or certificate; however the provisions shall not restrict, and are not in lieu of, the requirements in subsections (A) and (B).
- E.** For purposes of this Section the determination of a deficiency shall not be more restrictive than:
 1. Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or
 2. If the deficiency is due to the presence of a cognitive impairment, requiring supervision or verbal cueing by another person to protect the insured or others.
- F.** Licensed or certified professionals, such as physicians, nurses or social workers, shall perform assessments of activities of daily living and cognitive impairment.
- G.** The requirements in this Section are effective on and after November 10, 2005 and shall apply as follows:
 1. Except as provided in subsection (G)(2), the provisions of this Section apply to a long-term care policy issued in this state on or after January 10, 2005.
 2. The provisions of this Section do not apply to certificates issued on or after January 10, 2005, under a long-term care insurance policy issued to a group as defined in A.R.S. § 20-1691(5)(a), which policy was in force on January 10, 2005.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4).

R20-6-1021. Additional Standards for Benefit Triggers for Qualified Long-term Care Insurance Contracts

- A.** A qualified long-term care insurance contract shall pay only for qualified long-term care services received by a chronically ill individual provided under a plan of care prescribed by a licensed health care practitioner.
- B.** A qualified long-term care insurance contract shall condition the payment of benefits on a certified determination of the insured's inability to perform activities of daily living for an expected period of at least 90 days due to a loss of functional capacity or to severe cognitive impairment.
- C.** Licensed or certified professionals, including physicians, registered professional nurses, and licensed social workers, shall perform the certified determinations regarding activities of

daily living and cognitive impairment required under subsection (B).

- D.** Certified determinations required under to subsection (B) may be performed at the direction of the carrier as is reasonably necessary with respect to a specific claim, except that when a licensed health care practitioner has certified that an insured is unable to perform activities of daily living for an expected period of at least 90 days due to a loss of functional capacity and the insured is in claim status, the certified determination may not be rescinded and additional certified determinations may not be performed until after the expiration of the 90-day period.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4).

R20-6-1022. Standard Format Outline of Coverage

- A.** The outline of coverage prescribed in A.R.S. § 20-1691.06 shall be a free-standing document, using no smaller than 10 point type, and shall contain no advertising or promotional material.
- B.** Text that is capitalized or underscored in the standard format outline of coverage may be emphasized by other means that give prominence equivalent to capitalization or underscoring.
- C.** An insurer shall use the text and sequence of text in the standard format outline of coverage prescribed in Appendix J, unless otherwise specifically indicated.

Historical Note

New Section R20-6-1022 renumbered from R20-6-1015 and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4).

R20-6-1023. Requirement to Deliver Shopper's Guide

- A.** All prospective applicants of a long-term care insurance policy or certificate shall receive a long-term care shopper's guide approved by the Director. This requirement may be satisfied by delivery of the current edition of the long-term care shopper's guide in the format developed by the National Association of Insurance Commissioners.
 1. In the case of insurance producer solicitation, an insurance producer shall deliver the shopper's guide before presenting an application or enrollment form.
 2. In the case of direct response solicitations, the insurer shall provide the shopper's guide with any application or enrollment form.
- B.** A prospective applicant for a life insurance policy or rider containing accelerated long-term care benefits is not required to receive the guide described in subsection A, but shall receive the policy summary required under A.R.S. § 20-1691.06.

Historical Note

New Section R20-6-1023 renumbered from R20-6-1016 and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4).

R20-6-1024. Instructions for Appendices

Information that is designated as a "Drafting Instruction" in a form appended to this Article is not required to be included as part of the form. Any person using the form shall abide by the instructions when drafting, preparing, or completing the form.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4).

Department of Insurance

APPENDIX A
Long-term Care Insurance
Personal Worksheet

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and ask you to fill out the rest to help you and the company decide if you should buy this policy.

Premium Information

Policy Form Numbers _____

The premium for the coverage you are considering will be [\$_____ per month, or \$_____ per year,] [a one-time single premium of \$_____.]

Type of Policy (noncancellable/guaranteed renewable): _____

The Company's Right to Increase Premiums: _____

[The company cannot raise your rates on this policy.] [The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.] [Insurers shall use appropriate bracketed statement. Rate guarantees shall not be shown on this form.]

Rate Increase History

The company has sold long-term care insurance since [year] and has sold this policy since [year]. [The company has never raised its rates for any long-term care policy it has sold in this state or any other state.] [The company has not raised its rates for this policy form or similar policy forms in this state or any other state in the last 10 years.] [The company has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increases.]

(Drafting Instruction: A company may use the first bracketed sentence above only if it has never increased rates under any prior policy forms in this state or any other state. The issuer shall list each premium increase it has instituted on this or similar policy forms in this state or any other state during the last 10 years. The list shall provide the policy form, the calendar years the form was available for sale, and the calendar year and the amount (percentage) of each increase. The insurer shall provide minimum and maximum percentages if the rate increase is variable by rating characteristics. The insurer may provide, in a fair manner, additional explanatory information as appropriate.)

Questions Related to Your Income

How will you pay each year's premium?

☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

☐ Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?

(Drafting Instruction: The issuer is not required to use the bracketed sentence if the policy is fully paid up or is a noncancellable policy.)

What is your annual income? (check one) ☐ Under \$10,000 ☐ \$[10-20,000] ☐ \$[20-30,000] ☐ \$[30-50,000] ☐ Over \$50,000

(Drafting Instruction: The issuer may choose the numbers to put in the brackets to fit its suitability standards.)

How do you expect your income to change over the next 10 years? (check one)

☐ No change ☐ Increase ☐ Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection? (check one) ☐ Yes ☐ No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?

☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

The national average annual cost of care in [insert year] was [insert \$ amount], but this figure varies across the country. In ten years the national average annual cost would be about [insert \$ amount] if costs increase 5% annually.

(Drafting Instruction: The projected cost can be based on federal estimates in a current year. In the above statement, the second figure equals 163% of the first figure.)

What elimination period are you considering? Number of days _____ Approximate cost \$_____ for that period of care.

How are you planning to pay for your care during the elimination period? (check one)

☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)

☐ Under \$20,000 ☐ \$20,000-\$30,000 ☐ \$30,000-\$50,000 ☐ Over \$50,000

How do you expect your assets to change over the next ten years? (check one)

☐ Stay about the same ☐ Increase ☐ Decrease

If you are buying this policy to protect your assets and your assets are less than \$30,000, you may wish to consider other options for financing your long-term care.

Disclosure Statement

☐ The answers to the questions above describe my financial situation.

or

☐ I choose not to complete this information.
(Check one.)

☐ I acknowledge that the carrier and/or its agent (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. [For direct mail situations, use the following: I acknowledge that I have reviewed this form including the premium, premium rate increase history and potential for premium increases in the future.] **I understand the above disclosures. I understand that the rates for this policy may increase in the future.** (This box must be checked).

Signed: _____
(Applicant)

(Date)

☐ I explained to the applicant the importance of completing this information.

Signed: _____
(Insurance Producer)

(Date)

Insurance Producer's Printed Name: _____]

[In order for us to process your application, please return this signed statement to [name of company], along with your application.]

[My agent has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.]

Signed: _____
(Applicant)

(Date)

(Drafting Instruction: Choose the appropriate sentences depending on whether this is a direct mail or insurance producer sale.)

The company may contact you to verify your answers.

(Drafting Instruction: When the Long-term Care Insurance Personal Worksheet is furnished to employees and their spouses under employer group policies, the text from the heading "Disclosure Statement" to the end of the page may be removed.)

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). Former Appendix A renumbered to Appendix C; new Appendix A made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4).

Department of Insurance

APPENDIX B
Long-term Care Insurance
Potential Rate Increase Disclosure Form

Instructions:

This form provides information to the applicant regarding premium rate schedules, rate schedule adjustments, potential rate revisions, and policyholder options in the event of a rate increase.

Insurers shall provide all of the following information to the applicant:

Long-term Care Insurance
Potential Rate Increase Disclosure Form

1. **[Premium Rate] [Premium Rate Schedules]:** [Premium rate] [Premium rate schedules] that [is][are] applicable to you and that will be in effect until a request is made and [approved] for an increase [is][are] [on the application][(\$_____)]
2. **The [premium] [premium rate schedule] for this policy [will be shown on the schedule page of] [will be attached to] your policy.**
3. **Rate Schedule Adjustments:**
The company will provide a description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.) (fill in the blank): _____.
4. **Potential Rate Revisions:**
This policy is Guaranteed Renewable. This means that the rates for this product may be increased in the future. Your rates can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:

- Pay the increased premium and continue your policy in force as is.
- Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
- Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)
- Exercise your contingent nonforfeiture rights.* (This option may be available if you do not purchase a separate nonforfeiture option.)

Contingent Nonforfeiture

If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

You will keep some long-term care insurance coverage, if:

- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and
- You lapse (not pay more premiums) within 120 days of the increase.

Turn the Page

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you have paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

Example:

- You bought the policy at age 65 and paid the \$1,000 annual premium for 10 years, so you have paid a total of \$10,000 in premium.
- In the eleventh year, you receive a rate increase of 50%, or \$500 for a new annual premium of \$1,500, and you decide to lapse the policy (not pay any more premiums).
- Your "paid-up" policy benefits are \$10,000 (provided you have at least \$10,000 of benefits remaining under your policy.)

Turn the Page

Contingent Nonforfeiture Cumulative Premium Increase over Initial Premium That qualifies for Contingent Nonforfeiture (Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)	
Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). Former Appendix B renumbered to Appendix D; new Appendix B made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4).

APPENDIX C

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL HEALTH OR LONG-TERM CARE INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing health or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by [company name] Insurance Company. Your new policy provides [thirty (30)] days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all health or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY [INSURANCE PRODUCER OR OTHER REPRESENTATIVE]:

Use additional sheets, as necessary.)

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations which I call to your attention:

1. Health conditions that you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, even though a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probation periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its insurance producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

(Signature of Insurance Producer or Other Representative)_____
(Company Name)

(Typed Name and Address of Insurance Producer)

The above "Notice to Applicant" was delivered to me on:

(Date)_____
(Applicant's Signature)**Historical Note**

Adopted effective August 10, 1992 (Supp. 92-3). New Appendix C renumbered from Appendix A and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4).

APPENDIX D
NOTICE TO APPLICANT REGARDING REPLACEMENT OF HEALTH OR LONG-TERM CARE INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing health or long-term care insurance and replace it with the long-term care insurance policy being delivered and issued by [company name] Insurance Company. Your new policy gives you thirty (30) days to decide, without cost, whether you want to keep the policy. For your own information and protection, you should be aware of and seriously consider certain facts which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all health coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, even though a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [company name and address] within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

[COMPANY NAME]

Historical Note

New Appendix D renumbered from Appendix B and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005
(Supp. 04-4).

Department of Insurance

APPENDIX E
Long-term Care Insurance
Replacement and Lapse Reporting Form

For the State of _____

For the Reporting Year of _____

Company Name: _____ Due: June 30 annually
 Company Address: _____ Company NAIC Number: _____
 Contact Person: _____ Phone Number: (____) _____

Instructions

The purpose of this form is to report on a statewide basis information regarding long-term care insurance policy replacements and lapses. Every insurer shall maintain the following records for each insurance producer: (1) amount of long-term care insurance replacement sales as a percent of the insurance producer's total annual sales and (2) the amount of lapses of long-term care insurance policies sold by the insurance producer as a percent of the insurance producer's total annual sales. The tables below should be used to report the ten percent (10%) of the insurer's insurance producers with the greatest percentages of replacements and lapses.

Listing of the 10% of Insurance Producers with the Greatest Percentage of Replacements

Insurance Producer's Name	Number of Policies Sold By This Insurance Producer	Number of Policies Replaced By This Insurance Producer	Number of Replacements as % of Number of Policies Sold By This Insurance Producer

Listing of the 10% of Insurance Producers with the Greatest Percentage of Lapses

Insurance Producer's Name	Number of Policies Sold By This Insurance Producer	Number of Policies Lapsed By This Insurance Producer	Number of Lapses As % of Number Sold By This Insurance Producer

Company Totals

Percentage of Replacement Policies Sold to Total Annual Sales ____%

Percentage of Replacement Policies Sold to Policies In Force (as of the end of the preceding calendar year) ____%

Percentage of Lapsed Policies to Total Annual Sales ____%

Percentage of Lapsed Policies to Policies In Force (as of the end of the preceding calendar year) ____%

Historical Note

New Appendix E made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4).

APPENDIX F
Long-term Care Insurance
Claims Denial Reporting Form

For the State of _____

For the Reporting Year of _____

Company Name: _____ Due: June 30 annually

Company Address: _____

Company NAIC Number: _____

Contact Person: _____ Phone Number: _____

Line of Business: Individual Group

Instructions

The purpose of this form is to report all long-term care claim denials under in-force long-term care insurance policies. "Denied" means a claim that is not paid for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition.

		State Data	Nationwide Data ¹
1	Total Number of Long-Term Care Claims Reported		
2	Total Number of Long-Term Care Claims Denied/Not Paid		
3	Number of Claims Not Paid due to Preexisting Condition Exclusion		
4	Number of Claims Not Paid due to Waiting (Elimination) Period Not Met		
5	Net Number of Long-Term Care Claims Denied for Reporting Purposes (Line 2 Minus Line 3 Minus Line 4)		
6	Percentage of Long-Term Care Claims Denied of Those Reported (Line 5 Divided By Line 1)		
7	Number of Long-Term Care Claim Denied due to:		
8	• Long-Term Care Services Not Covered under the Policy ²		
9	• Provider/Facility Not Qualified under the Policy ³		
10	• Benefit Eligibility Criteria Not Met ⁴		
11	• Other		

1. The nationwide data may be viewed as a more representative and credible indicator where the data for claims reported and denied for your state are small in number.
2. Example—home health care claim filed under a nursing home only policy.
3. Example—a facility that does not meet the minimum level of care requirements or the licensing requirements as outlined in the policy.
4. Examples—a benefit trigger not met, certification by a licensed health care practitioner not provided, no plan of care.

Historical Note

New Appendix F made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4).

Department of Insurance

**APPENDIX G
RESCISSION REPORTING FORM FOR
LONG-TERM CARE POLICIES**

FOR THE STATE OF _____

FOR THE REPORTING YEAR _____

Company Name _____

Address: _____

Phone Number: _____

Due: March 1 annually

Instructions:

The purpose of this form is to report all rescissions of long-term care insurance policies or certificates. Those rescissions voluntarily effected by an insured are not required to be included in this report. Please furnish one form per rescission.

Policy Form #	Policy and Certificate #	Name of Insured	Date of Policy Issuance	Date/s Claim/s Submitted	Date of Rescission

Detailed reason for rescission:

Signature _____

Name and Title (please type) _____

Date _____

Historical Note

New Appendix G made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4).

APPENDIX H
Things You Should Know Before You Buy
Long-term Care Insurance

**Long-Term
Care
Insurance**

- A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.

- [You should **not** buy this insurance policy unless you can afford to pay the premiums every year.] [Remember that the company can increase premiums in the future.]

(Drafting Instruction: For single premium policies, delete this bullet; for noncancellable policies, delete the second sentence only.)

- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

Medicare

- Medicare does **not** pay for most long-term care.

Medicaid

- Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should not buy this policy if you are now eligible for Medicaid.

- Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.

- When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.

- Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

**Shopper's
Guide**

- Make sure the insurance company or agent gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling

- Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

Historical Note

New Appendix H made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4).

Department of Insurance

APPENDIX I
Long-term Care Insurance Suitability Letter

Dear [Applicant]:

Your recent application for long-term care insurance included a “personal worksheet,” which asked questions about your finances and your reasons for buying long-term care insurance. For your protection, state law requires us to consider this information when we review your application, to avoid selling a policy to those who may not need coverage.

[Your answers indicate that long-term care insurance may not meet your financial needs. We suggest that you review the information provided along with your application, including the booklet “Shopper’s Guide to Long-Term Care Insurance” and the page titled “Things You Should Know Before Buying Long-Term Care Insurance.” Your state insurance department also has information about long-term care insurance and may be able to refer you to a counselor free of charge who can help you decide whether to buy this policy.]

[You chose not to provide any financial information for us to review.]

(Drafting Instruction: Choose the paragraph that applies.)

We have suspended our final review of your application. If, after careful consideration, you still believe this policy is what you want, check the appropriate box below and return this letter to us within the next 60 days. We will then continue reviewing your application and issue a policy if you meet our medical standards.

If we do not hear from you within the next 60 days, we will close your file and not issue you a policy. You should understand that you will not have any coverage until we hear back from you, approve your application and issue you a policy.

Please check one box and return in the enclosed envelope.

☐ Yes, [although my worksheet indicates that long-term care insurance may not be a suitable purchase,] I wish to purchase this coverage. Please resume review of my application.

Drafting Instruction: Delete the phrase in brackets if the applicant did not answer the questions about income.

☐ **No.** I have decided not to buy a policy at this time.

APPLICANT’S SIGNATURE

DATE

Please return to [issuer] at [address] by [date].

Historical Note

New Appendix I made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4).

APPENDIX J

[COMPANY NAME]

[ADDRESS - CITY & STATE]

[TELEPHONE NUMBER]

LONG-TERM CARE INSURANCE

OUTLINE OF COVERAGE

[Policy Number or Group Master Policy and Certificate Number]

[Except for policies or certificates which are guaranteed issue, the following caution statement, or language substantially similar, shall appear as follows in the outline of coverage.]

Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

1. This policy is [an individual policy of insurance] [a group policy] which was issued in the [indicate jurisdiction in which group policy was issued].
2. **PURPOSE OF OUTLINE OF COVERAGE.** This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!**
3. **FEDERAL TAX CONSEQUENCES**

This [POLICY] [CERTIFICATE] is intended to be a federally tax-qualified long-term care insurance contract under Section 7702(B)(b) of the Internal Revenue Code of 1986, as amended.

or

Federal Tax Implications of this [POLICY] [CERTIFICATE]. This [POLICY] [CERTIFICATE] is not intended to be a federally tax-qualified long-term care insurance contract under Section 7702(B)(b) of the Internal Revenue Code of 1986, as amended. Benefits received under the [POLICY] [CERTIFICATE] may be taxable as income.

4. **TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED**

- (a) [For long-term care health insurance policies or certificates describe one of the following permissible policy renewability provisions:

- (1) Policies and certificates that are guaranteed renewable shall contain the following statement:] **RENEWABILITY: THIS POLICY [CERTIFICATE] IS GUARANTEED RENEWABLE.** This means you have the right, subject to the terms of your policy, [certificate] to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own, except that, in the future, **IT MAY INCREASE THE PREMIUM YOU PAY.**
- (2) [Policies and certificates that are noncancellable shall contain the following statement:] **RENEWABILITY: THIS POLICY [CERTIFICATE] IS NONCANCELLABLE.** This means that you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own and cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits, [Company Name] may increase your premium at that time for those additional benefits.

- (b) [For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy;]

- (c) [Describe waiver of premium provisions or state that there are not such provisions;]

5. **TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS**

[In bold type larger than the maximum type required to be used for the other provisions of the outline of coverage, state whether or not the company has a right to change the premium, and if a right exists, describe clearly and concisely each circumstance under which the premium may change.]

6. **TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.**

- (a) [Provide a brief description of the right to return - "free look" provision of the policy.]

- (b) [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]

7. **THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.** If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.

- (a) [For insurance producers] Neither [insert company name] nor its [agents or insurance producers] represent Medicare, the federal government or any state government.

- (b) [For direct response] [insert company name] is not representing Medicare, the federal government or any state government.

8. **LONG-TERM CARE COVERAGE.** Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute-care unit of a hospital, such as in a nursing home, in the community or in the home.

This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

9. **BENEFITS PROVIDED BY THIS POLICY**

- (a) [Covered services, related deductible(s), waiting periods, elimination periods and benefit maximums.]

- (b) [Institutional benefits, by skill level.]

(c) [Non-institutional benefits, by skill level.]

(d) Eligibility for Payment of Benefits

[Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and shall be defined and described as part of the outline of coverage.]

[Any additional benefit triggers shall be explained in this Section. If these triggers differ for different benefits, explanation of the triggers shall accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified.]

10. LIMITATIONS AND EXCLUSIONS.

[Describe:

(a) Preexisting conditions;

(b) Non-eligible facilities and providers;

(c) Non-eligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);

(d) Exclusions and exceptions;

(e) Limitations.]

[This Section shall provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in paragraph 6 above.]

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

11. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:

(a) That the benefit level will not increase over time;

(b) Any automatic benefit adjustment provisions;

(c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;

(d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations;

(e) Describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

12. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.

[State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.]

13. PREMIUM.

[(a) State the total annual premium for the policy;

(b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.]

14. ADDITIONAL FEATURES.

[(a) Indicate if medical underwriting is used;

(b) Describe other important features.]

15. CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE.

Historical Note

New Appendix J renumbered from Appendix C and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4).

ARTICLE 11. MEDICARE SUPPLEMENT INSURANCE

R20-6-1101. Incorporation by Reference and Modifications

A. The Department incorporates by reference the Model Regulation to Implement the National Association of Insurance Commissioners (NAIC) Medicare Supplement Insurance Minimum Standards Model Act, October 2008 (Model Regulation), and no future editions or amendments, which is on file with the Department of Insurance, 2910 N. 44th St., Phoenix, AZ 85018 and available from the National Association of Insurance Commissioners, Publications Department, 2301 McGee St., Suite 800, Kansas City, MO 64108.

B. The Model Regulation is modified as follows:

1. In addition to the terms defined in the Model Regulation, the following definitions apply:

a. "Agent" means an insurance producer as defined in A.R.S. § 20-281(5).

b. "Commissioner" means the Director of the Arizona Department of Insurance.

c. "HMO" and "health maintenance organization" mean a health care services organization as defined in A.R.S. § 20-1051(7).

d. "Regulation" means Article.

2. Section 8A(7)(c) reads:

c. Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862(b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within 90 days after the date of the loss of the group health plan and pays the premium attributable to the supplemental policy period, effective as of the date of termination of enrollment in the group health plan.

3. Section 8.1 is revised to insert the citation to A.R.S. § 20-1133 as follows:

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for

delivery in this state on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards. No issuer may offer any [1990 Standardized Medicare supplement benefit plan] for sale on or after June 1, 2010. Benefit standards applicable to Medicare supplement policies and certificates issued before June 1, 2010 remain subject to the requirements of A.R.S. § 20-1133.

4. Section 8.1(A)(7)(c) is revised to read as follows:
Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan (as defined in Section 186(b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within 90 days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.
5. Section 9.1 is revised to insert the citation to A.R.S. § 20-1133 as follows:
The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit plan standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued before June 1, 2010 remain subject to the requirements of A.R.S. § 20-1133.
6. Subsection G of Section 15 is revised as follows:
G. An insurer shall not file or request approval of a rate structure for its Medicare supplement policies or certificates based upon attained-age rating as a structure or methodology.
7. Tables for PLAN F or HIGH DEDUCTIBLE PLAN F are revised as follows:
 - a. For the table entitled "PARTS A & B" a column heading is revised from "AFTER YOU PAY \$[2000] DEDUCTIBLE,** PLAN PAYS" to "[AFTER YOU PAY \$[2000] DEDUCTIBLE,**] PLAN PAYS."
 - b. For the table entitled "PARTS A & B" a column heading is revised from "IN ADDITION TO \$[2000] DEDUCTIBLE,** YOU PAY" to "[IN ADDITION TO \$[2000] DEDUCTIBLE,**] YOU PAY."
 - c. For the table entitled "OTHER BENEFITS - NOT COVERED BY MEDICARE" a column heading is revised from "AFTER YOU PAY \$[2000] DEDUCTIBLE,** PLAN PAYS" to "[AFTER YOU PAY \$[2000] DEDUCTIBLE,**] PLAN PAYS."
 - d. For the table entitled "OTHER BENEFITS - NOT COVERED BY MEDICARE" a column heading is revised from "IN ADDITION TO \$[2000] DEDUCTIBLE,** YOU PAY" to "[IN ADDITION TO \$[2000] DEDUCTIBLE,**] YOU PAY."
8. Section 23 is revised as follows:

- A. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate to the extent such time was spent under the original policy.
- B. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods.

Historical Note

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1101 recodified from R4-14-1101 (Supp. 95-1). Amended effective August 16, 1996 (Supp. 96-3). Amended by final rulemaking at 8 A.A.R. 2454, effective May 13, 2002 (Supp. 02-2). Section repealed; new Section made by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3). Amended by final rulemaking at 15 A.A.R. 996, effective June 2, 2009 (Supp. 09-2).

R20-6-1102. Repealed

Historical Note

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted with changes effective May 28, 1992 (Supp. 92-2). R20-6-1102 recodified from R4-14-1102 (Supp. 95-1). Amended effective August 16, 1996 (Supp. 96-3). Amended by final rulemaking at 5 A.A.R. 618, effective February 4, 1999 (Supp. 99-1). Amended by final rulemaking at 5 A.A.R. 910, effective March 3, 1999 (Supp. 99-1). Amended by final rulemaking at 8 A.A.R. 2454, effective May 13, 2002 (Supp. 02-2). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1102.01 Repealed

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 618, effective February 4, 1999 (Supp. 99-1). Amended by final rulemaking at 5 A.A.R. 910, effective March 3, 1999 (Supp. 99-1). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1103. Repealed

Historical Note

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1103 recodified from R4-14-1103 (Supp. 95-1). Amended by final rulemaking at 8

A.A.R. 2454, effective May 13, 2002 (Supp. 02-2). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1104. Repealed**Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1104 recodified from R4-14-1104 (Supp. 95-1). Amended effective August 16, 1996 (Supp. 96-3). Amended by final rulemaking at 8 A.A.R. 2454, effective May 13, 2002 (Supp. 02-2). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1105. Repealed**Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1105 recodified from R4-14-1105 (Supp. 95-1). Amended effective August 16, 1996 (Supp. 96-3). Amended effective June 15, 1998 (Supp. 98-2). Amended by final rulemaking at 8 A.A.R. 2454, effective May 13, 2002 (Supp. 02-2). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1106. Repealed**Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1106 recodified from R4-14-1106 (Supp. 95-1). Amended effective June 15, 1998 (Supp. 98-2). Amended by final rulemaking at 5 A.A.R. 910 effective March 3, 1999 (Supp. 99-1). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1107. Repealed**Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted with changes effective May 28, 1992 (Supp. 92-2). R20-6-1107 recodified from R4-14-1107 (Supp. 95-1). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1108. Repealed**Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28,

1992 (Supp. 92-2). R20-6-1108 recodified from R4-14-1108 (Supp. 95-1). Amended effective August 16, 1996 (Supp. 96-3). Amended by final rulemaking at 5 A.A.R. 910 effective March 3, 1999 (Supp. 99-1). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1109. Repealed**Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1109 recodified from R4-14-1109 (Supp. 95-1). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1110. Repealed**Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1110 recodified from R4-14-1110 (Supp. 95-1). Amended effective August 16, 1996 (Supp. 96-3). Amended effective June 15, 1998 (Supp. 98-2). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1111. Repealed**Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1111 recodified from R4-14-1111 (Supp. 95-1). Amended by final rulemaking at 8 A.A.R. 2454, effective May 13, 2002 (Supp. 02-2). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1112. Repealed**Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1112 recodified from R4-14-1112 (Supp. 95-1). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1113. Repealed**Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1113 recodified from R4-14-

1113 (Supp. 95-1). Amended effective August 16, 1996 (Supp. 96-3). Amended effective June 15, 1998 (Supp. 98-2). Amended by final rulemaking at 5 A.A.R. 910 effective March 3, 1999 (Supp. 99-1). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1114. Repealed**Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1114 recodified from R4-14-1114 (Supp. 95-1). Amended effective August 16, 1996 (Supp. 96-3). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1115. Repealed**Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1115 recodified from R4-14-1115 (Supp. 95-1). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1116. Repealed**Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1116 recodified from R4-14-1116 (Supp. 95-1). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1117. Repealed**Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1117 recodified from R4-14-1117 (Supp. 95-1). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1118. Repealed**Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1118 recodified from R4-14-1118 (Supp. 95-1). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1119. Repealed**Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1119 recodified from R4-14-1119 (Supp. 95-1). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1120. Repealed**Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1120 recodified from R4-14-1120 (Supp. 95-1). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1121. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 910, effective March 3, 1999 (Supp. 99-1). Amended by final rulemaking at 8 A.A.R. 2454, effective May 13, 2002 (Supp. 02-2). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

Appendix A. Repealed**Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again and correction made to heading of form on last page of Appendix A effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). Appendix A repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

Appendix B. Repealed**Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again and corrections made to Plan C (Medicare (Part B) - Medical Services - Per Calendar Year) and Plan J (Other Benefits) effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). Amended effective August 16, 1996 (Supp. 96-3). Amended effective June 15, 1998 (Supp. 98-2). Amended by final rulemaking at 5 A.A.R. 910, effective March 3, 1999 (Supp. 99-1). Amended by final rulemaking at 8 A.A.R. 2454, effective May 13, 2002 (Supp. 02-2). Appendix B repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

Appendix C. Repealed**Historical Note**

Emergency rule adopted effective December 18, 1991,

pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). Amended effective August 16, 1996 (Supp. 96-3). Appendix C repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

Appendix D. Repealed

Historical Note

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). Amended effective August 16, 1996 (Supp. 96-3). Appendix D repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

Appendix E. Repealed

Historical Note

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). Appendix E repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

Appendix F. Repealed

Historical Note

Appendix F adopted effective August 16, 1996 (Supp. 96-3). Amended effective June 15, 1998 (Supp. 98-2). Amended by final rulemaking at 5 A.A.R. 910, effective March 3, 1999 (Supp. 99-1). Appendix F repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

ARTICLE 12. HIV/AIDS: PROHIBITED AND REQUIRED PRACTICES

R20-6-1201. Definitions

- A. "AIDS" means Acquired Immune Deficiency Syndrome.
- B. "Applicant" means an applicant for a life or disability insurance policy or coverage under a health care plan, as well as any potential certificate holder or dependent covered under such policy or plan.
- C. "Insurer" means life and disability insurers (including but not limited to health insurers), hospital and medical service corporations, and health care services organizations, including all employees, contractors, and agents thereof.
- D. "Person" means any individual, company, insurer, association, organization, society, reciprocal or inter-insurance exchange, partnership, syndicate, business trust, corporation, or entity.

Historical Note

Adopted effective March 7, 1994 (Supp. 94-1). R20-6-1201 recodified from R4-14-1201 (Supp. 95-1).

R20-6-1202. Applications for Insurance

- A. Insurers shall not use questions on applications for life or disability policies or health care plans that inquire directly or indirectly about:
 1. The sexual orientation of an applicant;

2. An applicant's receipt of transfusions of blood or blood products; or
3. Whether or not the applicant has had any HIV-related test, except as provided in subsection (B) of this rule.

- B. Insurers may include specific questions on applications for life or disability insurance policies or health care plans asking if the applicant has ever been diagnosed or treated for AIDS or AIDS-related conditions or tested positive for the presence of HIV antibodies, antigens, or the virus. No adverse underwriting decision shall be made on the basis of any prior positive HIV-related test or tests unless the insurer has verified that the prior test(s) consisted of both a positive screening test such as enzyme-linked immunoassay (ELISA) and a positive supplemental test such as a Western Blot. All such tests used shall be approved and licensed by the Food and Drug Administration and conducted in accordance with the manufacturer's directions for use, including but not limited to the manufacturers' specified interpretation of positivity.

Historical Note

Adopted effective March 7, 1994 (Supp. 94-1). R20-6-1202 recodified from R4-14-1202 (Supp. 95-1).

R20-6-1203. Testing for HIV; Consent Form

- A. An insurer may test for HIV infection in the same way that the insurer tests for other conditions that affect mortality and morbidity. No adverse underwriting decision shall be made on the basis of a positive result to an HIV-related test unless the result consists of both a positive screening test such as enzyme-linked immunoassay (ELISA) and a positive supplemental test such as a Western Blot. All such tests used shall be approved and licensed by the Food and Drug Administration and conducted in accordance with the manufacturers' directions for use, including but not limited to the manufacturers' specified interpretation of positivity.
- B. If an applicant is requested to take an HIV-related test in connection with an application for a life or disability insurance policy or a health care plan, the insurer shall reveal the use of such test to the applicant and shall obtain the written consent of the applicant prior to the administration of such test. The insurer shall allow the applicant up to 10 days within which to decide whether or not to sign the consent form, and no adverse underwriting decision may be made on the basis of the applicant's delay during this time period. Insurers need not provide pretest counseling to applicants but shall advise applicants of the availability of counseling in accordance with subsection (C) of this rule.
- C. The written consent form, which shall be approved by the Director in advance of its use, shall contain the following information:
 1. Purpose of the consent form. The form shall contain a clear disclosure that the test to be performed is a test for the presence of HIV antibodies, antigens, or the virus, and that underwriting decisions will be based on the results of such test. The form shall further provide notice of a period of not less than 10 days during which the applicant may decide whether or not to sign the form, along with a disclosure that the applicant's refusal to be tested may be used as a reason to deny coverage.
 2. Information on HIV. The form shall provide clear, concise, and accurate information on how the disease is spread and what behavior places persons at risk of contracting the virus.
 3. Pretest counseling considerations. The written consent form shall contain information advising the applicant that counseling is recommended by many public health organizations and that the applicant may obtain such counsel-

ing at the applicant's own expense. The form shall contain current information as provided by the Department regarding the availability in Arizona of free confidential or anonymous counseling through county health departments and through other governmental or government-funded agencies.

4. Disclosure of test results. The form shall advise the applicant that all test results shall be treated confidentially and that results shall be released only to the applicant and the named insurer or upon the applicant's written consent or as otherwise required or allowed by law, including but not limited to the release of information to the Department of Health Services as provided by law.
5. Meaning of positive test results. The form shall advise the applicant of the type of test (including but not limited to antibody, antigen, or viral culture) to be used, and that a positive test result indicates that the applicant has been infected with HIV but does not necessarily have AIDS. The form shall explain that a positive test result will adversely affect the application for insurance.
6. Consent. The consent form shall contain an attestation to be signed by the applicant or, if the applicant lacks legal capacity to consent, a person authorized pursuant to law to consent on behalf of the applicant, that he or she has read and understands the written consent form and voluntarily consents to the performance of a test for HIV and to the disclosure of the test results as described in the consent form. The applicant or the applicant's legal representative shall have the right to request and receive a copy of the written consent form. A photocopy of the form shall be as valid as the original.
7. Optional release of information to personal physician. In addition to the release of information to the insurer provided in the consent form, the applicant may, at the applicant's option, consent to the release of information to the applicant's personal physician. The form shall provide for such release to be separately signed and dated by the applicant, or if the applicant lacks legal capacity to consent, by a person authorized pursuant to law to consent on behalf of the applicant.
8. Time period during which release of information is effective. The consent form shall specify the time period during which any and all release provisions of the consent form shall be effective, but in no case shall such time period exceed 180 days from the date the consent form is signed by the applicant or the applicant's legal representative. No HIV-related information shall be released to any person after the expiration of that time period unless the insurer obtains the express written consent, pursuant to R20-6-1204, of the applicant or, if the applicant lacks legal capacity to consent, by a person authorized by law to consent on behalf of the applicant.

Historical Note

Adopted effective March 7, 1994 (Supp. 94-1). R20-6-1203 recodified from R4-14-1203 (Supp. 95-1).

R20-6-1204. Release of Confidential HIV-related Information; Release Form

- A. Except as required by law or authorized pursuant to a written consent to be tested, an insurer shall not disclose confidential HIV-related information to any person unless a written release form is executed by the applicant or, if the applicant lacks legal capacity to consent to such release, by a person authorized by law to consent to the release of information on behalf of the applicant. The applicant or the applicant's legal repre-

sentative shall be entitled to receive a copy of the release. A photocopy shall be as valid as the original.

- B. Such written release form shall contain the following information:

1. The name and address of the person to whom the information shall be disclosed;
2. The specific purpose for which disclosure is to be made; and
3. The time period during which the written release is to be effective but in no case shall such time period exceed 180 days from the date the release is signed by the applicant or the applicant's legal representative;
4. The signature of the applicant or of the person authorized by law to consent to such release, and the date the release form was signed.

Historical Note

Adopted effective March 7, 1994 (Supp. 94-1). R20-6-1204 recodified from R4-14-1204 (Supp. 95-1).

R20-6-1205. Benefits; Prohibited Practices

- A. Life and disability insurance policies or health care plans that provide benefits for prescription drugs shall provide benefits for any and all drugs and pharmaceutical forms of treatment for HIV and/or AIDS approved by the Food and Drug Administration pursuant to 21 U.S.C. Chapter 9 or licensed by the Food and Drug Administration pursuant to 42 U.S.C. Chapter 6A, including but not limited to Zidovudine, formerly Azidothymidine ("AZT"), Didanosine (ddI) and Zalcitabine (ddC), to the same extent as other prescription drugs and treatments.
- B. Insurers shall provide benefits for HIV, AIDS, and AIDS-related conditions in the same manner and to the same extent as those benefits provided for all other diseases.

Historical Note

Adopted effective March 7, 1994 (Supp. 94-1). R20-6-1205 recodified from R4-14-1205 (Supp. 95-1).

ARTICLE 13. RESERVED

ARTICLE 14. INSURANCE HOLDING COMPANY

R20-6-1401. Definitions

- A. "Executive officer" means chief executive officer, chief operating officer, chairman of the board, president, chief financial officer, treasurer, secretary, controller, and any other individual performing functions corresponding to those performed by the foregoing officers under whatever title.
- B. "Foreign insurer" shall include an alien insurer except where expressly noted otherwise.
- C. "Ultimate controlling person" means that person within a holding company system which is not controlled by any other person.
- D. Unless the context otherwise requires, other terms found in these rules are used as defined in A.R.S. § 20-481.

Historical Note

Adopted effective February 22, 1993 (Supp. 93-1). R20-6-1401 recodified from R4-14-1401 (Supp. 95-1).

R20-6-1402. Acquisition of Control – Statement Filing

- A. A person required to file a statement pursuant to A.R.S. § 20-481.02 shall furnish the required information on Form A, attached hereto as Appendix A, in accordance with the instructions contained in Appendix E.
- B. If the person being acquired is deemed to be a "domestic insurer" solely because it is a person controlling an insurer pursuant to A.R.S. § 20-481.02(A), the name of the domestic insurer on the cover page shall be indicated as follows: "[ABC Insurance Company), a subsidiary of [XYZ Holding Com-

pany].” Where such insurer is being acquired, references to “the insurer” contained in Form A shall refer to both the domestic subsidiary insurer and the person being acquired.

Historical Note

Adopted effective February 22, 1993 (Supp. 93-1). R20-6-1402 recodified from R4-14-1402 (Supp. 95-1).

R20-6-1403. Annual Registration of Insurers – Statement Filing

- A. An insurer required to file an annual registration statement pursuant to A.R.S. § 20-481.09 shall furnish the required information on Form B, attached hereto as Appendix B, in accordance with the instructions contained in Appendix E.
- B. Amendments to Form B shall be filed in the Form B format with only those items which are being amended reported. Each such amendment shall include at the top of the cover page “Amendment No. (insert number) to Form B for (insert year)” and shall indicate the date of the change and not the date of the original filings.

Historical Note

Adopted effective February 22, 1993 (Supp. 93-1). R20-6-1403 recodified from R4-14-1403 (Supp. 95-1).

R20-6-1404. Summary of Registration – Statement Filing

An insurer required to file an annual registration statement shall also furnish information required on Form C, attached hereto as Appendix C, in accordance with the instructions in Appendix B. An insurer shall file a copy of Form C in each state in which the insurer is authorized to do business, if requested by the Commissioner of that state.

Historical Note

Adopted effective February 22, 1993 (Supp. 93-1). R20-6-1404 recodified from R4-14-1404 (Supp. 95-1).

R20-6-1405. Alternative and Consolidated Registrations

- A. Any authorized insurer may file a registration statement on behalf of any affiliated insurer or insurers which are required to register pursuant to A.R.S. § 20-481.09. A registration statement may include information not required by this Article regarding any insurer in the insurance holding company system even if such insurer is not authorized to do business in this state. In lieu of filing a registration statement on Form B, the authorized insurer may file a copy of the registration statement or similar report which it is required to file in its state of domicile, provided:
 - 1. The statement or report contains substantially similar information required to be furnished on Form B; and
 - 2. The filing insurer is the principal insurance company in the insurance holding company system.
- B. An insurer filing a registration statement or report in lieu of Form B on behalf of an affiliated insurer shall set forth a brief statement of facts which will substantiate the filing insurer’s claim that it is the principal insurer in the insurance holding company system.
- C. With the prior approval of the Director, an unauthorized insurer may follow any of the procedures which could be done by an authorized insurer under subsection (A) above.
- D. Any insurer may take advantage of the provisions of this rule without obtaining the prior approval of the Director. The Director, however, reserves the right to require individual filings if he deems such filings necessary in the interest of clarity, ease of administration or the public good.

Historical Note

Adopted effective February 22, 1993 (Supp. 93-1). R20-6-1405 recodified from R4-14-1405 (Supp. 95-1).

R20-6-1406. Disclaimers and Termination of Registration

- A. A disclaimer of affiliation or a request for termination of registration claiming that a person does not, or will not upon the taking of some proposed action, control another person, hereinafter referred to in this rule as the “subject,” shall contain the following information:
 - 1. The number of authorized, issued and outstanding voting securities of the subject;
 - 2. The number and percentage of shares of the subject’s voting securities which are held of record or known to be beneficially owned by the person disclaiming control and all affiliates, and the number of such shares concerning which there is a right to acquire, directly or indirectly;
 - 3. All relationships and bases for affiliation between the subject and the person disclaiming control and all affiliates of such person;
 - 4. A statement explaining why such person should not be considered to control the subject.
- B. A request for termination of registration shall be deemed to have been granted unless the director, within 30 days after receiving the request, notifies the registrant otherwise.

Historical Note

Adopted effective February 22, 1993 (Supp. 93-1). R20-6-1406 recodified from R4-14-1406 (Supp. 95-1).

R20-6-1407. Transactions Subject to Prior Notice – Notice Filing

An insurer required to give notice of a proposed transaction pursuant to A.R.S. § 20-481.12 shall furnish the required information on Form D, attached hereto as Appendix D, in accordance with the instructions in Appendix E.

Historical Note

Adopted effective February 22, 1993 (Supp. 93-1). R20-6-1407 recodified from R4-14-1407 (Supp. 95-1).

R20-6-1408. Extraordinary Dividends and Other Distributions

- A. Requests for approval of extraordinary dividends or any other extraordinary distribution to shareholders shall include the following:
 - 1. The amount of the proposed dividend;
 - 2. The date established for payment of the dividend;
 - 3. A statement as to whether the dividend is to be in cash or other property and, if in property, a description thereof, its cost, and its fair market value together with all explanation of the basis for valuation;
 - 4. A copy of the calculations determining that the proposed dividend is extraordinary, including:
 - a. The amounts, dates and form of payment of all dividends or distributions, including regular dividends and excluding distributions of the insurer’s own securities, paid within the period of 12 consecutive months ending on the date fixed for payment of the proposed dividend for which approval is sought and commencing on the day after the same day of the same month in the last preceding year.
 - b. Surplus as regards policyholders, total capital and surplus, as of the 31st day of December next preceding;
 - c. If the insurer is a life insurer, the net gain from operations for the 12-month period ending the 31st day of December next preceding;
 - d. If the insurer is not a life insurer, the net investment income, net realized capital gains for the 12-month period ending the 31st day of December next preceding.

- ceding and the two preceding 12-months periods;
and
- e. If the insurer is not a life insurer, the dividends paid to stockholders excluding distributions of the insurer's own securities in the preceding two calendar years.
 - 5. A balance sheet and statement of income for the period intervening from the last annual statement filed with the Director and the end of the month preceding the month in which the request for dividend approval is submitted; and
 - 6. A brief statement as to the effect of the proposed dividend upon the insurer's surplus and the reasonableness of surplus in relation to the insurer's outstanding liabilities and the adequacy of surplus and assets relative to the insurer's financial needs.
- B.** Each registered insurer shall report to the Director all dividends and other distributions to shareholders within 15 business days following the declaration thereof, including the same information required by subsection (A)(4)(a) through (e) of this rule.

Historical Note

Adopted effective February 22, 1993 (Supp. 93-1). R20-6-1408 recodified from R4-14-1408 (Supp. 95-1).

Department of Insurance

APPENDIX A

FORM A

STATEMENT REGARDING THE ACQUISITION OF CONTROL OF OR MERGER WITH A DOMESTIC INSURER

[Name of Domestic Insurer]

By

[Name of Acquiring Person (Applicant)]

Filed with the Arizona Department of Insurance

Dated: , 19

Name, Title, address and telephone number of Individual to Whom Notices and Correspondence Concerning this Statement Should be Addressed:

ITEM 1. INSURER AND METHOD OF ACQUISITION

[State the name and address of the domestic insurer to which this application relates and a brief description of how control is to be acquired. State the federal identification number and the NAIC number of the domestic insurer.]

ITEM 2. IDENTITY AND BACKGROUND OF THE APPLICANT

[(a) State the name and address of the applicant seeking to acquire control over the insurer.]

[(b) If the applicant is not an individual, state the nature of its business operations for the past five years or for such lesser period as such person and any predecessors thereof shall have been in existence. Briefly describe the business intended to be done by the applicant and the applicant's subsidiaries.]

[(c) Furnish a chart or listing clearly presenting the identities of the inter-relationships among the applicant and all affiliates of the applicant, including NAIC numbers for all insurers. No affiliate need be identified if its total assets are equal to less than 1/2 of 1% of the total assets of the ultimate controlling person affiliated with the applicant. Indicate in such chart or listing the percentage of voting securities of each such person which is owned or controlled by the applicant or by any other such person. If control of any person is maintained other than by the ownership or control of voting securities, indicate the basis of such control. As to each person specified in such chart or listing indicate the type of organization (e.g. corporation, trust, partnership) and the state or other jurisdiction of domicile. If court proceedings involving a reorganization or liquidation are pending with respect to any such person, indicate which person, and set forth the title of the court, nature of proceedings and the date when commenced.)

ITEM 3. IDENTITY AND BACKGROUND OF INDIVIDUALS ASSOCIATED WITH THE APPLICANT

[The applicant if (s)he is an individual, or (2) all persons who are directors, executive officers or owners of 10% or more of the voting securities of the applicant if the applicant is not an individual shall provide the following information as to the in affidavit form:

(a) Affiant's full name, other names used at any time, home and business addresses and telephone numbers, social security number, date and place of birth, and residences for the last 10 years;

(b) Affiant's education, including dates, names of institutions, locations and degrees awarded;

(c) Affiant's membership in professional societies and associations;

(d) Affiant's employment history for the past 20 years, including positions held, dates, employers' names and mailing addresses;

(e) Whether Affiant has ever been in a position which imposed a fidelity bond, and if so, name of the insuring company and/or place of employment, whether any claims were made on the bond, and whether Affiant has ever been denied a fidelity bond or had a bond cancelled or revoked;

(f) Any professional, occupational or vocational licenses issued to Affiant by any public or governmental licensing agent or regulatory authority presently held or held in the past, including dates licenses issued, issuer of license, date of termination and reasons for termination, and whether any such license has ever been refused, suspended or revoked;

(g) Whether Affiant controls directly or indirectly or owns legally or beneficially 1% or more of the outstanding stock of any insurer, and if so, name and type of insurer, percent of ownership, how insurer is controlled, and details related to any pledging of the stock, with or without title transfer;

(h) Whether members of Affiant's immediate family subscribe or own, beneficially or of record, shares of stock of the applicant organization or its affiliates and whether any of the shares are pledged or hypothecated in any way;

(i) Whether Affiant has been adjudged or designated a bankrupt or a debtor under the United States Bankruptcy Code, Title 11 of the United States Code;

(j) Whether Affiant has been convicted, served with a criminal summons, questioned, arrested, taken into custody, indicted, charged with, tried for or ever been the subject of an investigation concerning the violation of any law, including convictions or judgments that have been expunged, set aside, reversed or dismissed, excluding only traffic violations which resulted in a penalty not exceeding \$200 and those incidents which occurred prior to the individual's 18th birthday;

(k) Whether Affiant has ever been the subject of disciplinary proceedings before any federal or state regulatory authority;

(l) Whether Affiant has ever been a management consultant, administrator, officer, director, trustee, investment committee member, key employee or controlling stockholder of any company or company affiliate which became insolvent or was placed under supervision or in

receivership, rehabilitation, liquidation or conservatorship or had its certificate of authority suspended or revoked while you occupied such position.

Such persons shall also submit fingerprints and the fingerprint processing fee in accordance with A.R.S. § 20-481.03(B).]

ITEM 4. NATURE, SOURCE AND AMOUNT OF CONSIDERATION

[(a) Describe the nature, source and amount of funds or other considerations used or to be used in effecting the merger or other acquisition of control. If any part of the same is represented or is to be represented by funds or other consideration borrowed or otherwise obtained for the purpose of acquiring, holding or trading securities, furnish a description of the transaction, the names of the parties thereto, the relationship, if any, between the borrower and the lender, the amounts borrowed or to be borrowed, and copies of all agreements, promissory notes and security arrangements relating thereto.]

[(b) Explain the criteria used in determining the nature and amount of such consideration.]

[(c) If the source of the consideration is a loan made in the lender's ordinary course of business and if the applicant wishes the identity of the lender to remain confidential, he must specifically request that the identity be kept confidential.)

ITEM 5. FUTURE PLANS OF INSURER

[Describe any plans or proposals which the applicant may have to declare an extraordinary dividend, to liquidate such insurer, to sell its assets to or merge it with any person or persons or to make any other material change in its business operations or corporate structure or management.]

ITEM 6. VOTING SECURITIES TO BE ACQUIRED

[State the number of shares of the insurer's voting securities which the applicant, its affiliates and any person listed in Item 3 plan to acquire, and the terms of the offer, request, invitation, agreement or acquisition, and a statement as to the method by which the fairness of the proposal was arrived at.]

ITEM 7. OWNERSHIP OF VOTING SECURITIES

[State the amount of each class of any voting security of the insurer which is beneficially owned or concerning which there is a right to acquire beneficial ownership by the applicant, its affiliates or any person listed in Item 3.]

ITEM 8. CONTRACTS, ARRANGEMENTS, OR UNDERSTANDINGS WITH RESPECT TO VOTING SECURITIES OF THE INSURER

[Give a full description of any contracts, arrangements or understandings with respect to any voting security of the insurer in which the applicant, its affiliates or any person listed in Item 3 is involved, including but not limited to transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. Such description shall identify the persons with whom such contracts, arrangements or understandings have been entered into.]

ITEM 9. RECENT PURCHASES OF VOTING SECURITIES

[Describe any purchases of any voting securities of the insurer by the applicant, its affiliates or any person listed in Item 3 during the 12 calendar months preceding the filing of this Statement. Include in such description the dates of purchase, the names of the purchasers, and the consideration paid or agreed to be paid therefore. State whether any such shares so purchased are hypothecated.]

ITEM 10. RECENT RECOMMENDATIONS TO PURCHASE

[Describe any recommendations to purchase any voting security of the insurer made by the applicant, its affiliates or any person listed in Item 3, or by anyone based upon interviews or at the suggestion of the applicant, its affiliates or any person listed in Item 3 during the 12 calendar months preceding the filing of this statement.)

ITEM 11. AGREEMENTS WITH BROKER-DEALERS

[Describe the terms of any agreement, contract or understanding made with any broker-dealer as to solicitation of voting securities of the insurer for tender and the amount of any fees, commissions or other compensation to be paid to broker-dealers with regard thereto.]

ITEM 12. FINANCIAL STATEMENTS AND EXHIBITS

[(a) Financial statements and exhibits shall be attached to this statement as an appendix, but list under this item the financial statements and exhibits so attached.]

[(b) The financial statements shall include the annual financial statements of the persons identified in Item 2(c) for the preceding five fiscal years (or for such lesser period as such applicant and its affiliates and any predecessors thereof shall have been in existence), and similar information covering the period from the end of such person's last fiscal year, if such information is available. Such statements may be prepared on either an individual basis, or, unless the Director otherwise requires, on a consolidated basis if such consolidated statements are prepared in the usual course of business.

The annual financial statements of the applicant shall be accompanied by the certificate of an independent public accountant to the effect that such statements present fairly the financial position of the applicant and the results of its operations for the year then ended, in conformity with generally accepted accounting principles or with requirements of insurance or other accounting principles prescribed or permitted under law. If the applicant is an insurer which is actively engaged in the business of insurance, the financial statements need not be certified, provided they are based on the Annual Statement of such person filed with the insurance department of the person's domiciliary state and are in accordance with the requirements of insurance or other accounting principles prescribed or permitted under the law and regulations of such state.]

If the applicant is an individual and annual financial statements have not been prepared for the preceding years, the financial statements for years other than the two most recent years may consist of true and correct copies of the applicant's federal income tax returns which have been signed by the applicant(s) and filed with the Internal Revenue Service.

[(c) File as exhibits copies of all tender offers for, requests or invitations for, tenders of, exchange offers for, and agreements to acquire or exchange any voting securities of the insurer and (if distributed) of additional soliciting material relating thereto, any proposed

Department of Insurance

employment, consultation, advisory or management contracts concerning the insurer, annual reports to the stockholders of the insurer and the applicant for the last two fiscal years, and any additional documents or papers required by Form A.)

ITEM 13. SIGNATURE AND CERTIFICATION

[Signature and certification required as follows:]

SIGNATURE

Pursuant to the requirements of A.R.S. § 20-481.02 _____ has caused this application to be duly signed on its behalf in the City of _____ and State of _____ on the _____ day of _____, 19 ____.

(SEAL)

Name of Applicant

BY _____
(Name)

(Title)

Attest:

(Signature of Officer)

(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached application dated _____, 19 _____, for and on behalf of _____; that (s)he is the _____

(Name of Applicant)

(Title of Officer)

of such company and that (s)he is authorize to execute and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

(Signature)

(Type or print name beneath)

Historical Note

Adopted effective February 22, 1993 (Supp. 93-1).

APPENDIX B

FORM B

INSURANCE HOLDING COMPANY SYSTEM ANNUAL REGISTRATION STATEMENT

Filed with the Insurance Department of the State of Arizona

By

[Name of Registrant]

On Behalf of Following Insurance Companies

Name

Address

Date:

, 19

Name, Title, Address and telephone number of Individual to Whom Notices and Correspondence Concerning This Statement Should Be Addressed:

ITEM 1. IDENTITY AND CONTROL OF REGISTRANT

[Furnish the exact name of each insurer registering or being registered (hereinafter called "the Registrant"), the federal identification number and the NAIC number of each, the home office address and principal executive offices of each; the date on which each Registrant became part of the insurance holding company system; and the method(s) by which control of each Registrant was acquired and is maintained.]

ITEM 2. ORGANIZATIONAL CHART

[Furnish a chart or listing clearly presenting the identities of and interrelationships among all affiliated persons within the insurance holding company system. The chart or listing should show the percentage of each class of voting securities of each affiliate which is owned, directly or indirectly, by another affiliate. If control of any person within the system is maintained other than by the ownership or control of voting securities, indicate the basis of such control. As to each person specified in such chart or listing, indicate the type of organization (e.g., - corporation, trust, partnership) and the state or other jurisdiction of domicile.]

ITEM 3. THE ULTIMATE CONTROLLING PERSON

[As to the ultimate controlling person in the insurance holding company system furnish the following information:

- (a) Name.
- (b) Home office address.
- (c) Principal executive office address.
- (d) The organizational structure of the person, i.e., corporation, partnership, individual, trust, etc.
- (e) The principal business of the person.
- (f) The name and address of any person who holds or owns 10% or more of any class of voting security, the class of such security, the number of shares held of record or known to be beneficially owned, and the percentage of class so held or owned.
- (g) If court proceedings involving a reorganization or liquidation are pending, indicate the title and location of the court, the nature of proceedings and the date when commenced.]

ITEM 4. BIOGRAPHICAL INFORMATION

[All persons who are directors, executive officers and/or owners of 10% or more of the voting securities of the ultimate controlling person shall provide the following information in an affidavit form:

- (a) Affiant's full name, other names used at any time, home and business addresses and telephone numbers, social security number, date and place of birth, and residences for the last 10 years;
- (b) Affiant's education, including dates, names of institutions, locations and degrees awarded;
- (c) Affiant's membership in professional societies and associations;
- (d) Affiant's employment history for the past 20 years, including positions held, dates, employers' names and mailing addresses;
- (e) Whether Affiant has ever been in a position which imposed a fidelity bond, and if so, name of the insuring company and/or place of employment, whether any claims were made on the bond, and whether Affiant has ever been denied a fidelity bond or had a bond cancelled or revoked;
- (f) Any professional, occupational or vocational licenses issued to Affiant by any public or governmental licensing agent or regulatory authority presently held or held in the past, including dates licenses issued, issuer of license, date of termination and reasons for termination, and whether any such license has ever been refused, suspended or revoked;
- (g) Whether Affiant controls directly or indirectly or owns legally or beneficially 1% or more of the outstanding stock of any insurer, and if so, name and type of insurer, percent of ownership, how insurer is controlled, and detail related to any pledging of the stock, with or without title transfer;
- (h) Whether members of Affiant's immediate family subscribe or own, beneficially or of record, shares of stock of the ultimate controlling person or its subsidiaries or affiliates and whether any of the shares are pledged or hypothecated in any way;
- (i) Whether Affiant has been adjudged or designated a bankrupt or a debtor under the United States Bankruptcy Code, Title 11 of the United States Code;

(j) Whether Affiant has been convicted, served with a criminal summons, questioned, arrested, taken into custody, indicted, charged with, tried for or ever been the subject of an investigation concerning the violation of any law, including convictions or judgments that have been expunged, set aside, reversed or dismissed, excluding only traffic violations which resulted in a penalty not exceeding \$200 and those incidents which occurred prior to Affiant's 18th birthday;

(k) Whether Affiant has ever been the subject of disciplinary proceedings before any federal or state regulatory authority;

(1) Whether Affiant has ever been a management consultant, administrator, officer, director, trustee, investment committee member, key employee of controlling stockholder of any company or company affiliate which became insolvent or was placed under supervision or in receivership, rehabilitation, liquidation or conservatorship or had its certificate of authority suspended or revoked while Affiant occupied such position.)

ITEM 5. TRANSACTIONS AND AGREEMENTS

[Briefly describe the following agreements in force, and material transactions currently outstanding or which have occurred during the last calendar year between the Registrant and its affiliates:

(1) loans, other investments, or purchases, sales or exchanges of securities of the affiliates by the Registrant or of the Registrant by its affiliates;

(2) purchases, sales or exchanges of assets;

(3) transactions not in the ordinary course of business;

(4) guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the Registrant's assets to liability, other than insurance contracts entered into in the ordinary course of the Registrant's business;

(5) all management agreements, service contracts and all cost-sharing arrangements;

(6) reinsurance agreements;

(7) dividends and other distributions to shareholders;

(8) consolidated tax allocation agreements; and

(9) any pledge of the Registrant's stock and/or of the stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system.

Sales, purchases, exchanges, loans or extensions of credit, investments or guarantees involving 1/2 of 1% or less of the Registrant's admitted assets as of the 31st day of December next preceding shall not be deemed material.

The description shall be in a manner as to permit the proper evaluation thereof by the Director and shall include at least the following: the nature and purpose of the transaction, the nature and amounts of any payments or transfers of assets between the parties, the identity of all parties to such transaction, and relationship of the affiliated parties to the Registrant.]

ITEM 6. LITIGATION OR ADMINISTRATIVE PROCEEDINGS

[A brief description of any litigation or administrative proceedings of the following types, either then pending or concluded within the preceding fiscal year, to which the ultimate controlling person or any of its directors or executive officers was a party or of which the property of any such person is or was the subject; give the names of the parties and the court or agency in which such litigation or proceeding is or was pending:

(a) Criminal prosecutions or administrative proceedings by any government agency or authority which may be relevant to the trustworthiness of any party thereto; and

(b) Proceedings which may have a material effect upon the solvency or capital structure of the ultimate holding company including, but not necessarily limited to, bankruptcy, receivership or other corporate reorganizations.]

ITEM 7. STATEMENT REGARDING PLAN OR SERIES OF TRANSACTIONS

[The insurer shall furnish a statement that transactions entered into since the filing of the prior year's annual registration statement are not part of a plan or series of like transactions, the purpose of which is to avoid statutory threshold amounts and the review that might otherwise occur.]

ITEM 8. FINANCIAL STATEMENTS AND EXHIBITS

[(a) Financial statements and exhibits shall be attached to this statement as an appendix, but list under this item the financial statements and exhibits so attached.

(b) The financial statements shall include the annual financial statements of the ultimate controlling person in the insurance holding company system as of the end of the person's latest fiscal year.

If at the time of the initial registration, the annual financial statements for the latest fiscal year are not available, annual statements for the previous fiscal year may be filed and similar financial information shall be filed for any subsequent period to the extent such information is available. Such financial statements may be prepared on either an individual basis, or unless the Director otherwise requires, on a consolidated basis if such consolidated statements are prepared in the usual course of business.

Unless the Director otherwise permits, the annual financial statements shall be accompanied by the certificate of an independent public accountant to the effect that such statements present fairly the financial position of the ultimate controlling person and the results of its operations for the year then ended, in conformity with generally accepted accounting principles or with requirements of insurance or other accounting principles prescribed or permitted under law. If the ultimate controlling person is an insurer which is actively engaged in the business of insurance, the annual financial statements need not be certified, provided they are based on the Annual Statement of such insurer filed with the insurance department of the insurer's domiciliary State and are in accordance with requirements of insurance or other accounting principles prescribed or permitted under the law and regulations of such state.

(c) Exhibits shall include copies of the latest annual reports to shareholders of the ultimate controlling person and proxy material used by the ultimate controlling person; and any additional documents or papers required by Form B.]

ITEM 9. FORM C REQUIRED

[A Form C, Summary of Registration Statement, must be prepared and filed with this Form B.]

ITEM 10. SIGNATURE AND CERTIFICATION

[Signature and certification required as follows:]

SIGNATURE

Pursuant to the requirements of A.R.S. § 20-481 et seq. _____ has caused this application to be duly signed on its behalf in the City of _____ and State of _____ on the _____ day of _____, 19 ____.

(SEAL)

Name of Applicant

BY _____
(Name)

(Title)

Attest:

(Signature of Officer)

(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached application dated _____, 19 ____, for and on behalf of _____; that (s)he is the _____

(Name of Applicant)

(Title of Officer)

of such company and that (s)he is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

(Signature)

(Type or print name beneath)

Historical Note

Adopted effective February 22, 1993 (Supp. 93-1).

Department of Insurance

APPENDIX C

FORM C

SUMMARY OF REGISTRATION STATEMENT

Filed with the Insurance Department of the State of Arizona

By

[Name of Registrant]

On Behalf of Following Insurance Companies

Name Address

Date: , 19

Name, Title, Address and telephone number of Individual to Whom Notices and Correspondence Concerning This Statement Should Be Addressed:

[Furnish a brief description of all items in the current annual registration statement which represent changes from the prior year's annual registration statement. The description shall be in a manner as to permit the proper evaluation thereof by the Director and shall include specific references to Item numbers in the annual registration statement and to the terms contained therein.

Changes occurring under Item 2 of Form B, insofar as changes in the percentage of each class of voting securities held by each affiliate is concerned, need only be included where such changes are ones which result in ownership or holdings of 10% or more of voting securities, loss or transfer of control, or acquisition or loss of partnership interest.

Changes occurring under Item 4 of Form B need only be included where: an individual is, for the first time, made a director or executive officer of the ultimate controlling person; a director or executive officer terminates his or her responsibilities with the ultimate controlling person; or in the event an individual is named president of the ultimate controlling person.

If a transaction disclosed on the prior year's annual registration statement has been changed, the nature of such change shall be included. If a transaction disclosed on the prior year's annual registration statement has been effectuated, furnish the mode of completion and any flow of funds between affiliates resulting from the transaction.

The insurer shall furnish a statement that transactions entered into since the filing of the prior year's annual registration statement are not part of a plan or series of like transactions whose purpose it is to avoid statutory threshold amounts and the review that might otherwise occur.]

SIGNATURE AND CERTIFICATION

[Signature and certification required as follows:]

SIGNATURE

Pursuant to the requirements of A.R.S. § 20-481 et seq. _____ has caused this application to be duly signed on its behalf in the City of _____ and State of _____ on the _____ day of _____, 19 ____.

(SEAL)

Name of Applicant

BY _____
(Name)_____
(Title)

Attest:

(Signature of Officer)_____
(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached application dated _____, 19 _____,
for and on behalf of _____; that (s)he is the _____

(Name of Applicant)

(Title of Officer)

of such company and that (s)he is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with such
instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

(Signature)_____
(Type or print name beneath)**Historical Note**

Adopted effective February 22, 1993 (Supp. 93-1).

Department of Insurance

APPENDIX D

FORM D

PRIOR NOTICE OF A TRANSACTION

Filed with the Insurance Department of the State of Arizona

By

[Name of Registrant]

On Behalf of Following Insurance Companies

Name Address

Date: , 19

Name, Title, Address and telephone number of Individual to Whom Notices and Correspondence Concerning This Statement Should Be Addressed:

ITEM 1. IDENTITY OF PARTIES TO TRANSACTION

[Furnish the following information for each of the parties to the transaction:

- (a) Name.
- (b) Home office address.
- (c) Principal executive office address.
- (d) The organizational structure, i.e. corporation, partnership, individual, trust, etc.
- (e) A description of the nature of the parties' business operations.
- (f) Relationship, if any, of other parties to the transaction to the insurer filing the notice, including any ownership or debtor/creditor interest by any other parties to the transaction in the insurer seeking approval, or by the insurer filing the notice in the affiliated parties.
- (g) Where the transaction is with a non-affiliate, the name(s) of the affiliate(s) which will receive, in whole or in substantial part, the proceeds of the transaction.]

ITEM 2. DESCRIPTION OF THE TRANSACTION

[Furnish the following information for each transaction for which notice is being given:

- (a) A statement as to whether notice is being given under A.R.S. § 20-481.12.
- (b) A statement of the nature of the transaction.
- (c) The proposed effective date of the transaction.]

ITEM 3. SALES, PURCHASES, EXCHANGES, LOANS, EXTENSIONS OF CREDIT, GUARANTEES OR INVESTMENTS

[Furnish a brief description of the amount and source of funds, securities, property or other consideration for the sale, purchase, exchange, loan, extension of credit, guarantee, or investment, whether any provision exists for purchase by the insurer filing notice, by any party to the transaction, or by any affiliate of the insurer filing notice, a description of the terms of any securities being received, if any, and a description of any other agreements relating to the transaction such as contracts or agreements for services, consulting agreements and the like. If the transaction involves other than cash, furnish a description of the consideration, its cost and its fair market value, together with an explanation of the basis for evaluation.

If the transaction involves a loan, extension of credit or a guarantee, furnish a description of the maximum amount which the insurer will be obligated to make available under such loan, extension of credit or guarantee, the date on which the credit or guarantee will terminate, and any provisions for the accrual of or deferral of interest.

If the transaction involves an investment, guarantee or other arrangement, state the time period during which the investment, guarantee or other arrangement will remain in effect, together with any provisions for extensions or renewals of such investments, guarantees or arrangements. Furnish a brief statement as to the effect of the transaction upon the insurer's surplus.

No notice need be given if the maximum amount which can at any time be outstanding or for which the insurer can be legally obligated under the loan, extension of credit or guarantee is less than (a) in the case of non-life insurers, the lesser of 3% of the insurer's admitted assets or 25% of surplus as regards policyholders, or (b) in the case of life insurers, 3% of the insurer's admitted assets, each as of the 31st day of December next preceding.]

ITEM 4. LOANS OR EXTENSIONS OF CREDIT TO A NON-AFFILIATE

[If the transaction involves a loan or extension of credit to any person who is not an affiliate, furnish a brief description of the agreement or understanding whereby the proceeds of the proposed transaction, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase the assets of, or to make investments in, any affiliate of the insurer making such loans or extensions of credit, and specify in what manner the proceeds are to be used to loan to, extend credit to, purchase assets of or make investments in any affiliate. Describe the amount and source of funds, securities, property or other consideration for the loan or extension of credit and, if the transaction is one involving consideration other than cash, a description of its cost and its fair market value together with an explanation of the basis for evaluation. Furnish a brief statement as to the effect of the transaction upon the insurer's surplus.

No notice need be given if the loan or extension of credit is one which equals less than, in the case of non-life insurers, the lesser of 3% of the insurer's admitted assets or 25% of surplus as regards policyholders or, with respect to life insurers, 3% of the insurer's admitted assets, each as of the 31st day of December next preceding.]

ITEM 5. REINSURANCE

[If the transaction is a reinsurance agreement or modification thereto, furnish a description of the known and/or estimated amount of liability to be ceded and/or assumed in each calendar year, the period of time during which the agreement will be in effect, and a statement whether an agreement or understanding exists between the insurer and non-affiliate to the effect that any portion of the assets constituting the consideration for the agreement will be transferred to one or more of the insurer's affiliates. Furnish a brief description of the consideration involved in the transaction, and a brief statement as to the effect of the transaction upon the insurer's surplus.]

No notice need be given for reinsurance agreements or modifications thereto if the reinsurance premium or a change in the insurer's liabilities in connection with the reinsurance agreement or modification thereto is less than 5% of the insurer's surplus as regards policyholders, as of the 31st day of December next preceding.]

ITEM 6. MANAGEMENT AGREEMENTS, SERVICE AGREEMENTS AND COST-SHARING ARRANGEMENTS

[For management and service agreements, furnish:

- (a) a brief description of the managerial responsibilities, or services to be performed.
- (b) a brief description of the agreement, including a statement of its duration, together with brief descriptions of the basis for compensation and the terms under which payment or compensation is to be made.]

[For cost-sharing arrangements, furnish:

- (a) a brief description of the purpose of the agreement.
- (b) a description of the period of time during which the agreement is to be in effect.
- (c) a brief description of each party's expenses or costs covered by the agreement.
- (d) a brief description of the accounting basis to be used in calculating each party's costs under the agreement.]

ITEM 7. SIGNATURE AND CERTIFICATION

[Signature and certification required as follows:]

SIGNATURE

Pursuant to the requirements of A.R.S. § 20-481 et seq. _____ has caused this application to be duly signed on its behalf in the City of _____ and State of _____ on the _____ day of _____, 19 ____.

(SEAL)

Name of Applicant

BY _____
(Name)

(Title)

Attest:

(Signature of Officer)

(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached application dated _____, 19 ____, for and on behalf of _____; that (s)he is the _____

(Name of Applicant) (Title of Officer)

of such company and that (s)he is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

(Signature)

(Type or print name beneath)

Historical Note

Adopted effective February 22, 1993 (Supp. 93-1).

APPENDIX E
INSTRUCTIONS ON FORMS A, B, C, D

Forms A, B, C, and D are intended to be guides in the preparation of the statements required by A.R.S. §§ 20-481.02 and 20-481.07. They are not intended to be blank forms which are to be filled in. The statements shall contain the numbers and captions of all items, but the text of the items may be omitted provided the answers thereto are prepared in such a manner as to indicate clearly the scope and coverage of the items. All instructions, whether appearing under the items of the form or elsewhere therein, are to be omitted. Unless expressly provided otherwise, if any item is inapplicable or the answer thereto is in the negative, an appropriate statement to that effect shall be made.

Two complete copies of each statement including exhibits, and all other papers and documents filed as a part thereof, shall be filed with the Director by personal delivery or mail addressed to: Insurance Director of the State of Arizona, Attention: Corporate and Financial Affairs Division. A copy of Form C shall be filed in each state in which an insurer is authorized to do business, if the Director of that state has notified the insurer of its request in writing. At least one of the copies shall be manually signed in the manner prescribed on the form. Unsigned copies shall be conformed. If the signature of any person is affixed pursuant to a power of attorney or other similar authority, a copy of such power of attorney or other authority shall also be filed with the statement.

Statements shall be prepared on paper 8 1/2"x 11" in size and bound at the top or the top left-hand corner. Exhibits and financial statements, unless specifically prepared for the filing, may be submitted in their original size. All copies of any statement, financial statements, or exhibits shall be clear, easily readable and suitable for photocopying. Debits in credit categories and credits in debit categories shall be designated so as to be clearly distinguishable as such on photocopies. Statements shall be in the English language and monetary values shall be stated in United States currency. If any exhibit or other paper or document filed with the statement is in a foreign language, it shall be accompanied by a translation into the English language and any monetary value shown in a foreign currency normally shall be converted into United States currency.

Information required by any item of Form A, Form B or Form D may be incorporated by reference in answer or partial answer to any other item. Information contained in any financial statement, annual report, proxy statement, statement filed with a governmental authority, or any other document may be incorporated by reference in answer or partial answer to any item of Form A, Form B or Form D provided such document or paper is filed as an exhibit to the statement. Excerpts of documents may be filed as exhibits if the documents are extensive. Documents currently on file with the Director which were filed within three years need not be attached as exhibits. References to information contained in exhibits or in documents already on file shall clearly identify the material and shall specifically indicate that such material is to be incorporated by reference in answer to the item. Matter shall not be incorporated by reference in any case where such incorporation would render the statement incomplete, unclear or confusing.

Where an item requires a summary or outline of the provisions of any document, only a brief statement shall be made as to the pertinent provisions of the document. In addition to such statement, the summary or outline may incorporate by reference particular parts of any exhibit or document currently on file with the Director which was filed within three years and may be qualified in its entirety by such reference. In any case where two or more documents required to be filed as exhibits are substantially identical in all material respects except as to the parties thereto, the dates of execution, or other details, a copy of only one of such documents need be filed with a schedule identifying the omitted documents and setting forth the material details in which such documents differ from the documents a copy of which is filed.

Information required need be given only insofar as it is known or reasonably available to the person filing the statement. If any required information is unknown and not reasonably available to the person filing, either because the obtaining thereof would involve unreasonable effort or expense, or because it rests peculiarly within the knowledge of another person not affiliated with the person filing, the information may be omitted, subject to the following conditions:

- (1) The person filing shall give such information on the subject as it possesses or can acquire without unreasonable effort or expense, together with the sources thereof; and
- (2) The person filing shall include a statement either showing that unreasonable effort or expense would be involved or indicating the absence of any affiliation with the person within whose knowledge the information rests and stating the result of a request made to such person for the information.

If it is impractical to furnish any required information, document or report at the time it is required to be filed, there may be filed with the Director as a separate document:

- (1) identifying the information, document or report in question;
- (2) stating why the filing thereof at the time required is impractical; and
- (3) requesting an extension of time for filing the information, document or report to a specified date. The request for extension shall be deemed granted unless the Director within 60 days after receipt thereof enters an order denying the request.

In addition to the information expressly required to be included in Form A, Form B, Form C and Form D, there shall be added such further material information, if any, as may be necessary to make the information contained therein not misleading. The person filing may also file such exhibits as it may desire in addition to those expressly required by the statement. Such exhibits shall be so marked as to indicate clearly the subject matters to which they refer. Changes to Forms A, B, C or D shall include on the top of the cover page the phrase: "Change No. (insert number) to" and shall indicate the date of the change and not the date of the original filing.

Historical Note

Adopted effective February 22, 1993 (Supp. 93-1).

ARTICLE 15. RESERVED**ARTICLE 16. CREDIT FOR REINSURANCE****R20-6-1601. Credit for Reinsurance**

- A.** The requirements of A.R.S. § 20-261.01(A)(1) through (4) shall be determined as of the date of the ceding insurer's statutory financial statement in which the credit for reinsurance is claimed as an asset to or a deduction from liability.
- B.** Accredited reinsurer.
1. No assuming insurer shall be an "accredited reinsurer" under A.R.S. § 20-261.01(A)(2) until it has submitted an application to the Department on a form provided by the Department and is approved by the Director.
 2. An application for accreditation as a reinsurer shall include:
 - a. Form AR-1. The requirement to file with the Director evidence of a reinsurer's submission to this state's jurisdiction and to submit to this state's authority to examine its books and records, as set forth in A.R.S. § 20-261.01(A)(2)(a) and (b), shall be accomplished by filing with the Director a properly executed Form AR-1, attached as Appendix A to this Article;
 - b. A certified copy of a letter or a certificate of authority or a certificate of compliance as evidence that the reinsurer is:
 - i. Licensed to transact insurance or reinsurance in at least one state, or
 - ii. A United States branch of an alien assuming insurer, that is entered through and licensed to transact insurance or reinsurance in at least one state;
 - c. A certified copy of the most recent annual statement filed with the insurance department of the reinsurer's state of domicile or entry and a copy of the most recent audited financial statement;
 - d. The payment of an application filing fee in accordance with A.R.S. § 20-230; and
 - e. Any other supporting documentation the Director may require.
 3. The Director may examine the reinsurer's books and records as necessary for the application for accreditation, in accordance with A.R.S. §§ 20-142 and 20-156 through 20-160.
 4. A reinsurer is an accredited reinsurer if, after submission of a complete application:
 - a. The reinsurer maintains surplus as regards policyholders in an amount not less than \$20 million, and the Director approves, or within 90 days of submission of the application, has not denied the application; or
 - b. The reinsurer maintains surplus as regards policyholders in an amount less than \$20 million, and the Director approves the application.
 5. An accredited reinsurer shall pay its annual filing fees, in accordance with A.R.S. § 20-167, by March 1 of each year and shall file annually with the Director, the following:
 - a. A certified copy of the annual statement that is filed with the insurance department of its state of domicile or entry, on or before March 1 of each year; and
 - b. A copy of the most recent audited financial statement, on or before June 1 of each year.
 6. The Director may revoke the accreditation of any reinsurer for cause, including failure to comply with A.R.S. § 20-261.01(A)(2) or this Section, after notice and a hearing, in accordance with A.R.S. §§ 20-161 through 20-166, and Title 41, Chapter 6, Article 10.
- 7.** A reinsurer may surrender its accreditation only upon application to, and approval by, the Director.
- 8.** A domestic ceding insurer for reinsurance shall not use as a credit an asset or a deduction from liability on account of reinsurance ceded under A.R.S. § 20-261.01(A)(2) if the assuming insurer's accreditation is denied, revoked, or surrendered.
- C.** Reinsurer domiciled and licensed in another state.
1. Substantially similar standards under A.R.S. § 20-261.01(A)(3) means credit for reinsurance standards that are equal to or exceed the standards of A.R.S. § 20-261.01 and this Section.
 2. The reinsurer shall submit to this state's authority to examine the books and records of the reinsurer under A.R.S. § 20-261.01(A)(3)(b) by filing Form AR-1.
- D.** Reinsurer maintaining trust funds.
1. The aggregate policy holders' surplus of a group of incorporated insurers under common administration under A.R.S. § 20-261.01(A)(4)(b) shall be calculated and reported in substantially the same manner as prescribed by the Annual Statement Instructions for Property and Casualty, National Association of Insurance Commissioners, copyright NAIC 1997, and the Accounting and Practices and Procedures Manual, for Property/Casualty Insurance Companies, National Association of Insurance Commissioners, copyright NAIC 1997 Revised Edition, The Annual Statement Instructions for Life, Accident and Health, National Association of Insurance Commissioners, copyright NAIC 1997, and the Accounting Practices and Procedures Manual for Life, Accident and Health Insurance Companies, National Association of Insurance Commissioners, copyright NAIC 1997, which are all incorporated by reference and on file with the Office of the Secretary of State and available from the National Association of Insurance Commissioners, Publications Department, 120 W. 12th Street, Suite 1100, Kansas City, Missouri 64105-1925. These incorporations by reference contain no future editions or amendments.
 2. The reinsurer maintaining trust funds shall submit to this state's authority to examine the reinsurer's books and records, under A.R.S. § 20-261.01(A)(4)(b), by filing Form A-1.
 3. For purposes of A.R.S. § 20-261.01(A)(4)(b), the trust instrument shall expressly state that:
 - a. Contested claims shall be valid and enforceable out of trust funds to the extent these claims remain unsatisfied 30 days after entry of final order of any court of competent jurisdiction in the United States.
 - b. Legal title to the trust assets shall be vested in the trustee for the benefit of the reinsurer grantor's United States policyholders and ceding insurers, and any assigns of and successors in interest to the policyholders and ceding insurers.
 - c. The trust is subject to examination upon the Director's request.
 - d. The trust shall remain in effect for as long as the assuming insurer, or any member or former member of a group of insurers, within the meaning of A.R.S. § 20-261.01(A)(4)(a) and (b) has outstanding obligations under a reinsurance agreement subject to the trust.
 - e. No later than February 28 of each year, the trustee shall file a written report stating:
 - i. The balance in the trust;

- ii. A list of the trust's investments at the preceding year-end; and
 - iii. A statement certifying the date of termination of the trust, if planned, or a statement certifying that the trust shall not expire before the next following December 31; and
 - f. An amendment to the trust is not effective unless reviewed and approved in advance by the Director.
- E.** For purposes of A.R.S. § 20-261.01(A)(5), "jurisdiction" means any state, district or territory of the United States or any lawful national government.

Historical Note

Adopted effective February 3, 1993 (Supp. 93-1). R20-6-1601 recodified from R4-14-1601 (Supp. 95-1).
Amended effective October 9, 1998 (Supp. 98-4).

R20-6-1602. Reduction from Liability for Reinsurance Ceded to an Unauthorized Assuming Insurer

For purposes of A.R.S. § 20-261.02(A)(1), monies held in trust for the ceding insurer under a reinsurance contract with the assuming insurer as security for the payment of obligations thereunder shall be so held in trust for the exclusive benefit of the ceding insurer.

Historical Note

Adopted effective February 3, 1993 (Supp. 93-1). R20-6-1602 recodified from R4-14-1602 (Supp. 95-1).

R20-6-1603. Trust Agreements

A. As used in this Section:

- 1. "Beneficiary" includes any successor of the named beneficiary by operation of law, including without limitation any receiver, conservator, rehabilitator or liquidator.
- 2. "Grantor" means the entity that has established a trust for the benefit of the beneficiary.
- 3. "Obligations," as used in subsection (B)(11) of this rule, means:
 - a. Reinsured losses and allocated loss expenses paid by the ceding company but not recovered from the assuming insurer;
 - b. Reserves for reinsured losses reported and outstanding;
 - c. Reserves for reinsured losses incurred but not reported; and
 - d. Reserves for allocated reinsured loss expenses and unearned premiums.

B. Required conditions.

- 1. The trust agreement shall be entered into between the beneficiary, the grantor and a trustee which shall be a qualified United States financial institution as defined in A.R.S. § 20-261.03.
- 2. The trust agreement shall create a trust account into which assets shall be deposited.
- 3. All assets in the trust account shall be held by the trustee at the trustee's office in the United States, except that a bank may apply for the Director's permission to use a foreign branch office of such bank as trustee for trust agreements established pursuant to this Section. If the Director approves the use of such foreign branch office as trustee, then its use must be approved by the beneficiary in writing and the trust agreement must provide that the written notice described in subsection (B)(4)(a) of this rule must also be presentable, as a matter of legal right, at the trustee's principal office in the United States.
- 4. The trust agreement shall provide that:
 - a. The beneficiary shall have the right to withdraw assets from the trust account at any time, without

- notice to the grantor, subject only to written notice from the beneficiary to the trustee;
 - b. No other statement or document is required to be presented in order to withdraw assets, except that the beneficiary may be required to acknowledge receipt of withdrawn assets;
 - c. It is not subject to any conditions or qualifications outside of the trust agreement; and
 - d. It shall not contain references to any other agreements or documents except as provided for under paragraph (11) of this subsection.
- 5. The trust agreement shall be established for the sole benefit of the beneficiary.
 - 6. The trust agreement shall require the trustee to:
 - a. Receive assets and hold all assets in a safe place;
 - b. Determine that all assets are in such form that the beneficiary, or the trustee upon direction by the beneficiary, may whenever necessary negotiate any such assets, without consent or signature from the grantor or any other person or entity;
 - c. Furnish to the grantor and the beneficiary a statement of all assets in the trust account upon its inception and at intervals no less frequent than the end of each calendar quarter;
 - d. Notify the grantor and the beneficiary within 10 days of any deposits to or withdrawals from the trust account;
 - e. Upon written demand of the beneficiary, immediately take any and all steps necessary to transfer absolutely and unequivocally all right, title and interest in the assets held in the trust account to the beneficiary and deliver physical custody of the assets to the beneficiary; and
 - f. Allow no substitutions or withdrawals of assets from the trust account, except on written instructions from the beneficiary, except that the trustee may, without the consent of but with notice to the beneficiary, upon call or maturity of any trust asset, withdraw such asset upon condition that the proceeds are paid into the trust account.
 - 7. The trust agreement shall provide that at least 30 days, but not more than 45 days, prior to termination of the trust account, written notification of termination shall be delivered by the trustee to the beneficiary.
 - 8. The trust agreement shall be made subject to and governed by the laws of the state in which the trust is established.
 - 9. The trust agreement shall prohibit invasion of the trust corpus for the purpose of paying compensation to, or reimbursing the expenses of, the trustee.
 - 10. The trust agreement shall provide that the trustee shall be liable for its own negligence, willful misconduct or lack of good faith.
 - 11. Notwithstanding other provisions of this rule, when a trust agreement is established in conjunction with a reinsurance agreement covering risks other than life, annuities and accident and health, where it is customary practice to provide a trust agreement for a specific purpose, such a trust agreement may provide that the ceding insurer shall undertake to use and apply amounts drawn upon the trust account, without diminution because of the insolvency of the ceding insurer or the assuming insurer, for the following purposes:
 - a. To pay or reimburse the ceding insurer for the assuming insurer's share under the specific reinsurance agreement regarding any losses and allocated

loss expenses paid by the ceding insurer, but not recovered from the assuming insurer, or for unearned premiums due to the ceding insurer if not otherwise paid by the assuming insurer;

- b. To make payment to the assuming insurer of any amounts held in the trust account that exceed 102% of the actual amount required to fund the assuming insurer's obligations under the specific reinsurance agreement; or
 - c. Where the ceding insurer has received notification of termination of the trust account and where the assuming insurer's entire obligations under the specific reinsurance agreement remain unliquidated and undischarged 10 days prior to the termination date, to withdraw amounts equal to the obligations and deposit those amounts in a separate account, in the name of the ceding insurer in any qualified United States financial institution as defined in A.R.S. § 20-261.03 apart from its general assets, in trust for such uses and purposes specified in subparagraphs (a) and (b) above as may remain executory after such withdrawal and for any period after the termination date.
12. The trust agreement shall provide that assets deposited in the trust account shall be valued according to their current fair market value and shall consist only of cash (United States legal tender), certificates of deposit (issued by a United States bank and payable in United States legal tender), and investments of the type permitted by A.R.S. Title 20, Chapter 3 or any combination of the above, provided that such investments are issued by an institution that is not the parent, subsidiary or affiliate of either the grantor or the beneficiary. The trust agreement shall further specify the types of investments to be deposited.

C. Permitted conditions

1. The trust agreement may provide that the trustee may resign upon delivery of a written notice of resignation, effective not less than 90 days after receipt by the beneficiary and grantor of the notice and that the trustee may be removed by the grantor by delivery to the trustee and the beneficiary of a written notice of removal, effective not less than 90 days after receipt by the trustee and the beneficiary of the notice, provided that no such resignation or removal shall be effective until a successor trustee has been duly appointed and approved by the beneficiary and the grantor and all assets in the trust have been duly transferred to the new trustee.
2. The grantor may have the full and unqualified right to vote any shares of stock in the trust account and to receive from time to time payments of any dividends or interest upon any shares of stock or obligations included in the trust account. Any such interest or dividends shall be either forwarded promptly upon receipt to the grantor or deposited in a separate account established in the grantor's name.
3. The trustee may be given authority to invest, and accept substitutions of, any funds in the account, provided that no investment or substitution shall be made without prior approval of the beneficiary, unless the trust agreement specifies categories of investments acceptable to the beneficiary and authorizes the trustee to invest funds and to accept substitutions which the trustee determines are at least equal in market value to the assets withdrawn and that are consistent with the restrictions in subsection (D)(1)(b) of this rule.
4. The trust agreement may provide that the beneficiary may at any time designate a party to which all or part of the

trust assets are to be transferred. Such transfer may be conditioned upon the trustee receiving, prior to or simultaneously with, other specified assets.

5. The trust agreement may provide that, upon termination of the trust account, all assets not previously withdrawn by the beneficiary shall, with written approval by the beneficiary, be delivered over to the grantor.
- D. Additional conditions applicable to reinsurance agreements entered into in conjunction with trust agreements.**
1. A reinsurance agreement entered into in conjunction with a trust agreement and the establishment of a trust account may contain provisions that:
 - a. Require the assuming insurer to enter into a trust agreement and to establish a trust account for the benefit of the ceding insurer, and specifying what the agreement is to cover;
 - b. Stipulate that assets deposited in the trust account shall be valued according to their current fair market value and shall consist only of cash (United States legal tender), certificates of deposit (issued by a United States bank and payable in United States legal tender), and investments of the types permitted by A.R.S. Title 20, Chapter 3 or any combination of the above, provided that such investments are issued by an institution that is not the parent, subsidiary or affiliate of either the grantor or the beneficiary. The reinsurance agreement may further specify the types of investments to be deposited;
 - c. Require the assuming insurer, prior to depositing assets with the trustee, to execute assignments or endorsements in blank, or to transfer legal title to the trustee of all shares, obligations or any other assets requiring assignments, in order that the ceding insurer, or the trustee upon the direction of the ceding insurer, may whenever necessary negotiate these assets without consent or signature from the assuming insurer or any other entity;
 - d. Require that all settlements of account between the ceding insurer and the assuming insurer be made in cash or its equivalent; and
 - e. Stipulate that the assets in the trust account, established pursuant to the provisions of the reinsurance agreement, may be withdrawn by the ceding insurer at any time, notwithstanding any other provisions in the reinsurance agreement and shall be utilized and applied by the ceding insurer or its successors in interest by operation of law, including without limitation any liquidator, rehabilitator, receiver or conservator of such company, without diminution because of insolvency on the part of the ceding insurer or the assuming insurer, only for the following purposes:
 - i. To reimburse the ceding insurer for the assuming insurer's share of premiums returned to the owners of policies reinsured under the reinsurance agreement because of cancellations of such policies;
 - ii. To reimburse the ceding insurer for their assuming insurer's share of surrenders and benefits or losses paid by the ceding insurer pursuant to the provisions of the policies reinsured under the reinsurance agreement;
 - iii. To fund an account with the ceding insurer in an amount at least equal to the deduction, for reinsurance ceded, from the ceding insurer's liabilities for policies ceded under the agree-

ment. The account shall include, but not be limited to, amounts for policy reserves, claims and losses incurred (including losses incurred but not reported), loss adjustment expenses and unearned premium reserves; and

- iv. To pay any other amounts the ceding insurer claims are due under the reinsurance agreement.
- f. Give the assuming insurer the right to seek approval from the ceding insurer to withdraw from the trust account all or any part of the trust assets and transfer those assets to the assuming insurer, provided:
 - i. The assuming insurer shall, at the time of withdrawal, replace the withdrawn assets with other qualified assets having a market value equal to the market value of the assets withdrawn so as to maintain at all times the deposit in the required amount, or
 - ii. After withdrawal and transfer, the market value of the trust account is no less than 102% of the required amount.
 - iii. The ceding insurer shall not unreasonably or arbitrarily withhold its approval.
- g. Provide for:
 - i. The return of any amount withdrawn in excess of the actual amounts required for subsections (D)(1)(e)(i), (ii) and (iii), or in the case of subsection (D)(1)(e)(iv), any amounts that are subsequently determined not to be due; and
 - ii. Interest payments, at a rate not in excess of the prime rate of interest of the trustee, on the amounts held pursuant to subsection (D)(1)(e)(iii).
- h. Permit the award by any arbitration panel or court of competent jurisdiction of:
 - i. Interest at a rate different from that provided in subparagraph (g)(ii),
 - ii. Court or arbitration costs,
 - iii. Attorney's fees, and
 - iv. Any other reasonable expenses.
- E. Financial reporting. A trust agreement may be used to reduce any liability for reinsurance ceded to an unauthorized assuming insurer in financial statements required to be filed with the Director in compliance with the provisions of this rule when established on or before the date of filing of the financial statement of the ceding insurer. Further, the reduction for the existence of an acceptable trust account may be up to the current fair market value of acceptable assets available to be withdrawn from the trust account at that time, but such reduction shall be no greater than the specific obligations under the reinsurance agreement that the trust account was established to secure.
- F. Existing agreements. Notwithstanding the effective date of this rule, any trust agreement or underlying reinsurance agreement in existence and approved by the Director prior to the effective date of this rule will continue to be acceptable until December 31, 1993, after which time the agreements will have to be in full compliance with the requirements of this rule for the trust agreement to be acceptable.
- G. Effect of failure to identify beneficiary. The failure of any trust agreement to specifically identify the beneficiary as defined in subsection (A) of this rule shall not be construed to affect any actions or rights which the Director may take or possess pursuant to the provisions of the laws of this state.

Historical Note

Adopted effective February 3, 1993 (Supp. 93-1). R20-6-1603 recodified from R4-14-1603 (Supp. 95-1).

R20-6-1604. Letters of Credit

- A. For purposes of A.R.S. § 20-261.02, a letter of credit shall contain an issue date, and an expiration date subject to the "evergreen clause" in subsection (D) of this Section. The letter of credit shall state that:
 - 1. The beneficiary need only draw a sight draft under the letter of credit and present it to obtain funds and that no other document need be presented for payment;
 - 2. The letter of credit is not subject to any conditions or qualifications not contained in the letter of credit; and
 - 3. The letter of credit does not contain reference to any other agreements, documents, or entities, except as provided in subsection (H)(1). As used in this Section, "beneficiary" includes any successor of the named beneficiary by operation of law, including any receiver, conservator, rehabilitator, or liquidator.
- B. The heading of the letter of credit may include a boxed section for use by the issuing bank, which contains the name of the applicant and other notations to provide a reference for the letter of credit. The boxed section shall be clearly marked to indicate that the information is for internal purposes only.
- C. A letter of credit shall state that the obligation of a qualified United States financial institution under the letter of credit is not contingent upon reimbursement.
- D. The term of the letter of credit shall be for no less than one year, and the letter of credit shall contain an "evergreen clause" which prevents the expiration of the letter of credit without due notice from the issuer. The "evergreen clause" shall provide for no less than 30 days' notice before expiration or nonrenewal.
- E. The letter of credit shall state whether it is subject to and governed by the laws of any state or the Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce, 1993 Revision (Publication 500) incorporated by reference and on file with the Office of the Secretary of State and available from ICC Publications, 156 Fifth Avenue, New York, New York 10010. This incorporation by reference contains no future additions or amendments. All drafts of letters of credit drawn according to Publication 500 shall be presentable at an office in the United States of a qualified United States financial institution.
- F. A letter of credit made subject to the Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce shall specifically provide for an extension of time to draw against the letter of credit if one or more of the occurrences specified in Article 17 of Publication 500 occur.
- G. If the letter of credit is issued by a financial institution other than a qualified United States financial institution as defined in A.R.S. § 20-261.03, then the letter of credit shall be confirmed by a qualified United States financial institution, and the following additional requirements shall be met:
 - 1. The financial institution issuing the letter of credit shall designate the confirming qualified United States financial institution as its agent for the receipt and payment of the drafts of the letter of credit, and
 - 2. The letter of credit shall contain an "evergreen clause."
- H. Reinsurance agreement provisions.
 - 1. The reinsurance agreement for which the letter of credit is obtained may:
 - a. Require the assuming insurer to provide a letter of credit to the ceding insurer and specify what it covers.

- b. Stipulate that the letter of credit provided by the assuming insurer under the reinsurance agreement may be drawn upon at any time, notwithstanding any other provisions in the agreement. The agreement shall be used by the ceding insurer or its successors in interest only for the following:
 - i. To reimburse the ceding insurer for the assuming insurer's share of premiums returned to the owners of the policies reinsured under the reinsurance agreement because of cancellation of the policies;
 - ii. To reimburse the ceding insurer for the assuming insurer's share of surrenders and benefits or losses paid policy owners and claimants by the ceding insurer under the policies reinsured under the reinsurance agreement;
 - iii. To fund an account with the ceding insurer in an amount at least equal to the deduction, for reinsurance ceded, from the ceding insurer's liabilities for policies ceded under the agreement. The amount shall include, but not be limited to, amounts for policy reserves, claims and losses incurred, and unearned premium reserves; and
 - iv. To pay any other amounts the ceding insurer claims under the reinsurance agreement.
- c. Require that the provisions of subsections (H)(a) and (b) be applied without diminution because of insolvency of the ceding insurer or assuming insurer.
- 2. Nothing contained in subsection (H)(1) precludes the ceding insurer and assuming insurer from providing:
 - a. An interest payment, at a rate not in excess of the prime rate of interest of a qualified United States financial institution as defined in A.R.S. § 20-261.03 issuing or confirming the letter of credit, on the amount held under subsection (H)(1)(b)(iii); and
 - b. The return of any amount drawn on a letter of credit which is in excess of the actual amount due or, in the case of subsection (H)(1)(b)(iv), any amount not payable.
- 3. If an insurer obtains a letter of credit in conjunction with a reinsurance agreement that covers risks other than life, annuities, and health, and it is customary practice to provide a letter of credit for a specific purpose, then the reinsurance agreement may state, instead of subsection (H)(1)(b)(iv) that the parties enter into a "Trust Agreement." The trust agreement may be incorporated into the reinsurance agreement or it may be a separate document.
- I. A letter of credit may not be used to reduce any liability for reinsurance ceded to an unauthorized assuming insurer in a financial statement required to be filed with the Director

unless a letter of credit naming the filing ceding insurer as beneficiary is issued on or before December 31 in the year for which the filing of the financial statement is made. The reduction in liability for the letter of credit may be up to the amount available under the letter of credit but no greater than the specific obligation the reinsurance agreement secures.

Historical Note

Adopted effective February 3, 1993 (Supp. 93-1). R20-6-1604 recodified from R4-14-1604 (Supp. 95-1).
Amended effective October 9, 1998 (Supp. 98-4).

R20-6-1605. Other Security

A ceding insurer may take credit for unencumbered funds withheld by the ceding insurer in the United States subject to withdrawal solely by the ceding insurer and under its exclusive control.

Historical Note

Adopted effective February 3, 1993 (Supp. 93-1). R20-6-1605 recodified from R4-14-1605 (Supp. 95-1).

R20-6-1606. Reinsurance Contract

Credit shall not be granted to a ceding insurer for reinsurance effected with assuming insurers meeting the requirements of R20-6-1601 or R20-6-1602 of this Article or otherwise in compliance with A.R.S. § 20-261.01 after the adoption of this Article unless the reinsurance agreement:

1. Includes a proper insolvency clause pursuant to A.R.S. § 20-261(C); and
2. Includes a provision pursuant to A.R.S. § 20-261.01(A)(6) and (B) when applicable whereby the assuming insurer, if an unauthorized assuming insurer, has submitted to the jurisdiction of an alternative dispute resolution panel or court of competent jurisdiction within the United States, has agreed to comply with all requirements necessary to give such court or panel jurisdiction, has designated an agent upon whom service of process may be effected, and has agreed to abide by the final decision of such court or panel.

Historical Note

Adopted effective February 3, 1993 (Supp. 93-1). R20-6-1606 recodified from R4-14-1606 (Supp. 95-1).

R20-6-1607. Contracts Affected

All new and renewal reinsurance transactions entered into after the effective date of this rule shall conform to the requirements of A.R.S. § 20-261.01 and this Article if credit is to be given to the ceding insurer for such reinsurance.

Historical Note

Adopted effective February 3, 1993 (Supp. 93-1). R20-6-1607 recodified from R4-14-1607 (Supp. 95-1).

Department of Insurance

State of _____)
County of _____) S.S.

On this _____ day of _____, 19____, before me, _____
the undersigned officers, personally appeared _____ President, _____ and _____

_____, Secretary, who acknowledged themselves to be the President and Secretary respectively, of _____ a corporation, and that they as such President and Secretary, respectively, being authorized to do so, executed the foregoing instrument for the purpose therein contained, by signing the name of the corporation by the President, attested by the Secretary, and affixing the corporate seal thereto.

IN WITNESS WHEREOF I hereto set my hand and official seal.

Notary Public

(Seal)

Commission expires: _____

Historical Note

Adopted effective February 3, 1993 (Supp. 93-1)

Department of Insurance

**EXHIBIT B
CERTIFIED COPY OF RESOLUTION**

At a meeting of the Board of Directors of this _____ (full and exact corporate name)
held
on the _____ day of _____, 19_____, at its office, a quorum of said Board was present, and, on motion, the
following resolution was duly passed by said Board:

RESOLVED, that this

(full and exact corporate name)

hereby authorizes its President and Secretary, under its corporate seal, to irrevocably appoint the Director of Insurance of the State of Arizona, and his or her successor or successors in office, its true and lawful attorney in and for the State of Arizona, upon whom all lawful process in any action, suit or legal proceeding against it, including any such action, suit or proceeding instituted by or on behalf of any ceding insurer domiciled in the State of Arizona, may be served.

It hereby further agrees that any lawful process against it, which is served upon and forwarded by said attorney by registered mail to the person last so designated by it to receive process, shall be of the same legal force and validity as if served personally upon it, and shall be deemed sufficient service, and that the appointment and authority of said attorney shall continue so long as any of its liability remains outstanding in said state, and that its removal from said state or dissolution shall not take away or impair the right to commence any action or legal proceeding against it, in the manner herein provided, upon a liability previously incurred.

And that it hereby further agrees that when any lawful process against or affecting it is served upon said Director of insurance, a copy of said proceedings shall be mailed to:

And that it hereby further agrees that its President and Secretary are authorized and instructed to execute and deliver in its name and on its behalf, a Power of Attorney and Certificate of Assuming Insurer, in accordance with this resolution.

* * * * *

I hereby certify that the above is a correct copy of the resolution of the Board of Directors of the said

(full and exact corporate name)

(Seal)

Secretary

Historical Note
Adopted effective February 3, 1993 (Supp. 93-1).

ARTICLE 17. EXAMINATIONS**R20-6-1701. Definitions**

- A. "Company" means any person engaging in or proposing or attempting to engage in any transaction or kind of insurance or surety business and any person or group of persons who may otherwise be subject to the administrative, regulatory or taxing authority of the Director.
- B. "Examination" shall be defined for purposes of this Article to mean any examination relating to the financial condition of a company.
- C. "Examiner" means any individual or firm having been authorized by the Director to conduct an examination under this Article.

Historical Note

Adopted effective February 22, 1993 (Supp. 93-1). R20-6-1701 recodified from R4-14-1701 (Supp. 95-1).

R20-6-1702. Authority, Scope, and Scheduling of Examinations

- A. The Director shall examine an insurer under A.R.S. § 20-156(A) at least once every five years.
- B. Instead of the examination under subsection (A), the Director may accept the most recent examination report prepared by the National Association of Insurance Commissioners insurance regulatory authority of another state on any foreign or alien insurer if:
 - 1. The insurance regulatory authority was accredited under the National Association of Insurance Commissioners' Financial Regulation Standards and Accreditation Program at the time of the examination,
 - 2. A National Association of Insurance Commissioners accredited insurance regulatory authority supervised the examination, or
 - 3. At least one examiner employed or contracted by a National Association of Insurance Commissioners accredited insurance regulatory authority:
 - a. Participated in and reviewed the examination work papers and report, and
 - b. Signed an affidavit stating that the examination was performed in a manner consistent with the standards and procedures required by the National Association of Insurance Commissioners accredited insurance regulatory authority.

Historical Note

Adopted effective February 22, 1993 (Supp. 93-1).
 Amended effective October 27, 1993 (Supp. 93-4). R20-6-1702 recodified from R4-14-1702 (Supp. 95-1).
 Amended by final rulemaking at 11 A.A.R. 2975, effective September 10, 2005 (Supp. 05-3).

R20-6-1703. Conduct of Examinations

- A. Upon determining that an examination should be conducted, the Director or the Director's designee shall issue an examination warrant appointing one or more examiners to perform the examination and instructing them as to the scope of the examination.
- B. Nothing contained in this Article shall be construed to limit the Director's authority to terminate or suspend any examination in order to pursue other legal or regulatory action pursuant to the insurance laws of this state or to pursue such action concurrent with the examination.
- C. The Director may disclose the content of an examination report, preliminary examination report or results, or any matter relating thereto, to the insurance department of any other state or country or to law enforcement officials of this or any other state or agency of the federal government at any time. Prior to

making such disclosure, the Director may require such other department or office to agree in writing to hold as confidential the examination report, preliminary examination report or results or any matter relating thereto until such time as the examination report, preliminary examination report or results or matter relating thereto are made public by the Director.

Historical Note

Adopted effective February 22, 1993 (Supp. 93-1). R20-6-1703 recodified from R4-14-1703 (Supp. 95-1).

R20-6-1704. Examination Reports

- A. All examination reports shall be comprised of only facts appearing upon the books, records, or other documents of the company, its agents or other persons examined, or as ascertained from the testimony of its officers or agents or other persons examined concerning its affairs, and such conclusions and recommendations as the examiners find warranted from the facts.
- B. No later than 60 days following completion of the examination, the examiner in charge shall submit to the Department a verified written report of examination under oath. Upon receipt of the verified report, the Department shall transmit the report to the company examined, together with a notice which shall afford the company examined a reasonable opportunity of not less than 10 days nor more than 30 days to make a written submission or rebuttal with respect to any matters contained in the examination report.
- C. Within 30 days after the end of the period allowed for the receipt of written submissions or rebuttals, the Director shall fully consider and review the report, together with any written submissions or rebuttals and any relevant portions of the examiner's workpapers and shall:
 - 1. File the examination report as submitted or with modification or corrections. If the examination report reveals that the company is operating in violation of any law, regulation or prior order of the Director, the Director may order the company to take any action necessary and appropriate to cure such violation; or
 - 2. Reject the examination report with directions to the examiners to reopen the examination for purposes of obtaining additional data, documentation or information, and resubmission pursuant to subsection (B).

Historical Note

Adopted effective February 22, 1993 (Supp. 93-1). R20-6-1704 recodified from R4-14-1704 (Supp. 95-1).

ARTICLE 18. PREPAID DENTAL PLAN ORGANIZATIONS**R20-6-1801. Definitions**

In this Chapter, the following definitions apply:

"Appointment" means a first-available, initial, non-emergent, diagnostic visit to a dentist.

"Board certified" means a dentist who is recognized by the appropriate specialty board of the Commission on Accreditation of Dental Education of the American Dental Association.

"Board eligible" means a dentist who successfully completes an approved training program in a specialty field recognized by the American Dental Association.

"Chief executive officer" means the person who has the authority and responsibility for the operation of a prepaid dental plan Organization according to applicable legal requirements and policies approved by the governing authority.

"Dental hygienist" means a person who is licensed to practice dental hygiene under A.R.S. § 32-1281 et seq.

Department of Insurance

“Dentist” means a person who is licensed to practice dentistry under A.R.S. § 32-1201 et seq.

“Department” means the Arizona Department of Insurance.

“Diagnostic service” means a dental service intended to identify a dental abnormality, and includes a radiograph and a clinical exam.

“Director” means the director of the Arizona Department of Insurance.

“Emergency dental service” means a dental service intended to evaluate and stabilize a dental condition of recent onset, control bleeding, and relieve pain, and includes the provision of local anesthesia, and elimination of acute infection, but does not mean a medication that is prescribed by the dentist.

“General dentist” means a dentist whose practice is not limited to a specific area and who is not board certified.

“Governing authority” means the persons, including a board of trustees or board of directors, who have the ultimate authority and responsibility for the direction of a prepaid dental plan Organization.

“Organization” means a prepaid dental plan organization as defined in A.R.S. § 20-1001.

“Patient” means a person who is being attended by a dentist or dental hygienist to receive an examination, diagnosis, or dental treatment, or a combination of an examination, diagnosis, and dental treatment.

“Preventive service” means dental care intended to maintain dental health and prevent dental disease, including any combination of oral hygiene education, routine prophylaxis, and application of fluorides.

“Prophylaxis” means cleaning the teeth of a patient with healthy tissue using mild abrasives and dental instruments to remove plaque, calculus, and stains above the gum line.

“Provider directory” means an Organization’s published listing of all contracted network dentists.

“Radiograph” means a picture produced on a sensitive surface by a form of radiation other than light, including x-ray.

“Restorative service” means the use of a metal or composite filling or crown.

“Specialist” means a dentist whose practice is limited to one of the nine specialty categories recognized by the American Dental Association: endodontics, oral and maxillofacial surgery, oral and maxillofacial radiology, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics, prosthodontics, oral pathology, or dental public health.

“Treatment plan” means a statement of the services to be performed to eliminate or alleviate a patient’s symptoms or disease, based on a dentist’s assessment of the patient’s dental history, the clinical examination, and the dentist’s diagnosis.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

R20-6-1802. Application for Certificate of Authority

- A. A person who wishes to operate as prepaid dental plan organization in Arizona shall file an application for certificate of authority under A.R.S. § 20-1003 for the director’s review and approval under A.R.S. § 20-1004. The application shall contain all the information required in A.R.S. § 20-1003 and R20-6-1802.

- B. An authorized insurer shall issue the fidelity bond required under A.R.S. § 20-1004(A)(4).
- C. An Organization shall not commence operation of, or service under, a prepaid dental plan without approval of the director under A.R.S. § 20-1004.
- D. An application is deemed filed with the director when the director receives it. The applicant shall include fees under A.R.S. § 20-167 with the application.
- E. An applicant not domiciled in this state shall file a power of attorney as required by A.R.S. § 20-1003(A)(11) on a Department-prescribed form, with the application.
- F. Within 180 days after the director issues a certificate of authority to an Organization, the Organization shall notify the director in writing of each member appointed to the board of directors for the Organization under A.R.S. § 20-1003(A)(4).
- G. At the time it submits its application for certificate of authority, an Organization shall submit a written program of compliance with supporting documents that specify how the Organization will comply with the provisions of this Article. The written program of compliance shall contain the following:
1. The responsibilities of and qualifications for the following positions:
 - a. The Organization’s chief executive officer, and
 - b. The Organization’s dental director;
 2. A plan for provision of basic dental services required under R20-6-1806(A) and a copy of the schedule of benefits required under R28-6-1806(B);
 3. A description of the system for delivery of services under R20-6-1807;
 4. A description of the geographic area designated under R20-6-1808;
 5. A plan for compliance with contract requirements under R20-6-1809 and a copy of a contract with a general dentist and a specialist;
 6. A plan for compliance with records requirements under R20-6-1810; and
 7. The Organization’s quality improvement plan under R20-6-1811.
- H. An application shall include the following information:
1. The proposed number of members, and
 2. A copy of a letter from each network dentist that documents the dentist’s intent to contract with the Organization to provide services to patients under the Organization’s prepaid dental plan.
- I. The director may require that an applicant for a certificate of authority under A.R.S. § 20-1003(A)(14) submit information that discloses biographical, employment and business financial history, criminal activity, fingerprints, or any information that relates to the ability to operate a prepaid dental plan for principals, principal officers, controlling persons, and insurance producers of the applicant, if necessary for the protection of residents of this State.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

R20-6-1803. Chief Executive Officer

- A. The governing authority shall appoint a chief executive officer (CEO). The CEO shall have:
1. The education and experience to manage the Organization, and
 2. Responsibility for the geographic area in Arizona that the Organization serves, including:
 - a. Implementing the policies of the governing authority, and

- b. Maintaining adequate personnel to ensure compliance with applicable Arizona statutes and rules.
- B. The governing authority shall notify the Department within ten days after the effective date of a change in the appointment of the CEO.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

R20-6-1804. Dental Director

- A. The governing authority or CEO shall appoint as the Organization's dental director a dentist licensed to practice dentistry in any state or territory of the United States or the District of Columbia.
- B. The dental director shall perform at least the following functions for the Organization's geographic area in Arizona:
 - 1. Participate on the Organization's quality improvement committee required under R20-6-1811;
 - 2. Oversee the Organization's program and processes for:
 - a. Maintaining and improving clinical quality of care, including continuity of care;
 - b. Provider relations;
 - c. Facility and dental record reviews; and
 - d. Provider credentialing and recredentialing;
 - 3. Be knowledgeable about and participate in decisions regarding the Organization's operations;
 - 4. Comply with A.R.S. § 20-2510(B) and (C) when directly denying, on the basis of medical necessity, a health care provider's request for prior authorization; and
 - 5. Timely respond to matters within the Organization's Arizona geographic area that require personal onsite attention or ensure that a designee who meets the requirements specified in subsection (D) timely responds to those matters.
- C. Matters that require personal onsite attention include:
 - 1. Urgent patient care issues that require examination of dental records or X-rays;
 - 2. Prompt personal discussion with a provider of urgent concerns relating to credentialing, disciplinary problems, access to care, or quality of care.
- D. Any designee acting under subsection (B)(5) shall:
 - 1. Be a dentist licensed to practice dentistry in any state or territory of the United States or the District of Columbia;
 - 2. Have expedient access to the dental director, the CEO, and other organization management personnel as necessary to resolve any matter requiring personal onsite attention; and
 - 3. Have the education, experience, and Organizational knowledge required to address the matter requiring personal onsite attention.
- E. The Organization shall notify the Department in writing within ten days after the effective date of a change in the appointment of the dental director or any designee.
- F. The requirements for a designee under subsections (B)(5), (D), and (E) shall not apply to an Organization with fewer than 2,000 members in Arizona.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

R20-6-1805. Required Reporting

- A. An Organization shall submit to the Department in writing for review any proposed change to the program of compliance. The Department shall notify the Organization in writing within 30 days of receipt of the proposed change whether the submission is administratively complete. The Department shall com-

plete its substantive review and notify the Organization of approval or disapproval of the proposed change within 60 days of notification of administrative completeness.

- B. An Organization shall provide the following information about the prepaid dental plan to the Department quarterly:
 - 1. The total number of members and the number of members assigned to each general dentist's office;
 - 2. A list of all contracted network general dentists and specialists that notes those who have been added or deleted since the previous quarterly report;
 - 3. Verification that each specialist added to the network since the last quarterly report has graduated from a specialty graduate program accredited by the American Dental Association; Documentation of the Organization's quality improvement activities, including the number of providers who have been credentialed or re-credentialed since the last quarterly report, the number of facility reviews, and the number of chart reviews;
 - 4. The average wait time measured in weeks for an appointment for each network dentistry office;
 - 5. A copy of the current provider directory; and
 - 6. A complaint log with a summary of Organization responses by complaint category.
- C. An Organization shall submit the following information to the Department at least annually:
 - 1. Member satisfaction survey results and supporting data;
 - 2. Results of a survey of network general dentistry offices with supporting data confirming a recall system under R20-6-1809(B)(2);
 - 3. An electronic database that lists the name, address, and telephone number of each provider and whether the provider is accepting new members. The Organization shall submit the database for general dentists and specialists separately. The Organization shall submit any changes to this database to the Department quarterly; and
 - 4. A report that compiles all the copays listed in all the schedules of benefits offered by the Organization, with comparisons of the copays to the usual, customary, and reasonable fees, as determined by the Organization, for the procedures listed on the schedule of benefits.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

R20-6-1806. Basic Dental Services

- A. A prepaid dental plan shall provide the basic dental services listed below:
 - 1. Emergency dental services on a 24-hour-per-day basis,
 - 2. Diagnostic services,
 - 3. Preventive services, and
 - 4. Restorative services.
- B. An Organization shall publish and make available to its members and purchasers a schedule of benefits that includes the dental plan's basic dental services and other available dental services and any associated copays.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

R20-6-1807. System for Delivery of Services

- A. An Organization shall have a system for delivery of services that includes:
 - 1. An adequate network of general dentists. To determine network adequacy, the Department shall consider the following:

- a. Geographic distribution of network general dentists' offices,
 - b. The number of dental offices accepting new members,
 - c. The percentage of all network members who are able to schedule an appointment within nine weeks,
 - d. The availability of trained clinical support staff in the Arizona geographic area,
 - e. The ratio of population growth to the increase or decrease in the number of dentists in the Arizona geographic area, and
 - f. Current availability for appointments in all general dentist practices in Arizona; and
2. Provision for using specialists for dental services that cannot be provided by the Organization's network of contracted specialists, if the services are covered benefits.
- B.** If a network dental office that is open to new members has an appointment wait time of longer than nine weeks, for three consecutive calendar quarters, the director may require the Organization to close the office to new members until the wait time is less than nine weeks.
- C.** If more than 15% of the network offices that are open to new members have an appointment wait time of longer than nine weeks, the Organization shall submit a plan to the Department under which the Organization will, within 90 days, reduce the wait time to less than nine weeks. If the Organization does not reduce the wait time to less than nine weeks within the 90 day period the Organization shall refer the members who are waiting for an appointment to another network general dentist or a non-network general dentist who can schedule the member for an appointment in less than nine weeks. The member may choose to continue dental care under the prepaid dental plan with the referred dentist for the remainder of the member's enrollment period. The Organization shall provide the non-network services to the referred member at a cost that is no greater than if the services are provided by the member's assigned network dentist.
- D.** An Organization shall pay for emergency dental services provided to a member by a dentist licensed in the jurisdiction where the services are provided, subject to plan limitations disclosed in the dental care plan, including emergency dental services that occur:
- 1. Within the geographic area served by the member's designated provider but the provider is unavailable, or
 - 2. Occurs outside of the member's designated geographic service area.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

R20-6-1808. Geographic Areas

- A.** An Organization shall designate the geographic areas in Arizona in which the Organization intends to provide dental services that are reasonably convenient to the prospective members. The Organization shall provide a description of the geographic areas and locations of all facilities in which dental care will be provided under the prepaid dental plan. This information shall accompany or be included in any advertisements or sales materials provided to prospective employer groups and prospective members.
- B.** An Organization shall define its geographic areas by citing at least one of the following:
- 1. Local government jurisdictions, such as cities or counties;
 - 2. Street boundaries; or
 - 3. Area within a specified radius of an intersection.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

R20-6-1809. Contract Requirements

- A.** An Organization shall have a written contract with each provider that documents the requirements for providing services under the prepaid dental plan and the terms of the agreements between the parties. The Organization shall ensure that the provider complies with all contract requirements.
- B.** In addition to the requirements in subsection (A), an Organization shall ensure that its contract with a provider includes the following provisions:
- 1. That the Organization has authority to review the provider's records,
 - 2. That the provider is responsible to implement and maintain a process to inform assigned members of the need to schedule periodic preventive dental services based on the member's oral health status, and
 - 3. That the provider is responsible to complete any procedure undertaken upon a member if the contract is terminated or expires.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

R20-6-1810. Records

- A.** Dental records are the property of the provider and shall not be removed from the provider's possession, except:
- 1. With the patient's permission, including for routing records to a dental or medical practitioner for consultation or evaluation; or
 - 2. When subpoenaed by a court or BODEX.
- B.** An Organization shall maintain at its principal office a copy of each issued or delivered advertising matter or sales material, letter of solicitation, evidence of coverage, provider directory, certificate, agreement, or contract. The Organization shall note the date each advertising matter or sales material is filed with the Department and the date of distribution to any person. The advertising matter or sales material shall be maintained for at least three years.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

R20-6-1811. Quality Improvement

- A.** An Organization shall have a governing authority.
- B.** The governing authority shall appoint a quality improvement committee that consists of the chief executive officer or designee, the dental director, the person who manages the Organization's quality improvement process, and at least one dental health professional. The committee may also include network allied health professionals and members of the plan.
- C.** The quality improvement committee shall:
- 1. Meet at least quarterly,
 - 2. Review and evaluate dental services delivered under the Organization's plan, and
 - 3. Establish procedures for recordkeeping and distribution of committee reports.
- D.** An Organization shall provide the director with a copy of the minutes of each quality improvement committee meeting within 30 days of the quality improvement committee meeting.
- E.** An Organization shall maintain a written quality improvement plan that contains procedures for each of the following:
- 1. Ensuring that a dentist licensed in any state or territory of the United States or District of Columbia reviews and

- evaluates dental care and services provided by each contracted general dentist at least once every three years;
2. Allocation of the Organization's resources to analyze a problem or any identified deficiency;
 3. Implementing a corrective action plan and methods for monitoring improvement;
 4. Notifying a member in writing of the member's responsibility to cooperate with those providing dental care services and of the member's rights to:
 - a. Voice concerns about the Organization or care provided;
 - b. Be provided with information about the Organization, its services, providers, and member rights and responsibilities;
 - c. Participate in decisions about the member's dental care; and
 - d. Be treated with respect and have the right to privacy recognized;
 5. Monitoring and improving membership satisfaction;
 6. Maintaining an accurate provider directory that meets at least the following requirements:
 - a. Lists only credentialed providers who are currently scheduling members for diagnosis and treatment; and
 - b. Clearly designates providers who are not accepting new members;
 7. Review by the dental director of the following for initial credentialing of network providers:
 - a. Query to the National Practitioner Data Bank;
 - b. Query to BODEX;
 - c. Valid United States Drug Enforcement Administration certificate, if applicable;
 - d. Evidence of current malpractice insurance; and
 - e. Documentation that each specialist has graduated from an accredited specialty graduate program as required by BODEX.
 8. Recredentialing, at least every three years, that updates information obtained in subsections (E)(7)(b) through (d), for the dental director's review.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

R20-6-1812. Confidentiality of Records

An Organization shall not disclose information obtained pertaining to the diagnosis, treatment, or health of a member to any person except:

1. To the extent necessary to carry out this Article;
2. Upon the express written consent of the member, applicant, provider, or Organization, as appropriate; or
3. Under statute or court order for the production or discovery of evidence or as part of a civil or criminal investigation.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

R20-6-1813. Assignment of Members

- A. Within 30 days of enrollment, an Organization shall assign a member to the provider the member chooses. The Organization, however, shall choose and assign a provider to a member within 30 days of any of the following:
 1. Receipt of a member enrollment form that does not designate a provider, or receipt of a member enrollment form that designates a provider who is unavailable;

2. The date of the notice that the member's assigned provider intends to cease providing services; or
 3. The date the member's assigned provider becomes unavailable, for any reason.
- B. An Organization shall give each member the option of selecting a network provider other than the provider assigned by the Organization under subsection (A).
 - C. An Organization shall maintain a continuous assignment process in compliance with subsection (A) and (B), allowing no more than 4% of members to be unassigned at any time.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

ARTICLE 19. HEALTH CARE SERVICES ORGANIZATIONS OVERSIGHT

R20-6-1901. Applicability

- A. This Article applies to:
 1. All proposed and existing health care services organizations (HCSOs), and
 2. Each product offered by an HCSO under the HCSO's certificate of authority.
- B. The Department shall not issue a certificate of authority to an HCSO unless the HCSO meets the requirements of this Article.
- C. The Department shall not require an existing HCSO to re-file information already on file with the Department, but the HCSO shall modify its operations and procedures as may be necessary to comply with this Article and file with the Department all additional information necessary to make statements complete and current.
- D. This Article applies to inpatient emergency care, but does not apply to emergency services.
- E. This Article applies only to covered services.

Historical Note

New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2). Amended by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1902. Definitions

In this Article, the following definitions apply:

"Access" or "accessibility" means the extent to which an enrollee can obtain timely covered services from a contracted provider at the appropriate level of care, and appropriate location.

"Adult" means an enrollee in the age group the HCSO has designated for an adult.

"Adult PCP" means a primary care provider practicing in any specialty the HCSO designates as adult primary care.

"Ancillary provider" means a provider of laboratory, radiology, pharmacy or rehabilitative services, physical therapy, occupational therapy, or speech therapy, home health services, dialysis, and durable medical equipment or medical supplies dispensed by order or prescription of a provider with the appropriate prescribing authority.

"Available" or "availability" means the extent to which the plan has contracted providers of the appropriate type and numbers at geographic locations to afford members access to timely covered services.

"Chief executive officer" or "CEO" means the person who has the authority and responsibility for the operation of the health care services organization according to applicable legal

requirements and policies approved by the governing authority.

“Child” means an enrollee in the age group the HCSO has designated for children.

“Contracted” means a provider has a current written agreement or an employment arrangement with an HCSO to provide covered services to an enrollee, or a current written agreement or an employment arrangement with a contracted provider to provide covered services to an enrollee.

“Covered” or “covered services” means the health care services described as covered benefits in the HCSO’s evidence of coverage.

“Day” means calendar day unless specified otherwise.

“Department” means the Department of Insurance.

“Effective process” means written policies and procedures that:

- Outline the steps that the HCSO implements and consistently follows internally,

- The HCSO subjects to internal quality improvement, and

- The HCSO communicates to providers when established or changed.

“Emergency services” has the meaning in A.R.S. § 20-2801(3).

“Enrollee” means an individual who is enrolled in a health plan operated by an HCSO.

“Facility” means an institution that is licensed or authorized to furnish health care services in this state, including general hospitals, special hospitals, residential treatment centers, residential rehabilitation centers, skilled nursing facilities, urgent care centers, and ambulatory surgical treatment centers.

“Governing authority” means a person or body such as a board of trustees or board of directors in whom the ultimate authority and responsibility for the direction of the HCSO is vested.

“HCSO” means a health care services organization.

“Health care services” has the meaning in A.R.S. § 20-1051(6).

“High profile” means one of no fewer than four specialties designated by the HCSO, and does not include obstetrics-gynecology. An HCSO may designate a specialty as high profile on the basis of high volume or other basis the HCSO reasonably determines is directly related to providing covered services to a member.

“Hospital” means a facility that provides inpatient care, medical services, and continuous nursing services for the diagnosis and treatment of patients.

“Inpatient care” means the covered services that an enrollee who is admitted to a hospital receives for at least 24 consecutive hours.

“Inpatient emergency care” means covered services that would be emergency services if provided in a licensed hospital emergency facility.

“License” means documented authorization issued by the appropriate state of Arizona agency to operate a facility in Arizona, or to practice a health care profession in Arizona.

“Medically necessary” has the meaning set forth in the HCSO’s evidence of coverage.

“Network” means the group of providers contracted with an HCSO to provide covered services to an enrollee covered under the HCSO’s health benefit plan.

“Network exception” means an enrollee receives covered services from a non-contracted provider either:

- Because there is no contracted provider accessible or available that can provide the enrollee timely covered services, or

- For any reason the HCSO determines it is in the enrollee’s best interests to receive care from a non-contracted provider.

“Non-contracted” means a provider that does not have a contract with an HCSO to provide services to an enrollee.

“Normal business hours” means 8:00 a.m. to 5:00 p.m., Monday through Friday, excluding state or national holidays.

“Outpatient care” means covered services that an enrollee who is not an inpatient receives.

“Pediatric primary care provider” means a physician or practitioner practicing in any specialty the HCSO designates as pediatric primary care.

“Physician” means a licensed doctor of allopathic, chiropractic, optometric, osteopathic, or podiatric medicine.

“Practitioner” means any individual other than a physician who is licensed to furnish health care services, including behavioral health care services, in this state.

“Preventive care” means health maintenance care the HCSO provides or arranges to prevent illness and to improve the general health of an enrollee, including:

- Immunizations,

- Health education,

- Health evaluation and follow-up,

- Early disease detection,

- Screening tests appropriate for a person’s age and gender, and

- Periodic health care examinations.

“Primary care” means any specialty the HCSO designates as primary care.

“Primary care physician” or “PCP” means a physician or practitioner practicing in a specialty the HCSO designates as primary care.

“Provider” means any physician, practitioner, ancillary provider, or facility.

“Quality improvement” means an HCSO’s system for assessing and improving the level of performance of key process and outcomes.

“Routine care” means covered primary care for an enrollee’s non-urgent, symptomatic condition.

“Rural” means a zip code area with fewer than 1,000 persons per square mile as calculated annually by a population data gathering service designated by the Director.

“Service area” means any geographic area designated by any HCSO and approved by the Director under A.R.S. § 20-1053(A)(11).

“Specialty care provider” or “SCP” means a physician or practitioner who has education, training, or qualifications in a specialty, other than primary care, beyond the education or qualifications required for the license.

“Specialty” or “specialty care” means a specific area of medicine practiced by a physician or practitioner who has education, training, or qualifications in that specific area of medicine in addition to the education or qualifications required for the physician’s or practitioner’s license.

“Special hospital” means a hospital that is licensed to provide hospital services within a specific area of medicine, or limits patient admission according to age, gender, type of disease, or medical condition.

“Suburban area” means any zip code area with 1,000-3,000 persons per square mile, as calculated annually by a population data gathering service designated by the Director.

“Telemedicine” means diagnostic, consultation, and treatment services that occur in the physical presence of an enrollee on a real-time basis through interactive audio, video, or data communication.

“Timely” means services are provided at the time when medically necessary.

“Travel expenses” has the meaning set forth in writing by an HCSO.

“Urban area” means a zip code with more than 3,000 persons per square mile as calculated annually by a population data gathering service designated by the Director.

“Urgent care” means unscheduled services for an enrollee’s condition that requires medical attention not amenable to scheduling in order to avoid a serious risk of harm.

Historical Note

New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2). Amended by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1903. Documentation

The CEO shall ensure that the HCSO’s policies, procedures, plans, class specifications, orders, reports, minutes of meetings, contracts, agreements, records, and duty schedules are in writing, compiled and indexed in one or more manuals, and readily available for inspection by the Director.

Historical Note

New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2). Amended by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1904. Health Care Plan

- A. An HCSO shall submit a statement to the Department that describes the proposed health care plan.
- B. The HCSO shall have an organized system for the delivery of health care services contained in subsection (D) that includes the following:
 1. Contracted providers that provide services under the plan;
 2. An effective process to promote a continuing relationship between an enrollee and the same PCP; and
 3. An effective process for referrals that ensures continuity of care to an enrollee.
- C. The HCSO shall list:
 1. The proposed or actual enrollment;
 2. The number and names of contracted, employed, or HCSO-owned providers that will serve the enrollees and the board eligibility or certification of each physician, if applicable; and

3. The plan for providing covered services to enrollees as required under this Article.

- D. The HCSO’s health care plan shall provide within the geographic area served the following basic health care services covered by the monthly charges in the evidence of coverage:
 1. Emergency care that includes emergency services and inpatient emergency care;
 2. Inpatient care;
 3. Specialty care, primary care, or ancillary care that includes diagnostic and therapeutic services;
 4. Outpatient care;
 5. Preventive care; and
 6. Emergency ambulance services under A.R.S. § 20-2801(2), and other ambulance services when approved by a plan physician.
- E. The HCSO shall provide appropriate coverage for out-of-area emergency care to an enrollee traveling outside the area served by the HCSO.

Historical Note

New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2). R20-6-1904 repealed; new Section R20-6-1904 renumbered and amended from R20-6-1906 by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1905. Geographic Area

- A. An applicant shall describe the proposed geographic area in at least one of the following ways:
 1. Legal description,
 2. Local governmental jurisdiction such as city or county,
 3. Census tracts,
 4. Street boundaries, or
 5. Area within a specified radius of a specified intersection or a specified primary care center.
- B. An applicant shall submit a map that shows the boundaries for the proposed geographic area.
- C. An applicant shall submit a description of the proposed network including the data required under R20-6-1913(A)(2) and (A)(3).
- D. All advertising matter and sales material provided a prospective enrollee shall include a description of the geographic area in terms readily understandable by the general public.

Historical Note

New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2). R20-6-1905 repealed; new Section R20-6-1905 renumbered and amended from R20-6-1907 by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1906. Chief Executive Officer

- A. The governing authority shall appoint a CEO who has appropriate education and experience to manage the HCSO. The governing authority shall define the authority and duties of the CEO in writing. The CEO is the appointed representative of the governing authority and is the executive officer of the HCSO.
- B. The CEO shall have at least the following duties and responsibilities:
 1. Manage the HCSO;
 2. Establish and implement policies, procedures, and effective processes of the HCSO;
 3. Act as liaison between the governing authority and the providers of healthcare and other services to the HCSO; and
 4. Establish a written plan of authority that will be in place in the CEO’s absence.

- C. When there is a change of CEO, the governing authority shall notify Department within 10 days after the effective date of change.
- D. The HCSO shall ensure that all HCSO employees and contracted providers are knowledgeable about and qualified to perform the duties assigned to them through employment or by contract.
- E. The HCSO shall designate a central place of business within the major geographic area served at which the CEO shall be based and from which the HCSO shall direct administrative activities.

Historical Note

New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2). Section R20-6-1906 renumbered to R20-6-1904; new Section R20-6-1906 renumbered and amended from R20-6-1908 by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1907. Medical Director

- A. The HCSO shall designate a physician as medical director.
- B. The medical director shall be responsible for planning and implementing the method for the continuing review and evaluation of health care provided by the HCSO and the continuing education of its providers of health care services. The medical director may also serve as the CEO if the medical director has appropriate education and experience to manage the HCSO.
- C. The medical director responsibilities include:
 1. Supervising medical staff;
 2. Performance planning and evaluating medical staff;
 3. Coordinating medical staff activities; and
 4. Developing medical care policies.

Historical Note

New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2). Section R20-6-1907 renumbered to R20-6-1905; new Section R20-6-1907 renumbered and amended from R20-6-1909 by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1908. Quality Assurance

- A. The HCSO shall provide an effective process for a continuing review and evaluation of the covered services it provides to enrollees to ensure that:
 1. Treatment and level of covered services are appropriate and adequate and
 2. The quality of covered services is acceptable to the HCSO.
- B. The HCSO shall have a quality assurance committee that includes at least the CEO or designee, the medical director, and representative network providers. The quality assurance committee shall:
 1. Arrange for physicians or practitioners to review and evaluate covered services provided by others physicians or practitioners within the respective disciplines.
 2. Adopt administrative procedures covering frequency of meetings, recordkeeping, committee reports, and disseminating the reports.
- C. The HCSO's effective process in subsection (A) shall include the following:
 1. Standards for health care;
 2. Monitoring of care;
 3. Analysis of any deficiency;
 4. Correcting a deficiency including submitting a schedule for correcting the deficiency, requiring continuing educa-

tion for the provider, if appropriate, and follow-up and periodic reassessment of the deficiency.

Historical Note

New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2). Section R20-6-1908 renumbered to R20-6-1906; new Section R20-6-1908 renumbered and amended from R20-6-1911, by final rulemaking at 11 A.A.R. 4861, effective December 31, 2006 (Supp. 05-4).

R20-6-1909. Evaluation of Network

Each HCSO shall have an effective process to evaluate the adequacy of its network to provide an enrollee with timely covered services.

Historical Note

New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2). Former R20-6-1909 renumbered to R20-6-1907; new Section R20-6-1909 made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1910. Process for Referral, Prior Authorization, Precertification, or Network Exception

- A. An HCSO shall have an effective process for assisting an enrollee to obtain timely covered services when the enrollee or enrollee's referring provider cannot find a contracted provider who is timely accessible or available.
- B. An HCSO shall have an effective process during normal business hours for handling referrals, prior authorizations, precertifications, or network exceptions necessary for timely routine care. This process may include the HCSO's procedure for standing referrals required in A.R.S. § 20-1057.01.
- C. Each HCSO shall have an effective process to handle referrals or network exceptions necessary for timely urgent care seven days a week.
- D. An HCSO that requires prior authorization or precertification for urgent care shall have an effective process to handle requests for prior authorization or precertification 24 hours a day, seven days a week.
- E. An HCSO shall have an effective process for handling network exceptions that ensures the HCSO reimburses an enrollee for any out-of-network cost the enrollee incurs that the enrollee would not have incurred if the enrollee had received the services in-network.

Historical Note

New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1911. HCSO Communication with Providers

An HCSO shall have an effective process for communicating with contracted providers regarding the following:

1. The providers in the network,
2. Contractual or administrative changes relating to enrollee access or provider availability, and
3. Procedures for handling claims and grievances submitted by providers.

Historical Note

New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2). Former R20-6-1911 renumbered to R20-6-1908; new R20-6-1911 made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1912. Network Directories

- A.** An HCSO shall publish a provider network directory as follows:
1. An HCSO shall list the name, address, telephone number, specialty, and hospital affiliation for all in-area contracted physicians or practitioners.
 2. An HCSO may list ancillary providers by corporate or group name and is not required to list individual physicians or practitioners.
 3. An HCSO is not required to list physicians or practitioners in the following areas of specialties or areas of practice:
 - a. Emergency medicine;
 - b. Anesthesiology, except anesthesiologists who provide pain management services;
 - c. Hospital-based pathology;
 - d. Hospital-based radiology; and
 - e. Hospitalists.
 4. An HCSO that lists any of the physicians or practitioners in subsections R20-6-1912(A)(3)(a) through (A)(3)(e) may list by corporate or group name and is not required to list individual physicians or practitioners.
 5. An HCSO that uses hospitalists is not required to list the hospital affiliations of PCPs who do not admit or attend hospitalized members.
 6. An HCSO shall publish a provider network directory that lists all its contracted facilities and contains:
 - a. The name, address, and telephone number of each facility;
 - b. For each hospital at which the HCSO uses hospitalists, if any, a statement that the HCSO uses hospitalists at that hospital;
 - c. For an HCSO that uses hospitalists and does not list them in the directory, information on how an enrollee can find out what hospitalists or group of hospitalists it uses at each hospital;
- B.** The network directory shall conspicuously state in the directory the following:
1. Changes occur in the network after the directory is published and some providers listed in the directory may no longer be contracted,
 2. Enrollee coverage may depend on the contract status of the provider,
 3. Where the enrollee can obtain more recent directory information,
 4. The effective date of the network directory, and
 5. The method for an enrollee or prospective enrollee to find out which PCPs are accepting new enrollees from the HCSO.
- C.** Each HCSO shall make its network directory available on paper to enrollees or prospective enrollees requesting it. The HCSO shall:
1. Publish the paper directory at least once a year;
 2. Update or supplement the information in the paper directory at least every six months;
 3. Explain in the paper directory how an enrollee or prospective enrollee can use or get assistance using the HCSO's online or telephone directories, if any; and
 4. Have discretion to list physicians' or practitioners' hospital affiliations in its paper directory.
- D.** Each HCSO that has an online network directory shall:
1. Update the online directory at least monthly;
 2. Make the online directory easy to use and user friendly; and
 3. Explain, in the online directory, how an enrollee or prospective enrollee can obtain a paper directory.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1913. Demographic Information Reports

- A.** An HCSO shall report the following data to the Department:
1. For each enrollee, report annually:
 - a. Street address,
 - b. Zip code,
 - c. Gender, and
 - d. Year of birth.
 2. For all contracted providers, report semiannually:
 - a. Provider name,
 - b. Street address or addresses at which the provider provides covered services,
 - c. Zip code, and
 - d. Arizona license number,
 3. For all contracted physicians or practitioners, report semiannually:
 - a. Specialty, and
 - b. Medical or other applicable degree or information that designates the type of physician or practitioner.
- B.** The HCSO shall report the information in subsection (A) to the Department by the following deadlines:
1. For information in subsection (A)(1) as of December 31 of each calendar year, by February 15 of the next calendar year.
 2. For information in subsection (A)(2) as of June 30, by August 15 of the same calendar year.
 3. For information in subsection (A)(2) as of December 31, by February 15 of the next calendar year.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1914. Access

An HCSO shall provide to or arrange for its enrollees services or appointments for services as follows:

1. For preventive care services from a contracted PCP, an appointment date within 60 days of the enrollee's request, or sooner if necessary, for the enrollee to be immunized on schedule.
2. For routine-care services from a contracted PCP, an appointment date within 15 days of the enrollee's request to the PCP or sooner if medically necessary.
3. For specialty care services from a contracted SCP, an appointment date within 60 days of the enrollee's request or sooner if medically necessary.
4. In-area urgent care services from a contracted provider seven days per week.
5. Timely non-emergency inpatient care services from a contracted facility.
6. Timely services from a contracted physician or practitioner in a contracted facility including inpatient emergency care.
7. Services from a contracted ancillary provider during normal business hours, or sooner if medically necessary.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1915. Alternative Access

- A.** As an alternative to providing access to covered services from a physician, an HCSO may provide access to covered services from an appropriately licensed practitioner.

- B. As an alternative to providing access to covered services at a hospital under R20-6-1914, an HCSO may provide access to covered services at another appropriately licensed facility.
- C. As an alternative to providing access to covered services from a physician or practitioner who sees an enrollee in person under R20-6-1914, an HCSO may provide access to necessary covered services through:
 - 1. Telephone calls and messages,
 - 2. Electronic mail,
 - 3. Communication with the physician's or practitioner's staff,
 - 4. Coverage by another physician or practitioner, or
 - 5. Telemedicine,
- D. An HCSO that panels enrollees to PCPs may panel enrollees to appropriately licensed practitioners.
- 2. High profile specialty care services from a contracted SPC within 20 miles or 60 minutes of the enrollee's home; and
- 3. Inpatient care in a contracted hospital, or a contracted special hospital within 30 miles or 90 minutes of the enrollee's home.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1919. Geographic Availability in a Rural Area

An HCSO shall provide each enrollee living in a rural area with primary care services from a contracted physician or practitioner within 30 miles or 90 minutes of the enrollee's home.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1920. Travel Requirements

- A. An HCSO may require an enrollee to travel a greater distance in-area to obtain covered services from a contracted provider than the enrollee would have to travel to obtain equivalent services from a non-contracted provider, except where a network exception is medically necessary. Nothing in this Section creates an exception to R20-6-1918 through R20-6-1920.
- B. If the HCSO prior-authorizes services that require an enrollee to travel outside the HCSO service area because the services are not available in the area, the HCSO shall reimburse the enrollee for travel expenses. Except as provided under R20-6-1904(E)(6), an HCSO is not required to reimburse an enrollee for travel expenses the enrollee incurs to obtain covered services in-area.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1921. Enforcement Consideration

In determining the appropriate enforcement action or penalties for failure to comply with these rules, the Department shall consider any documentation the HCSO provides regarding:

- 1. Whether seasonal shifts in demand affect access and availability of covered services;
- 2. Whether the HCSO's demographic information has changed significantly since the HCSO's most recent report;
- 3. Whether an enrollee has refused to accept covered services the HCSO has offered in the time-frames or locations required of the HCSO by this Article;
- 4. Whether an enrollee has requested and obtained covered services from a contracted provider whose location, or appointment availability, or capacity result in the HCSO's non-compliance; and
- 5. Whether market factors indicate that on a short-term basis, compliance is not possible. Market factors include shortage of providers, enrollee or provider location, and provider practice or contracting patterns.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

Historical Note

New Section made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1916. Availability Ratios

- A. An HCSO shall maintain a ratio of contracted adult PCPs to adults that is adequate to provide those adults with covered services. An HCSO with a Medicare Advantage (MA) plan may have one ratio that applies to both its insured and MA populations, or a separate ratio for each.
- B. An HCSO shall maintain a ratio of contracted pediatric PCPs to children that is adequate to provide those children enrollees with covered services.
- C. An HCSO shall maintain a ratio of contracted high profile SCPs to enrollees that is adequate to provide those enrollees with covered services that include services at contracted facilities. An HCSO with a MA plan may have one ratio that applies to both its insured and MA populations, or a separate ratio for each.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1917. Geographic Availability in an Urban Area

An HCSO shall provide each enrollee living in an urban area of the HCSO's service area the following:

- 1. Primary care services from a contracted PCP located within 10 miles or 30 minutes of the enrollee's home;
- 2. High profile specialty care services from a contracted SCP located within 15 miles or 45 minutes of the enrollee's home; and
- 3. Inpatient care in a contracted general hospital, or contracted special hospital, within 25 miles or 75 minutes of the enrollee's home.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1918. Geographic Availability in a Suburban Area

Each HCSO shall provide each enrollee member living in a suburban area within the HCSO's service area the following:

- 1. Primary care from a contracted PCP located within 15 miles or 45 minutes of the enrollee's home;

ARTICLE 20. CAPTIVE INSURERS**R20-6-2001. Reserved****R20-6-2002. Fees; Examination Costs**

- A.** A corporation applying for a license to do business as a captive insurer, under A.R.S. § 20-1098, shall pay a nonrefundable fee of \$1,000.00 to the Department for issuance of the license. A captive insurer that is a protected cell captive insurer, as defined in A.R.S. § 20-1098, also shall pay to the Department a nonrefundable fee of \$1,000 for each participant contract application that establishes a protected cell under A.R.S. § 20-1098.05(B)(9). The fee is payable in full at the time the applicant submits the application for license to the Department under A.R.S. § 20-1098.01.
- B.** A captive insurer shall pay a nonrefundable annual renewal fee of \$5,500.00 to the Department at the time of filing its annual report under A.R.S. § 20-1098.07. Under A.R.S. § 20-1098.01(J), a captive insurer that is a protected cell captive insurer also shall pay to the Department a nonrefundable annual renewal fee of \$2,500.00 for each protected cell at the time of filing its annual report under A.R.S. § 20-1098.07.
- C.** A captive insurer shall pay a nonrefundable fee of \$200.00 to the Department at the time of filing for issuance of an amended certificate of authority.
- D.** In addition to the fees prescribed in subsections (A) and (B), an applicant for a captive insurer license or a licensed captive insurer shall pay the costs of any examination the Director conducts, under A.R.S. § 20-1098.08.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 2478, effective July 1, 2002 (Supp. 02-2). Amended by final rulemaking at 11 A.A.R. 2977, effective September 13, 2005 (Supp. 05-3). Subsection (A) corrected at request of the Department, Office File No. M11-252, filed July 20, 2011 (Supp. 11-3).

ARTICLE 21. CUSTOMER INFORMATION SECURITY PROGRAM

Article 21, consisting of R20-6-2101 through R20-6-2104, made by final rulemaking at 10 A.A.R. 2260, effective July 13, 2004 (Supp. 04-2).

R20-6-2101. Definitions

The following definitions apply in this Article:

1. "Consumer" means an individual, or the individual's legal representative, who seeks to obtain, obtains, or has obtained an insurance product or service from a licensee that is to be used primarily for personal, family, or household purposes, and about whom the licensee has nonpublic personal information. Consumer can include a prospective applicant, policyholder, certificateholder, insured, or claimant.
2. "Customer" means a consumer who has a continuing relationship with a licensee under which the licensee provides one or more insurance products or services to the consumer that are used primarily for personal, family, or household purposes.
3. "Customer information" means nonpublic personal information and privileged information about a customer whether in paper, electronic, or other form, that is maintained by or on behalf of an insurance institution, insurance producer, or insurance support organization.
4. "Customer information systems" means the electronic, or physical methods used to access, collect, store, use, transmit, protect, or dispose of customer information.

5. "Insurance institution" has the meaning prescribed in A.R.S. § 20-2102(10).
6. "Insurance producer" means a person required to be licensed under A.R.S. Title 20, Chapter 2, Article 3 to sell, solicit, or negotiate insurance and includes a managing general agent as defined in A.R.S. § 20-311.
7. "Insurance support organization" has the meaning prescribed in A.R.S. § 20-2102(13).
8. "Licensee" means an insurance institution, insurance producer, or insurance support organization, but does not include a purchasing group or an unauthorized insurer in regard to the excess line business conducted under Title 20, Chapter 2, Article 5.
9. "Personal information" has the meaning prescribed in A.R.S. § 20-2102(19).
10. "Privileged information" has the meaning prescribed in A.R.S. § 20-2102(22).
11. "Service provider" means a person that maintains, processes, or otherwise is permitted access to customer information through its provision of services directly to a licensee.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 2260, effective July 13, 2004 (Supp. 04-2).

R20-6-2102. Customer Information Security Program

A licensee shall implement a comprehensive written customer information security program that includes administrative, technical, and physical safeguards for the protection of customer information. The administrative, technical, and physical safeguards included in the information security program shall be appropriate to the size and complexity of the licensee and the nature and scope of its activities.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 2260, effective July 13, 2004 (Supp. 04-2).

R20-6-2103. Objectives of Customer Information Security Program

A licensee's customer information security program shall be designed to:

1. Ensure the security and confidentiality of customer information;
2. Protect against any anticipated threats or hazards to the security or integrity of the information; and
3. Protect against unauthorized access to or use of the information.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 2260, effective July 13, 2004 (Supp. 04-2).

R20-6-2104. Guidelines for Methods of Development and Implementation

A licensee may implement the requirements of R20-6-2102 and R20-6-2103 by the actions and procedures prescribed in this Section, which are non-exclusive illustrations:

1. A licensee may assess risk by:
 - a. Identifying reasonably foreseeable internal or external threats that could result in unauthorized disclosure, misuse, alteration, or destruction of customer information or customer information systems;
 - b. Assessing the likelihood and potential damage of these threats, taking into consideration the sensitivity of customer information; and

- c. Assessing the sufficiency of policies, procedures, customer information systems, and other safeguards in place to control risks.
- 2. A licensee may manage and control risk by:
 - a. Designing its information security program to control the identified risks, commensurate with the sensitivity of the information, as well as the complexity and scope of the licensee's activities;
 - b. Training staff to implement the licensee's information security program; and
 - c. Regularly testing or otherwise regularly monitoring the key controls, systems and procedures of the information security program. The licensee shall determine the frequency and nature of these tests or other monitoring practices by the licensee's risk assessment.
- 3. A licensee may oversee service provider arrangements by:
 - a. Exercising appropriate due diligence in selecting its service providers; and
 - b. Requiring its service providers to implement measures designed to meet the objectives of this Article, and, where indicated by the licensee's risk assessment, taking appropriate steps to confirm that its service providers have satisfied these obligations.
- 4. A licensee may monitor, evaluate, and adjust, as appropriate, its information security program in light of any relevant changes in technology, the sensitivity of its customer information, internal or external threats to information, and the licensee's own changing business arrangements, such as mergers and acquisitions, alliances and joint ventures, outsourcing arrangements, and changes to customer information systems.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 2260, effective July 13, 2004 (Supp. 04-2).

ARTICLE 22. MILITARY PERSONNEL

R20-6-2201. Military Sales Practices

- A. The Department incorporates by reference the National Association of Insurance Commissioners (NAIC) Military Sales Practices Model Regulation June 2007 (Model Regulation), and no future editions or amendments, which is on file with the Department of Insurance, 2910 N. 44th St., Phoenix, AZ 85018 and available from the National Association of Insurance Commissioners, Publications Department, 2301 McGee St., Suite 800, Kansas City, MO 64108.
- B. The Model Regulation is modified as follows:
 - 1. In addition to the terms defined in the Model Regulation, the following definitions apply:
 - a. "Commissioner" means the Director of the Arizona Department of Insurance.
 - b. "Regulation" means Article.
 - 2. Section 3 is modified to insert "A.R.S. § 20-106, 20-142 and 20-143" after "of."
 - 3. Section 7(E)(5)(b) is modified to insert "A.R.S. § 20-1241 et seq., R20-6-202, and R20-6-209" after "requirements of."
 - 4. Subsection 7(F)(5) of the Model Regulation is excluded from this Section.

Historical Note

New Section made by final rulemaking at 13 A.A.R. 4215, effective January 5, 2008 (Supp. 07-4).

ARTICLE 23. THRESHOLD RATE REVIEW – INDIVIDUAL HEALTH INSURANCE

R20-6-2301. Applicability; Definitions

- A. This Article applies to rates charged by health insurers for individual health insurance. This Article does not apply to rates charged by health insurers for the following:
 - 1. Health insurance that a health insurer issues to an employer or to any group described in either A.R.S. § 20-1401 or A.R.S. § 20-1404(A), except health insurance issued to an association or its individual members as described in R20-6-2301(B)(7)(b);
 - 2. Grandfathered health plan coverage as defined in 45 CFR 147.140; or
 - 3. Health insurance that covers excepted benefits as described in section 2791(c) of the PHS Act, 42 U.S.C. 300gg-91(c).
- B. In this Article, the following definitions apply:
 - 1. "Department" means the Arizona Department of Insurance.
 - 2. "Blanket disability insurance" has the meaning prescribed in A.R.S. § 20-1404(A).
 - 3. "CMS" means the Centers for Medicare & Medicaid Services.
 - 4. "Federal medical loss ratio standard" means the applicable medical loss ratio standard determined under 45 CFR 158, Subpart B.
 - 5. "Health insurance" means disability insurance as defined in A.R.S. § 20-253, a health care plan as defined in A.R.S. § 20-1051(5) and disability insurance or a health care plan offered by a hospital service corporation, medical service corporation or hospital, medical, dental and optometric service corporation as defined in A.R.S. § 20-822(3).
 - 6. "Health insurer" means an insurer, as that term is defined in A.R.S. § 20-104, authorized to transact disability insurance in Arizona, a health care services organization as defined in A.R.S. § 20-1051(7) or a hospital service corporation, medical service corporation or hospital, medical, dental and optometric service corporation as defined in A.R.S. § 20-822(3).
 - 7. "Individual health insurance" means health insurance that a health insurer issues to either:
 - a. An individual, to cover:
 - i. The individual, or
 - ii. The individual's dependents, or
 - iii. The individual and the individual's dependents.
 - b. An association or its individual members to cover the individual members and their dependents, and which the Department would regulate under A.R.S. Title 20, Chapter 6 as individual health insurance if the health insurer did not issue it to an association or individual members of an association.
 - 8. "PHS Act" means Part A of Title XXVII of the Public Health Service Act, 42 U.S.C. Chapter 6A.
 - 9. "Product" means a package of health insurance benefits with a discrete set of rating and pricing methodologies that a health insurer offers as individual insurance in Arizona.
 - 10. "Preliminary justification" means a justification that consists of the parts described in R20-6-2302(A).
 - 11. "Rate increase" means an increase of the rates for an individual health insurance product that a health insurer offers in Arizona that:
 - a. Results from a change to the underlying rate structure of the product, and
 - b. May result in premium changes for the product.

12. "Secretary" means the Secretary of the United States Department of Health and Human Services.
13. "Threshold rate increase" means a rate increase that meets or exceeds an Arizona-specific threshold as noticed by the Secretary in 45 CFR 154.200, provided:
 - a. The average increase for all enrollees weighted by premium volume meets or exceeds the applicable threshold; and
 - b. If a rate increase that does not otherwise meet or exceed the Arizona-specific threshold meets or exceeds the Arizona-specific threshold when combined with a previous increase or increases during the 12-month period preceding the date on which the rate increase would become effective, then the rate increase must be considered to meet or exceed the Arizona-specific threshold and is subject to threshold rate review that shall include a review of the aggregate rate increases during the applicable 12-month period.
14. "Threshold rate review" means the review by the Department under this Article of a threshold rate increase.
15. "Unreasonable rate increase" means a rate increase that results in benefits that are not reasonable in relation to the premium the health insurer charges for the product. The following factors are relevant in determining whether a rate increase results in benefits that are unreasonable in relation to premium:
 - a. The rate increase results in a projected medical loss ratio below the federal medical loss ratio standard after accounting for any adjustments allowable under federal law;
 - b. One or more of the assumptions on which the health insurer based the rate increase is not supported by sound actuarial reasoning, data and analysis;
 - c. The choice of assumptions or combination of assumptions on which the insurer based the rate increase is unreasonable;
 - d. The health issuer provides data or documentation that is incomplete, inadequate or otherwise does not provide a basis upon which the Department can determine the reasonableness of a rate increase; or
 - e. The increase results in premium differences between insureds within similar risk categories that are unfairly discriminatory under A.R.S. Title 20, Chapter 2, Article 6.
- f. Three year history of rate increases for the product associated with the rate increase.
2. Preliminary Justification Part II. A written description that justifies the rate increase and that contains a simple and brief narrative describing the data and assumptions the health insurer used to develop the rate increase, and includes the following:
 - a. An explanation of the most significant factors causing the rate increase, including a brief description of the relevant claims and non-claims expense increases reported in subsection (A)(1); and
 - b. A brief description of the overall experience of the policy, including historical and projected expenses, and loss ratios.
- B. A health insurer may submit a single, combined preliminary justification that contains all the information in subsections (A)(1) and (2) for threshold rate increases that affect more than one product if the health insurer has aggregated the claims experience of all products to calculate the rate increases and the rate increases are the same for all products.

Historical Note

New Section made by final rulemaking at 18 A.A.R. 2721, effective October 3, 2012 (Supp. 12-4).

R20-6-2303. Timing for Submission of Preliminary Justification

- A. If R20-6-607 applies to a threshold rate increase, the health insurer shall submit its preliminary justification to the Department and to CMS on the date on which the health insurer files the rate increase request under R20-6-607.
- B. If R20-6-607 does not apply to a threshold rate increase, the health insurer shall submit the preliminary justification to the Department and to CMS at least 60 days prior to the date the health insurer intends to implement the threshold rate increase in Arizona.
- C. The Department shall provide access from its website to the Parts I and II of the Preliminary Justifications of the proposed rate increases that it reviews and have a mechanism for receiving public comments on those proposed rate increases.

Historical Note

New Section made by final rulemaking at 18 A.A.R. 2721, effective October 3, 2012 (Supp. 12-4).

R20-6-2304. Response to Unreasonableness Determination

If the health insurer receives from CMS a notice that the Department has determined that the health insurer's threshold rate increase is unreasonable, the health insurer shall select one of the following three options:

1. Option to not implement the rate increase determined unreasonable. Within 30 days of receiving from CMS the Department's determination, the health insurer shall notify the Department and CMS that it will not implement the rate increase and request the Department to withdraw the rate increase request;
2. Option to implement a smaller rate increase than the rate determined unreasonable. Within 30 days of receiving from CMS the Department's determination, the health insurer shall notify the Department and CMS, on a form and in the manner prescribed by the Secretary, that it intends to implement a rate increase that is smaller than the one determined unreasonable. One of the following shall apply to this option:
 - a. If the health insurer selects this option and the smaller rate increase is not a threshold rate increase, the smaller rate increase is not subject to this Article;

Historical Note

New Section made by final rulemaking at 18 A.A.R. 2721, effective October 3, 2012 (Supp. 12-4).

R20-6-2302. Disclosure of Preliminary Justification

- A. Preliminary Justification. For each threshold rate increase for each affected product, a health insurer shall submit to the Department and to CMS, on a form and in the manner prescribed by the Secretary in 45 CFR 154.215, a preliminary justification that contains all of the following:
 1. Preliminary Justification Part I. A summary of the content of the threshold rate increase that includes:
 - a. Historical and projected claims experience;
 - b. Trend projections related to utilization, and service or unit cost;
 - c. Any claims assumptions related to benefit changes;
 - d. Allocation of the overall rate increase to claims and non-claims costs;
 - e. Per enrollee per month allocation of current and projected premium; and

- b. If the health insurer selects this option, and R20-6-607 applied to the rate increase the Department determined to be unreasonable, the health insurer shall revise the rate increase filing to reflect the smaller rate increase or file a new rate increase. If the smaller rate increase is a threshold rate increase, the health insurer shall submit a new preliminary justification on the date the health insurer revises the rate increase filing or files a new rate increase; or
 - c. If the health insurer selects this option, and R20-6-607 did not apply to the rate increase the Department determined to be unreasonable, and the smaller increase is a threshold rate increase, the health insurer shall submit to the Department and to CMS a new preliminary justification at least 60 days prior to the date the health insurer intends to implement the smaller increase in Arizona.
3. Option to implement the rate increase determined unreasonable. Within 10 business days after the health insurer either implements the rate increase that the Department determined unreasonable, or receives from CMS the Department's determination, the health insurer shall:
- a. Submit, to the Department and to CMS, a final justification in response to the Department's determination. The information in the final justification shall be the same as the information submitted by the insurer under R20-6-2302(A)(1) and (2) in the preliminary justification supporting the rate increase; and
 - b. Prominently post on its website, on a form and in the manner prescribed by the Secretary under 45 CFR 154.230 the following information:
 - i. The Department's determination that the rate increase is unreasonable and Department's explanation of the Department's analysis of the relevant factors set forth in R20-6-2305(A)(1) and (2), and
 - ii. The health insurer's final justification for implementing the rate increase.
 - c. Continue to make the information in subsection (3)(b) available to the public on its website for at least three years.

Historical Note

New Section made by final rulemaking at 18 A.A.R. 2721, effective October 3, 2012 (Supp. 12-4).

R20-6-2305. Threshold Rate Increase Documentation Requirements

- A. For a threshold rate increase, a health insurer shall submit to the Department documentation that is sufficient to allow the Department to assess:
 - 1. The reasonableness of the assumptions used by the health insurer to develop the proposed rate increase and the validity of the historical data underlying the assumptions, and
 - 2. The health insurer's data related to past projections and actual experience.
- B. To the extent applicable to the submission under review by the Department, the health insurer shall submit documentation that includes all of the following:
 - 1. The impact of medical trend changes by major service categories;
 - 2. The impact of utilization changes by major service categories;
 - 3. The impact of cost-sharing changes by major service categories;
 - 4. The impact of benefit changes;
 - 5. The impact of changes in enrollee risk profile;
 - 6. The impact of any overestimate or underestimate of medical trend for prior year periods related to the rate increase;
 - 7. The impact of changes in reserve needs;
 - 8. The impact of changes in administrative costs related to programs that improve health care quality;
 - 9. The impact of changes in other administrative costs;
 - 10. The impact of changes in applicable taxes, licensing or regulatory fees;
 - 11. Medical loss ratio;
 - 12. The health insurance insurer's capital and surplus; and
 - 13. Other relevant documentation at the discretion of the Director.
- C. A health insurer shall submit all documentation required under subsection (A) or (B) at the same time that:
 - 1. The health insurer submits the preliminary justification required under R20-6-2302, or
 - 2. The health insurer submits any new preliminary justification required under R20-6-2304(2)(b) and (c).

Historical Note

New Section made by final rulemaking at 18 A.A.R. 2721, effective October 3, 2012 (Supp. 12-4).

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