Delaware Register of Regulations

Office of the Registrar of Regulations,
Legislative Council,
State of Delaware

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IN THIS ISSUE:

Pursuant to 29 **Del.C.** Chapter 11, Subchapter III, this issue of the *Register* contains all documents required to be published, and received, on or before December 15, 2011.

INFORMATION ABOUT THE DELAWARE REGISTER OF REGULATIONS

DELAWARE REGISTER OF REGULATIONS

The *Delaware Register of Regulations* is an official State publication established by authority of 69 *Del. Laws*, c. 107 and is published on the first of each month throughout the year.

The *Delaware Register* will publish any regulations that are proposed to be adopted, amended or repealed and any emergency regulations promulgated.

The *Register* will also publish some or all of the following information:

- Governor's Executive Orders
- Governor's Appointments
- Agency Hearing and Meeting Notices
- Other documents considered to be in the public interest.

CITATION TO THE DELAWARE REGISTER

The *Delaware Register of Regulations* is cited by volume, issue, page number and date. An example would be:

15 **DE Reg.** 24-47 (07/01/11)

Refers to Volume 15, pages 24-47 of the *Delaware Register* issued on July 1, 2011.

SUBSCRIPTION INFORMATION

The cost of a yearly subscription (12 issues) for the *Delaware Register of Regulations* is $135.00. Single copies are available at a cost of $12.00 per issue, including postage. For more information contact the Division of Research at 302-744-4114 or 1-800-282-8545 in Delaware.

CITIZEN PARTICIPATION IN THE REGULATORY PROCESS

Delaware citizens and other interested parties may participate in the process by which administrative regulations are adopted, amended or repealed, and may initiate the process by which the validity and applicability of regulations is determined.

Under 29 **Del.C.** §10115 whenever an agency proposes to formulate, adopt, amend or repeal a regulation, it shall file notice and full text of such proposals, together with copies of the existing regulation being adopted, amended or repealed, with the Registrar for publication in the *Register of Regulations* pursuant to §1134 of this title. The notice shall describe the nature of the proceedings including a brief synopsis of the subject, substance, issues, possible terms of the agency action, a reference to the legal authority of the agency to act, and reference to any other regulations that may be impacted or affected by the proposal, and shall state the manner in which persons may present their views; if in writing, of the place to which and the final date by which such views may be submitted; or if at a public hearing, the date, time and place of the hearing. If a public hearing is to be held, such public hearing shall not be scheduled less than 20 days following publication of notice of the proposal in the *Register of Regulations*. If a public hearing will be held on the proposal, notice of the time, date, place and a summary of the nature of the proposal shall also be published in at least 2 Delaware newspapers of general circulation. The notice shall also be mailed to all persons who have made timely written requests of the agency for advance notice of its regulation-making proceedings.

The opportunity for public comment shall be held open for a minimum of 30 days after the proposal is published in the *Register of Regulations*. At the conclusion of all hearings and after receipt, within the time allowed, of all written materials, upon all the testimonial and written evidence and information submitted, together with summaries of the evidence and information by subordinates, the agency shall determine whether a regulation should be adopted, amended or repealed and shall issue its conclusion in an order which shall include: (1) A brief summary of the evidence and information submitted; (2) A brief summary of its findings of fact with respect to the evidence and information, except where a rule of procedure is being adopted or amended; (3) A decision to adopt, amend or repeal a regulation or to take no action and the decision shall be supported by its findings on the evidence and information received; (4) The exact text and citation of such regulation adopted, amended or repealed; (5) The effective date of the order; (6) Any other findings or conclusions required by the law under which the agency has authority to act; and (7) The signature of at least a quorum of the agency members.

The effective date of an order which adopts, amends or repeals a regulation shall be not less than 10 days from the date the order adopting, amending or repealing a regulation has been published in its final form in the *Register of Regulations*, unless such adoption, amendment or repeal qualifies as an emergency under §10119.

Any person aggrieved by and claiming the unlawfulness of any regulation may bring an action in the Court for declaratory relief.

No action of an agency with respect to the making or consideration of a proposed adoption, amendment or repeal of a regulation shall be subject to review until final agency action on the proposal has been taken.

When any regulation is the subject of an enforcement action in the Court, the lawfulness of such regulation may be reviewed by the Court as a defense in the action.

Except as provided in the preceding section, no judicial review of a regulation is available unless a complaint therefor is filed in the Court within 30 days of the day the agency order with respect to the regulation was published in the *Register of Regulations*.

CLOSING DATES AND ISSUE DATES FOR THE DELAWARE REGISTER OF REGULATIONS

ISSUE DATE	CLOSING DATE	CLOSING TIME
February 1	January 16	4:30 p.m.
March 1	February 15	4:30 p.m.
April 1	March 15	4:30 p.m.
May 1	April 16	4:30 p.m.
June 1	May 15	4:30 p.m.

DIVISION OF RESEARCH STAFF

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PROPOSED

FINAL

The table printed below lists the regulations that have been proposed, adopted, amended or repealed in the preceding issues of the current volume of the *Delaware Register of Regulations*.

The regulations are listed alphabetically by the promulgating agency, followed by a citation to that issue of the *Register* in which the regulation was published. Proposed regulations are designated with (Prop.); Final regulations are designated with (Final); Emergency regulations are designated with (Emer.); and regulations that have been repealed are designated with (Rep.).

Symbol Key

Arial type indicates the text existing prior to the regulation being promulgated. Underlined text indicates new text. Language which is ~~stricken~~ through indicates text being deleted.

Proposed Regulations

Under 29 **Del.C.** §10115 whenever an agency proposes to formulate, adopt, amend or repeal a regulation, it shall file notice and full text of such proposals, together with copies of the existing regulation being adopted, amended or repealed, with the Registrar for publication in the *Register of Regulations* pursuant to §1134 of this title. The notice shall describe the nature of the proceedings including a brief synopsis of the subject, substance, issues, possible terms of the agency action, a reference to the legal authority of the agency to act, and reference to any other regulations that may be impacted or affected by the proposal, and shall state the manner in which persons may present their views; if in writing, of the place to which and the final date by which such views may be submitted; or if at a public hearing, the date, time and place of the hearing. If a public hearing is to be held, such public hearing shall not be scheduled less than 20 days following publication of notice of the proposal in the *Register of Regulations*. If a public hearing will be held on the proposal, notice of the time, date, place and a summary of the nature of the proposal shall also be published in at least 2 Delaware newspapers of general circulation. The notice shall also be mailed to all persons who have made timely written requests of the agency for advance notice of its regulation-making proceedings.

DEPARTMENT OF AGRICULTURE

HARNESS RACING COMMISSION

Statutory Authority: 3 Delaware Code, Section 10005 (3 **Del.C.** §10005)
3 **DE Admin. Code** 501

501 Harness Racing Rules and Regulations

PUBLIC NOTICE

The Delaware Harness Racing Commission, pursuant to 3 **Del.C.** §10005, proposes to change its Rule 7.1.4 and 8.3.5.9.4. The Commission will hold a public hearing on the proposed rule changes at Dover Downs on February 14, 2012 at 10:15 A.M.

Written comments should be sent to Hugh J. Gallagher, Executive Director of the Delaware Harness Racing Commission, Department of Agriculture, 2320 South DuPont Highway, Dover, Delaware 19901. Written comments will be accepted for thirty (30) days from the date of publication in the *Register of Regulations* on January 1, 2012.

The proposed changes are for the purpose of updating the Rules and to more accurately reflect current policies, practices and procedures. Copies are published online at the *Register of Regulations* website: http://regulations.delaware.gov/services/current_issue.html

A copy is also available for inspection at the Harness Racing Commission office.

501 Harness Racing Rules and Regulations

(Break in Continuity of Sections)

7.0 Rules of the Race

7.1 Declarations and Drawing

(Break in Continuity within Sections)

7.1.4 Coupled Entries

When the starters in a race include two or more horses owned by the same person, or trained in the same stable or by the same management, they shall be coupled as an "entry", and a wager on one horse in the entry shall be a wager on all horses in the "entry"; provided, however, that ~~when a trainer enters two or more horses~~ in a stake, early closing, ~~futurity,~~ free-for-all or other special event ~~under bona fide separate ownership~~, such horses may, at the request of the Association, made through the Presiding Judge be permitted to race as separate entries. Upon such request, the Presiding Judge shall have discretion to determine whether the horses are to race as separate entries. If the race is split in two or more divisions, horses in an "entry" shall be seeded in separate divisions insofar as possible, but the divisions in which they compete and their post positions shall be drawn by lots. The above provisions shall also apply to elimination heats. The person making the declaration of a horse that qualifies as a coupled entry with another horse entered in the same event shall be responsible to designate the word "entry" on the declaration blank. The Presiding Judge shall be responsible for coupling horses. In addition to the foregoing, horses separately owned or trained may be coupled as an entry where it is necessary to do so to protect the public interest for the purpose of pari-mutuel wagering only; provided, however, that where this is done entries may not be rejected.

(Break in Continuity of Sections)

8.0 Veterinary Practices, Equine Health Medication

8.3 Medications and Foreign Substances

(Break in Continuity within Sections)

8.3.5.9 Bleeder List

8.3.5.9.4 A horse which bleeds (EPIH) based on the criteria set forth in 8.3.5.9.1 above shall be restricted from racing at any facility under the jurisdiction of the Commission, as follows:

8.3.5.9.4.1 1st time - 10 days suspension from racing;

8.3.5.9.4.2 2nd time within 365 day period - the horse must serve a 30 day(s) suspension from racing, provided that the horse must be added to or remain on the Bleeder List, and must complete a satisfactory qualifying race before resuming racing, after the mandatory 30-day rest period; after 365 days without another incident of EPIH all horses revert back to a first time bleeder status;

8.3.5.9.4.3 3rd time within 365 day period - the horse must serve a 30 day(s) suspension from racing, and the horse shall be added to the Steward's List, to be removed at the discretion of the Commission Veterinarian following a satisfactory qualifying race after the mandatory 30-day rest period; after 365 days without another incident of EPIH all horses revert back to a first time bleeder status and

8.3.5.9.4.4 4th time within 365 day period - barred for life.

***Please Note: As the rest of the sections were not amended, they are not being published here. A complete copy of the final regulation is available at:**

501 Harness Racing Rules and Regulations

DEPARTMENT OF EDUCATION

OFFICE OF THE SECRETARY

Statutory Authority: 14 Delaware Code, Section 122(d) (14 **Del.C.** §122(d))
14 **DE Admin. Code** 852

Education Impact Analysis Pursuant To 14 Del.C. Section 122(d)

852 Child Nutrition

A. Type of Regulatory Action Required
Repeal

B. Synopsis of Subject Matter of the Regulation

The Secretary of Education intends to repeal 14 **DE Admin. Code** 852 Child Nutrition**.** The rationale for repealing this regulation is as follows: 1) all districts and schools that participate in the U.S. Department of Agriculture food programs follow the federal requirements of those programs and are monitored based those regulations; and 2) all schools and districts are required to follow any state laws related to the procurement and offering of foods and beverages. The Department provides technical assistance and training to schools and districts on the federal and state requirements as needed and/or as requested.

The Department is cognizant that any mandates above what is required by federal and state law may have a fiscal cost that would need to be absorbed by the district or charter school or the parents of students. A district or charter school may require additional limitations to the foods and beverages provided to its students, staff or the public. Currently all nineteen of our school districts have voluntarily imposed higher nutritional standards in the foods served under the school breakfast and school lunch programs.

Persons wishing to present their views regarding this matter may do so in writing by the close of business on or before February 3, 2012 to Susan Haberstroh, Education Associate, Regulation Review, Department of Education, at 401 Federal Street, Suite 2, Dover, Delaware 19901. A copy of this regulation is available from the above address or may be viewed at the Department of Education business office.

C. Impact Criteria

1. Will the amended regulation help improve student achievement as measured against state achievement standards? The repeal of the regulation should not affect student achievement as measured against state achievement standards because schools and districts are required to follow state and federal laws related to nutritional programs.

2. Will the amended regulation help ensure that all students receive an equitable education? The repeal of the regulation should not affect all students receiving an equitable education because schools and districts are required to follow state and federal laws related to nutritional programs.

3. Will the amended regulation help to ensure that all students' health and safety are adequately protected? Federal and state laws are in place that support all students' health related to nutritional programs for these students.

4. Will the amended regulation help to ensure that all students' legal rights are respected? The repeal of the regulation should not affect students' legal rights because schools and districts are required to follow state and federal laws related to nutritional programs.

5. Will the amended regulation preserve the necessary authority and flexibility of decision making at the local board and school level? The amended regulation will preserve the necessary authority and flexibility of decision making at the local board and school level.

6. Will the amended regulation place unnecessary reporting or administrative requirements or mandates upon decision makers at the local board and school levels? The repeal of the regulation will not place unnecessary reporting or administrative requirements or mandates upon decision makers at the local board and school levels.

7. Will the decision making authority and accountability for addressing the subject to be regulated be placed in the same entity? The decision making authority and accountability for addressing the subject to be regulated will remain in the same entity.

8. Will the amended regulation be consistent with and not an impediment to the implementation of other state

educational policies, in particular to state educational policies addressing achievement in the core academic subjects of mathematics, science, language arts and social studies? The repeal of the regulation should not be an impediment to the implementation of other state educational policies.

9. Is there a less burdensome method for addressing the purpose of the regulation? There is no less burdensome method for addressing the purpose of the regulation.

10. What is the cost to the State and to the local school boards of compliance with the regulation? There is no additional cost to the State and to the local school boards of compliance with the regulation.

~~**852 Child Nutrition**~~

~~**1.0 Required Policy**~~

~~Each school district shall have a Child Nutrition Policy which at a minimum shall provide that:~~

~~1.1 Meals served to children are nutritious and well balanced as defined by USDA 7CFR Part 210.10 Nutrition Standards for Lunches and Menu Planning Methods and USDA 7CFR Part 220.8 Nutrition Standards for Breakfast and Menu Planning Alternatives.~~

~~1.2 The foods sold in addition to meals be selected to promote healthful eating habits and exclude those foods of minimal nutritional value as defined by the Food and Nutrition Service, USDA 7 CFR Part 210, Appendix B.~~

~~1.3 Purchasing practices ensure the use of quality products.~~

~~1.4 Students have adequate time to eat breakfast and lunch.~~

~~1.5 Nutrition education be an integral part of the curriculum from preschool to twelfth grade.~~

~~1.6 Food service personnel use training and resource materials developed by the Department of Education and the United States Department of Agriculture to motivate children in selecting healthy diets.~~

3 DE Reg. 524 (10/1/99)
8 DE Reg. 540 (10/1/04)

DEPARTMENT OF FINANCE

DIVISION OF UNCLAIMED PROPERTY

Statutory Authority: 12 Delaware Code, Section 1156 (12 **Del.C.** §1156)

PUBLIC NOTICE

Regulation on Practices and Procedures for Appeals of Determinations of the Audit Manager

NATURE OF PROCEEDINGS; SYNOPSIS OF THE SUBJECT AND SUBSTANCE OF THE PROPOSED REGULATION

In accordance with procedures set forth in 29 **Del.C.**, Ch. 11, Subch. III and 29 **Del.C.**, Ch. 101, the Department of Finance is proposing to adopt a regulation on practices and procedures for appeals of determinations of the Audit Manager as described in 12 **Del.C.** §1156. The proposed regulation sets forth the rules governing practices and procedures for those appeals.

STATUTORY BASIS AND LEGAL AUTHORITY TO ACT

12 **Del.C.** §1154; 12 **Del.C.** §1156; 12 **Del.C.** §1208.

OTHER REGULATIONS AFFECTED

None.

HOW TO COMMENT ON THE PROPOSED REGULATION

Members of the public may receive a copy of the proposed regulation at no charge by United States Mail by writing or calling Mr. Mark Udinski, Department of Finance, Escheator of the State of Delaware, Carvel State Building, 820 North French Street, P.O. Box 8763, Wilmington, Delaware 19899-8763, phone (302) 577-8260, or facsimile (302) 577-8565. Members of the public may present written comments on the proposed regulation by submitting such written comments to Mr. Mark Udinski at the address of the Delaware Department of Finance as set forth above. Written comments must be received on or before January 31, 2012.

Regulation on Practices and Procedures for Appeals of Determinations of the Audit Manager

1.0 Construction of Rules of Practice and Procedure

1.1 Unless otherwise provided, these Rules of Practice govern appeals to the Secretary of Finance of any determination by the Audit Manager brought under 12 **Del.C.** §1156.

1.2 For purposes of these rules: (1) any term in the singular includes the plural, and any term in the plural includes the singular, if such use would be appropriate; and (2) any use of a masculine, feminine, or neuter gender encompasses such other genders as would be appropriate.

2.0 Appearance and Practice Before the Independent Reviewer

2.1 In any appeal, a person may be represented by an attorney at law admitted to practice before the Supreme Court of the State of Delaware. Attorneys who are not so admitted must apply for admission *pro hac vice* through Rule 2.2 below.

2.2 Pursuant to Rule 72(a) of the Delaware Supreme Court Rules, attorneys who are not members of the Delaware Bar may be admitted *pro hac vice* in an appeal in the discretion of the independent reviewer upon written motion by a member of the Delaware Bar who maintains an office in this State for the practice of law ("Delaware Counsel"). Pursuant to Delaware Supreme Court Rule 72(c), Delaware Counsel for any party shall appear in the matter for which admission *pro hac vice* is filed and shall sign or receive service of all notices, orders, pleadings or other papers filed in the matter and shall attend all proceedings before the independent reviewer, unless excused by the independent reviewer.

2.3 Designation of address for service; notice of appearance; withdrawal.

2.3.1 When an attorney first makes any filing or otherwise appears in a representative capacity before an independent reviewer in an appeal, he or she shall file with the independent reviewer, and keep current, a written notice of appearance stating the name of the appeal; the attorney's name, bar identification number, business address, telephone number, and electronic mail address; and the name and address of the person or persons represented.

2.3.2 Withdrawal by any attorney shall be permitted only by written order of the independent reviewer. A motion seeking leave to withdraw shall state with specificity the reason for such withdrawal.

3.0 Appointment of an Independent Reviewer

If a holder timely files a written notice of appeal with the Secretary of Finance of a determination of the Audit Manager, the Secretary of Finance shall designate a qualified person to act as the independent reviewer in a particular appeal, or indefinitely until the authority is transferred. If no independent reviewer has been generally designated, the Audit Manager shall give notice to the Secretary of Finance requesting the appointment of an independent reviewer for the particular appeal.

4.0 Disqualification and Recusal of an Independent Reviewer

If at any time an independent reviewer believes himself or herself to be disqualified from considering an appeal, the independent reviewer shall issue a notice stating that he or she is withdrawing from the appeal and setting forth the reasons therefor.

5.0 *Ex Parte* Communications

5.1 No party to an appeal, or counsel to or representative of a party to an appeal, shall make or knowingly cause to be made an *ex parte* communication relevant to the merits of that appeal to the independent reviewer.

5.2 No independent reviewer with respect to an appeal shall make or knowingly cause to be made to a party to that appeal, or counsel to a party to that appeal, an *ex parte* communication relevant to the merits of that appeal.

6.0 Motions

6.1 Generally. Unless made during a hearing or conference, a motion shall be in writing, shall state with particularity the grounds therefor, shall set forth the relief or order sought, and shall be accompanied by a written brief of the points and authorities relied upon and a proposed order. All written motions shall be served in accordance with Rule 7.0, be filed in accordance with Rule 8.0, meet the requirements of Rule 9.0, and be signed in accordance with Rule 10.0. The independent reviewer may order that an oral motion be submitted in writing. No oral argument shall be heard on any motion unless the independent reviewer otherwise directs.

6.2 Opposing and reply briefs. Briefs in opposition to a motion shall be served and filed within 20 days after service of the motion. Reply briefs shall be served and filed within 10 days after service of the brief in opposition.

6.3 Length limitation. A brief in support of or opposition to a motion shall not exceed 10 pages, exclusive of pages containing any table of contents, table of authorities, and/or addendum. Requests for leave to file briefs in excess of 10 pages are disfavored.

7.0 Service of Papers by Parties

7.1 Service initiating an appeal. At the outset of an appeal, the notice of appeal and any accompanying papers shall be served on the Audit Manager by certified mail, return receipt requested. The return of a return receipt signed by the Audit Manager is not required for service to be effective.

7.2 Service of all other filings.

7.2.1 When required. In every appeal, each paper, including each notice of appearance, written motion, brief, or other written communication, shall be served upon each party in accordance with the provisions of this section until such time as a notice of appearance has been served by counsel for the party or other person represented pursuant to Rule 2.0, after which time service shall be made pursuant to paragraph 7.2.2 of this section upon counsel for the party or other person represented, unless service upon the party or other person represented is ordered by the independent reviewer.

7.2.2 How made. Service shall be made by delivering a copy of the filing. “Delivering” means:

7.2.2.1 Personal service by handing a copy to the person required to be served; or leaving a copy at the person's office with a clerk or other person in charge thereof, or, if there is no one in charge, leaving it in a conspicuous place therein; or, if the office is closed, or the person to be served has no office, leaving it at the person's dwelling house or usual place of abode with some person of suitable age and discretion then residing therein;

7.2.2.2 Mailing the papers through the U.S. Postal Service by first class, registered, or certified mail or Express Mail delivery addressed to the person;

7.2.2.3 Sending the papers through a commercial courier service or express delivery service; or

7.2.2.4 Transmitting the papers by facsimile machine or electronic mail transmission where the following conditions are met:

7.2.2.4.1 The persons serving each other by facsimile transmission or electronic mail transmission have agreed to do so in a writing, and

7.2.2.4.2 Receipt of each document served is confirmed electronically or by a manually signed receipt.

7.2.3 When service is complete. Personal service, service by U.S. Postal Express Mail or service by commercial courier or express delivery service is complete upon delivery. Service by mail is complete upon mailing. Service by facsimile or electronic mail transmission is complete upon confirmation of transmission.

8.0 Filing of Papers with the Independent Reviewer: Procedures

8.1 When to file. All papers required to be served by a party upon any person shall be filed with the independent reviewer at the time of service. Papers required to be filed with the independent reviewer must be received within the time limit, if any, for such filings.

8.2 Where to file. Filing of papers shall be made by filing the original papers or duplicates of the original papers with the independent reviewer.

8.3 To whom to direct the filing. All motions, objections, applications or other filings made during an appeal shall be directed to and decided by the independent reviewer.

8.4 Certificate of service. Papers filed with the independent reviewer shall be accompanied by a certificate stating the name of the person or persons served, the date of service, the method of service and the mailing address, facsimile telephone number, or electronic mail address to which service was made, if not made in person.

9.0 Filing of Papers: Form

9.1 Specifications. Papers filed in connection with any administrative appeal shall:

9.1.1 Be on one grade of unglazed white paper measuring 8-1/2 x 11 inches, except that, to the extent that the reduction of larger documents would render them illegible, such documents may be filed on larger paper;

9.1.2 Be typewritten or printed in either ten or twelve-point typeface or otherwise reproduced by a process that produces permanent and plainly legible copies;

9.1.3 Include at the head of the paper, or on a title page, the title of the appeal, the names of the parties, the subject of the particular paper or pleading, and the file number assigned to the appeal;

9.1.4 Be paginated with all margins at least one inch wide;

9.1.5 Be double-spaced, with single-spaced footnotes and single-spaced indented quotations; and

9.1.6 Be stapled, clipped or otherwise fastened in the upper left corner.

9.2 Signature required. All papers must be dated and signed as provided in Rule 10.0.

9.3 Suitability for record keeping. Documents which, in the opinion of the independent reviewer, are not suitable for computer scanning or microfilming may be rejected. The party submitting the document shall have 10 days within which to provide a suitable copy.

10.0 Filing of Papers: Signature Requirement and Effect.

10.1 General requirements. Every filing of a party represented by counsel shall be signed by Delaware Counsel of record in his or her name and shall state that counsel's bar identification number, business address, electronic mail address, and telephone number.

10.2 Effect of signature.

10.2.1 The signature of counsel or a party shall constitute a certification that:

10.2.1.1 the person signing the filing has read the filing;

10.2.1.2 to the best of his or her knowledge, information and belief, formed after reasonable inquiry, the filing is well grounded in fact and is warranted by existing law or a good faith argument for the extension, modification, or reversal of existing law; and

10.2.1.3 the filing is not made for any improper purpose, such as to harass or to cause unnecessary delay or needless increase in the cost of adjudication.

10.2.2 If a filing is not signed, the independent reviewer shall strike the filing, unless it is signed promptly after the omission is called to the attention of the person making the filing.

11.0 Computation of Time

11.1 Computation. In computing any period of time prescribed in or allowed by these Rules of Practice or by order of the independent reviewer, the day 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 included unless it 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. Unless otherwise specified, intermediate Saturdays, Sundays and State legal holidays shall be excluded from the computation when the period of time prescribed or allowed is 10 days or less, not including any additional time allowed for service by mail in paragraph 11.2 of this section. If on the day a filing is to be made, weather or other conditions have caused the designated filing location to close, the filing deadline shall be extended to the end of the next day that is neither a Saturday, Sunday nor State legal holiday.

11.2 Additional time for service by mail. If service is made by mail, three days shall be added to the prescribed period for response.

12.0 Notice of Appeal: Form and Content

12.1 Each notice of appeal shall be in writing and signed by the holder's Delaware Counsel. The notice of appeal shall specify in reasonable detail the matters in which the holder asserts that the Audit Manager erred in the determination of the protest of the holder, and any statutory provision, rule or regulation the Audit Manager is alleged to be violating or to have violated.

12.2 If the appeal consists of several claims, each claim shall be stated separately.

12.3 Upon filing of the notice of appeal, the holder shall within 20 days designate all evidence it deems necessary to include in the record on appeal. The Audit Manager shall then have an additional 10 days within which to designate all evidence he or she deems necessary to include in the record on appeal.

12.4 It shall not be necessary to include copies of any evidence as a part of the record if (and to the extent that) all parties having an interest in the outcome of the appeal shall execute within 10 days after the filing of the appeal a written stipulation that the evidence may be omitted as part of the record, in which case the stipulation shall be included as part of the record; provided that the independent reviewer or any Chancellor or Vice Chancellor of the Court of Chancery (as the case may be) may order copies of all or part of the omitted evidence to be filed as a part of the record at any time during the pendency of the appeal.

13.0 Notice of Appeal: Amendment and Withdrawal

13.1 At any time prior to the end of the thirty days after the date on which the determination by the Audit Manager of the holder's protest is mailed, the holder may amend the notice of appeal, after which period the notice of appeal may not be amended.

13.2 The holder may withdraw the notice of appeal without prejudice at any time prior to the end of the thirty days after the date on which the determination by the Audit Manager of the holder's protest was mailed, but the holder may only re-file before the end of the thirty days after the date on which the determination by the Audit Manager of the holder's protest was mailed. Otherwise the withdrawal shall be with prejudice.

14.0 Scheduling a Hearing.

14.1 Independent reviewer order requiring hearing. Upon the filing of the notice of appeal, the independent reviewer should promptly schedule an oral hearing on the appeal to be held, absent agreement of the parties, within 90 days after the date on which the Secretary of Finance appoints the independent reviewer.

14.2 Notice of hearing. Upon scheduling a hearing, the independent reviewer shall issue a notice stating the date, time and place of the hearing, and shall serve such notice on the parties.

15.0 Pre-Hearing Submissions

15.1 Submissions generally. At least 5 days prior to the oral hearing date, or at such other time ordered by the independent reviewer, the holder and the Audit Manager shall each submit to the independent reviewer and each other a brief containing argument and referencing supporting documentation from the record before the Audit Manager or an explanation as to why such supporting documentation is not available.

15.2 Timing of production. The independent reviewer may modify the time limits for production of evidence set by these rules.

16.0 Oral Hearings

16.1 Oral Hearings. The oral hearing on the appeal shall be held upon order of the independent reviewer.

16.1.1 All hearings shall be conducted in a fair, impartial, expeditious and orderly manner.

16.1.2 All hearings shall open to the public unless otherwise ordered by the independent reviewer.

16.1.3 All hearings shall be recorded by sound, sound-and-visual, or stenographic means. The cost of recording shall initially be borne by the Audit Manager, subject to later assessment as costs against a party or between the parties in the independent reviewer's discretion, and subject to confirmation by the Secretary of Finance. Any party may at its own expense arrange for a transcription to be made from the recording of any oral hearing recorded by non-stenographic means.

16.2 Continuance. Any motion for a continuance of the hearing date shall be filed as far in advance of the hearing date as practicable. Motions must be for good cause and state with specificity the reason for the continuance request. Any motion for a continuance filed within 10 days of a scheduled hearing is disfavored and will be denied in the absence of extraordinary circumstances.

16.3 Hearing procedure. In the hearing, each party is entitled to present its case or defense by oral argument.

17.0 Evidence

17.1 Admissibility. The independent reviewer may consider all relevant evidence *de novo* on the record.

17.1.1 The independent reviewer may make reference to and be guided by the Delaware Uniform Rules of Evidence. Notwithstanding those rules, the independent reviewer may consider any evidence that reasonable and prudent individuals would commonly accept in the conduct of their affairs, and give probative effect to that evidence.

17.1.2 Evidence may not be excluded solely on the ground that it is hearsay, but the weight to be given to any such evidence is subject to the independent reviewer's discretion.

17.2 Objections. Objections to the admission or exclusion of evidence must be made on the record and shall be in short form, stating the grounds relied upon.

18.0 Proposed Findings of Fact and Conclusions of Law, and Post-hearing Briefs.

18.1 At the discretion of the independent reviewer, the parties may be ordered to file proposed findings of fact and conclusions of law, or post-hearing briefs, or both. The independent reviewer may order that such proposed findings and conclusions be filed together with, or as part of, post-hearing briefs.

18.2 Proposed findings of fact or other statements of fact in briefs shall be supported by specific references to the record.

18.3 In any case in which the independent reviewer has ordered the filing of proposed findings of fact and conclusions of law, or post-hearing briefs, the independent reviewer shall, after consultation with the parties, prescribe the period within which proposed findings of fact and conclusions of law and/or post-hearing briefs are to be filed. The period shall be reasonable under all the circumstances but the total period allowed for the filing of post-hearing submissions shall not exceed 30 days after the conclusion of the hearing unless the independent reviewer permits a different period and sets forth in an order the reasons why a longer period is necessary.

18.4 Unless the independent reviewer orders otherwise, no post-hearing submission shall exceed 25 pages, exclusive of cover sheets, tables of contents and tables of authorities, and exclusive of the evidence in the record to which the post-hearing submission refers.

19.0 Decision After a Hearing.

19.1 In any appeal in which a hearing is held, the independent reviewer shall issue a written decision. The decision shall be submitted to the Secretary of Finance within 90 days after the last day of the hearing or the filing of any post-hearing submission, whichever is later. The decision shall include: (i) a brief summary of the evidence; (ii) findings of fact based on the evidence; (iii) conclusions of law; and (iv) an assessment of costs, including the independent reviewer's fee, against a party or between the parties in the independent reviewer's discretion.

19.2 The Secretary of Finance may adopt or reject the independent reviewer's decision in whole or in part. If the Secretary of Finance modifies or rejects, in whole or in part, the decision of the independent reviewer, the Secretary of Finance shall issue a determination in writing setting forth the basis of any rejection or modification of the independent reviewer's decision.

20.0 Failure to Appear at Hearing

A party's failure to appear at a hearing that has been duly noticed shall not be cause to continue the hearing. If the independent reviewer so orders, the hearing shall proceed in the party's absence, which shall be noted in the record.

21.0 Disruptive Conduct

If a party, or counsel to a party, engages in conduct in violation of an order of the independent reviewer, or other disruptive conduct during an oral hearing, the independent reviewer may impose non-monetary sanctions therefor, including the issuance of an order: (i) excluding the party and/or his or her counsel from any further participation in the hearing; (ii) striking briefs from the record; (iii) providing that certain facts shall be taken to be established for purposes of the appeal; or (iv) providing for such other relief as is just and equitable under the circumstances.

22.0 Appeals

22.1 Any holder aggrieved by a final determination of the Secretary of Finance may file an appeal to the Court of Chancery. A copy of the notice of appeal shall be promptly filed with the Secretary of Finance.

22.2 Upon the filing of an appeal to the Court of Chancery, the administrative record shall be filed with the Court in accordance with Court of Chancery Rule 72.

22.3 Any party that files an appeal to the Court of Chancery shall be responsible for filing with the Court in a timely manner the transcript of that portion of the appeal in which error allegedly occurred. Each party on appeal shall bear his, her or its own costs of transcription.

DIVISION OF UNCLAIMED PROPERTY

Statutory Authority: 12 Delaware Code, Section 1198 (12 **Del.C.** §1198)

PUBLIC NOTICE

Regulation on Practice and Procedure for Establishing Running of the Full Period of Dormancy for Certain Securities Related Property

NATURE OF PROCEEDINGS; SYNOPSIS OF THE SUBJECT AND SUBSTANCE OF THE PROPOSED REGULATION

In accordance with procedures set forth in 29 **Del.C.**, Ch. 11, Subch. III and 29 **Del.C.**, Ch. 101, the

Department of Finance is proposing to adopt a regulation on practices and procedures for establishing whether the full period of dormancy has run against certain securities related property as described in 12 **Del.C.** §1198. The proposed regulation sets forth the rules governing practices and procedures for those determinations.

STATUTORY BASIS AND LEGAL AUTHORITY TO ACT

12 **Del.C.**, §1154; 12 **Del.C.**, §1198; 12 **Del.C.,** §1199; 12 **Del.C.**, §1208.

OTHER REGULATIONS AFFECTED

None.

HOW TO COMMENT ON THE PROPOSED REGULATION

Members of the public may receive a copy of the proposed regulation at no charge by United States Mail by writing or calling Mr. Mark Udinski, Department of Finance, Escheator of the State of Delaware, Carvel State Building, 820 North French Street, P.O. Box 8763, Wilmington, Delaware 19899-8763, phone (302) 577-8260, or facsimile (302) 577-8565. Members of the public may present written comments on the proposed regulation by submitting such written comments to Mr. Mark Udinski at the address of the Delaware Department of Finance as set forth above. Written comments must be received on or before January 31, 2012.

Regulation on Practice and Procedure for Establishing Running of the Full Period of Dormancy for Certain Securities and Related Property

1.0 Construction of Rules of Practice and Procedure

1.1 Unless otherwise provided, these Rules of Practice and Procedure govern the determination or whether the full period of dormancy has run against certain securities and related property as described in 12 **Del.C.** §1198.

1.2 For purposes of these rules: (1) any term in the singular includes the plural, and any term in the plural includes the singular, if such use would be appropriate; and (2) any use of a masculine, feminine, or neuter gender encompasses such other genders as would be appropriate.

2.0 Definitions

2.1 All capitalized terms in this regulation shall have the same meaning ascribed to them in 12 **Del.C.** §1198 as it may be amended from time to time.

2.2 "Securities and Related Property" shall mean Property that consists of (a) intangible ownership interests in corporations, whether or not represented by a stock certificate, bonds and other securities; (b) dividends, cash, stock and other distributions made (or attempted to be made) by issuers of securities in respect of the securities issued; (c) certificates of membership in a corporation or association; (d) funds deposited by a Holder with fiscal agents or fiduciaries for payment to Owners of dividends, coupon interest and liquidation value of stocks and bonds; and (e) funds to redeem stocks and bonds.

3.0 Attempt to Contact Owners of Securities and Related Property

No more than 120 days, and no less than 60 days, before reporting to the State Escheator any Securities and Related Property with a value of $250.00 or more that is otherwise deemed to be Abandoned Property, the Holder of the Securities and Related Property shall attempt to contact the apparent Owner of the Property by letter sent via first class mail, postage prepaid, in substantially the following form:

[Date]

Missing Owner Name
Missing Owner Last-Known Address
[City], [State] [Zip Code]

Re: Abandoned or Unclaimed Property

Dear [Missing Owner Name]:

Our records show that we, [Holder], are holding unclaimed property that may belong to you. We have not had direct contact with you since [mm/dd/yyyy]. The check or identifying number for the [$Amount] we are holding is No. [xxxxxx], and the item is dated [mm/dd/yyyy].

Under Delaware law, we may be required to deliver this property to the State Escheator, on or before [mm/dd/yyyy] if the property is not claimed. Please complete the information below and return this letter to [Holder] no later than [mm/dd/yyyy], so that we may meet our unclaimed property reporting obligations. Do not forget to sign and date your response.

□_____ I am entitled to the above referenced property. Please issue a new check and mail to the following address:

_____
_____
_____

□_____ I am not entitled to the above referenced funds or these funds have already been paid to me.

□_____ I am aware of these funds and choose not to claim them at the present time.

□_____ Please change the address on my account to:

_____
_____
_____

_____ _____
Owner signature Date signed

If any letter is returned to the Holder undelivered, or if any letter appears to have been delivered but the apparent Owner of the Property fails to respond to the letter before the Holder's report of Abandoned Property is due, the Securities and Related Property shall be deemed Abandoned Property against which a full Period of Dormancy has run.

4.0 Attempt to Contact Owner Excused

The Holder is excused from attempting to contact the apparent Owner if the Holder has no record of an address for the apparent Owner, or if the Holder has already given notice to the apparent Owner in a form substantially similar to that required by this regulation under existing federal or state law, rules, or regulations within 90 days of the time specified for notice in this regulation.

5.0 Cost of Compliance; Charge Against Property

A Holder that provides notice under this regulation may charge the cost of postage and other reasonable administrative costs, not to exceed five dollars per mailing, against the Securities and Related Property.

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF LONG TERM CARE RESIDENTS PROTECTION

Statutory Authority: 16 Delaware Code, Section 1101 (16 **Del.C.** §1101)

3310 Neighborhood Homes for Persons with Developmental Disabilities

PUBLIC NOTICE

The Division of Long Term Care Residents Protection (DLTCRP) in conjunction with the Division of Developmental Disability Services (DDDS) propose a revision of Regulation 3310, Neighborhood Homes for Persons with Developmental Disabilities**.**

Any person who wishes to make written suggestions, compilations of data, testimony, briefs or other written materials concerning the proposed new regulations must submit same to Deborah Gottschalk, Chief Policy Advisor, Office of the Secretary, Main Admin Building, 1901 North DuPont Highway, P.O. Box 906, New Castle, Delaware 19720-0906 or by fax to (302) 255-4429 by Tuesday, January 31, 2012.

The action concerning the determination of whether to adopt the proposed regulation will be based upon the results of Department and Division staff analysis and the consideration of the comments and written materials filed by other interested persons.

SUMMARY OF PROPOSED CHANGES

Background

DLTCRP and DDDS identified the need to revise the regulations to promote person centered care in these residential settings. Additionally, the revision establishes performance standards that are definitive and that can be used across providers to measure their performance.

Summary of Proposal

This regulatory proposal essentially re-writes the regulations in particular; Provider Performance Standards; Person's Services and Supports; Staff Stability and Competency; and Safety and Sanitation. The extent of changes also required extensive revisions to the Definitions.

The proposed changes affect the following policy sections:

3310, Neighborhood Homes for Persons with Developmental Disabilities

Statutory Authority

29 **Del.C.** §7903(10), Powers, duties and functions of the Secretary.

3310 Neighborhood Homes for Persons with Developmental Disabilities

***Please Note: Due to the size of the proposed regulation, it is not being published here. A copy of the regulation is available at:**

3310 Neighborhood Homes for Persons with Developmental Disabilities

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DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

Statutory Authority: 31 Delaware Code, Section 512 (31**Del.C.** §512)

PUBLIC NOTICE

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Dental Services

In compliance with the State's Administrative Procedures Act (APA - Title 29, Chapter 101 of the Delaware Code) and under the authority of Title 31 of the Delaware Code, Chapter 5, Section 512 and with 42 CFR

§447.205, Delaware Health and Social Services (DHSS) / Division of Medicaid and Medical Assistance (DMMA) is proposing to amend the Title XIX Medicaid State Plan regarding Medicaid dental benefits for eligible recipients. Dental services are available only to clients under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program.

Any person who wishes to make written suggestions, compilations of data, testimony, briefs or other written materials concerning the proposed new regulations must submit same to Sharon L. Summers, Planning & Policy Development Unit, Division of Medicaid and Medical Assistance, 1901 North DuPont Highway, P.O. Box 906, New Castle, Delaware 19720-0906 or by fax to 302-255-4425 by January 31, 2012.

The action concerning the determination of whether to adopt the proposed regulation will be based upon the results of Department and Division staff analysis and the consideration of the comments and written materials filed by other interested persons.

SUMMARY OF PROPOSAL

The proposed provides notice to the public that the Division of Medicaid and Medical Assistance (DMMA) intends to amend the Title XIX Medicaid State Plan regarding Medicaid dental benefits for eligible recipients. Dental services are available only to clients under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program.

Statutory Authority

- 42 CFR §447.205, *Public notice of changes in Statewide methods and standards for setting payment rates;*
- 42 CFR §441 Subpart B, *Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) of Individuals under Age 21*; and,
- 42 CFR §440.100, *Dental services*.

Background

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) legislation and includes periodic screening, vision, dental, and hearing services. In addition, Section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care service listed at Section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.

Summary of Proposal

The Division of Medicaid and Medical Assistance (DMMA), pursuant to the requirement of 42 CFR §447.205, gives notice to the following action relating to Medicaid reimbursement for dental services for eligible recipients under age 21 years.

With approval of the Centers for Medicare and Medicaid Services (CMS) by a submitted state plan amendment, effective for services provided on or after April 1, 2012, DMMA modifies reimbursement for dental services provided under the EPSDT program.

The provisions of this state plan amendment are subject to approval by the CMS.

Fiscal Impact Statement

The proposed revision imposes no increase in cost on the General Fund.

DMMA PROPOSED REGULATION #11-61
REVISION:

ATTACHMENT 4.19-B
Page 19

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: **DELAWARE**
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES –

OTHER TYPES OF CARE

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services are reimbursed as follows. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both government and private providers.

~~1. Screening services - fee for service.~~

~~2. Treatment services - fee for service.~~

~~3. Dental Treatment - reimburse 85% of billed charges for routine dental services.~~

~~4. Specialized Dental Services - reimburse (a) a percentage of charges for non-orthodontic related services and (b) a flat fee for service for orthodontic related services.~~

~~a. Percentage of Charges for non-orthodontic services - The State pays 85% of billed charges for medically necessary non-orthodontic dental care, determined by: 1) the consideration that 65-70% of the usual & customary rate is nationally known to account for the dental provider's actual costs; and, 2) an allowance of an additional mark-up to permit a reasonable and fair profit and as incentive for providers to participate in the Medicaid Program in order to create adequate access to dental care.~~

~~b. Flat Fee for Service for orthodontic services - The State identifies three primary orthodontic related services that encompass orthodontic reimbursement: 1) Pre-orthodontic treatment visit; 2) Comprehensive orthodontic treatment of the adolescent dentition; and, 3) Periodic orthodontic treatment visit. Rates for each orthodontic service are determined by adopting the 75th percentile of orthodontic rates paid by the Division of Public Health Special Dental Program, which, compare favorably to commercial coverage and encourage provider participation and adequate access to orthodontic care. Care provided outside of these three services will be reimbursed at a percentage of charges. Medicaid reimbursement for these three orthodontic services will be the lower of the submitted charges or the established Medicaid rate.~~

Dental Services – Effective for dates of service on or after April 1, 2012, Delaware pays for dental services at the lower of:

- the provider's billed amount that represents their usual and customary charge; or
- the Delaware Medicaid maximum allowed amount per unit per covered dental procedure code according to a published fee schedule.

The Delaware Medicaid dental fee schedule will be developed based on the National Dental Advisory Service (NDAS) annual Comprehensive Fee Report. For each covered dental procedure code, Delaware's maximum allowable amount will be computed as a percentage of the NDAS published national fee. Delaware will rebase its dental fee schedule rates each time the NDAS publishes a new survey.

General Dental Services shall be paid at 84% of the NDAS 70th percentile amounts Specialty Dental Services shall be paid at 80% of the NDAS 80th percentile amounts.

The Delaware Medicaid Dental Fee Schedule is effective April 1 through March 31 of each year.

The State reserves the right to adjust the fee schedule in order to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems such as HCPCS and CPT and CDT;
3. Establish an initial maximum allowable amount for a new procedure code based on information that was not available when the fee schedule was established for the current year;
4. Adjust the maximum allowable amount when the State determines that the current amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

The dental fee schedule is available on the Delaware Medicaid Assistance Program (DMAP) website at: http://www.dmap.state.de.us/downloads.html

DIVISION OF PUBLIC HEALTH

Statutory Authority: 16 Delaware Code, Section 122(3)p (16 **Del.C.** §122(3)p)
16 **DE Admin. Code** 4405

4405 Free Standing Surgical Centers

PUBLIC NOTICE

The Office of Health Facilities Licensing and Certification, Health Systems Protection Section, Division of Public Health, Department of Health and Social Services, is proposing revisions to the State of Delaware Regulations Governing Free Standing Surgical Centers. Due to the extensive number of amendments the Division has concluded that the current regulations should be repealed and replaced in their entirety with the proposed regulations being published. The purpose of the amendments is to update the requirements so that they are in concert with current healthcare standards and to align them more closely with current federal requirements. On January 1, 2012, the Division plans to publish as proposed the amended regulations and hold them out for public comment per Delaware law.

Copies of the proposed regulations are available for review in the January 1, 2012 edition of the Delaware *Register of Regulations*, accessible online at: http://regulations.delaware.gov or by calling the Office of Health Facilities Licensing and Certification at (302) 283-7220.

Any person who wishes to make written suggestions, testimony, briefs or other written materials concerning the proposed regulations must submit same to Deborah Harvey by Monday, January 30, 2012 at:

Deborah Harvey
Division of Public Health
417 Federal Street
Dover, DE 19901
Email: Deborah.Harvey@state.de.us
Phone: (302) 744-4913

4405 Free Standing Surgical Centers

***Please Note: Due to the size of the proposed regulation, it is not being published here. A copy of the regulation is available at:**

4405 Free Standing Surgical Centers

DIVISION OF SOCIAL SERVICES

Statutory Authority: 31 Delaware Code, Section 512 (31 **Del.C.** §512)

DSSM 5311 - Notifying Appellants and Others of Hearings;
DSSM 5312 - Responding to Fair Hearing Requests

PUBLIC NOTICE

In compliance with the State's Administrative Procedures Act (APA - Title 29, Chapter 101 of the Delaware Code) and under the authority of Title 31 of the Delaware Code, Chapter 5, Section 512, Delaware Health and Social Services (DHSS) / Division of Social Services is proposing to amend policies in the Division of Social Services Manual (DSSM) regarding Fair Hearings, specifically, *Notifying Appellants and Others of Hearings and Responding to Fair Hearing Requests*.

Any person who wishes to make written suggestions, compilations of data, testimony, briefs or other written materials concerning the proposed new regulations must submit same to Sharon L. Summers, Policy, Program & Development Unit, Division of Social Services, 1901 North DuPont Highway, P.O. Box 906, New Castle, Delaware

19720-0906 or by fax to (302) 255-4425 by January 31, 2012.

The action concerning the determination of whether to adopt the proposed regulation will be based upon the results of Department and Division staff analysis and the consideration of the comments and written materials filed by other interested persons.

SUMMARY OF PROPOSAL

The proposal described below amends policies in the Division of Social Services Manual (DSSM) regarding Fair Hearings, specifically, *Notifying Appellants and Others of Hearings and Responding to Fair Hearing Requests*.

Statutory Authority

45 CFR §205.10, *Hearings*

Summary of Proposed Changes

DSSM 5311, *Notifying Applicants and Others of Hearings*: Text was modified to clarify that the word "record" refers to the "case record". Case record is meant to include the totality of all files and records on the client. This clarification was made to ensure that clients can access their full case record and not just the materials that were submitted with the fair hearing summary.

DSSM 5312, *Responding to Fair Hearing Requests*: Text was modified to include reference to the Managed Care Organization (MCO) or other Contractor. This change clarifies that MCOs prepare fair hearing summaries where there are appeals of MCO actions.

Other proposed changes include minor formatting and punctuation changes.

DSS PROPOSED REGULATION #11-52
REVISIONS:

5311 NOTIFYING APPELLANTS AND OTHERS OF HEARINGS

45 CFR 205.10(a)(8), (a)(13)(i)

This policy applies to applicants and recipients of any public assistance program administered by the Division of Social Services (DSS) or the Division of Medicaid and Medical Assistance (DMMA).

1. Hearings Are Made Accessible to the Appellant

   The Hearing Office will arrange the time, date, and place of the hearing so that it is accessible to the appellant.

2. Hearing Office Provides Advance Notice

   The Hearing Office will mail written notice to all parties involved at least 12 days before the hearing.

Exception: An appellant may request less notice in order to speed up the scheduling of the hearing.

3. Hearing Notice is Specific

   The hearing notice will:

   ~~1.~~A. Inform the appellant or representative of the name, address, and phone number of the person to notify if it is not possible for the appellant to attend the scheduled hearing.

   ~~2.~~B. Stipulate that the hearing request will be dismissed if the appellant or his or her representative fails to appear for the hearing without good cause (~~i.e.,~~ e.g., death in family, personal illness, unexpected emergency).

   ~~3.~~C. Include the hearing procedures and any other information that would provide the appellant with an understanding of the proceedings that would contribute to the effective presentation of the household's case. It will also include the fair hearing summary and documents filed for the hearing.

   ~~4.~~D. Explain that the appellant has the right to bring an attorney or other representative to his or her hearing.

~~5.~~E. Explain that the appellant may present any information that he or she desires at the hearing.

~~6.~~F. Explain that the appellant or representative may examine the case record prior to or during the hearing.

5312 RESPONDING TO FAIR HEARING REQUESTS

45 CFR 205.10

This policy applies anytime anyone requests a fair hearing due to a decision made by the Division of Social Services (DSS) or the Division of Medicaid and Medical Assistance (DMMA) for a program administered by DSS or DMMA.

1. The State Agency Prepares a Hearing Summary

   Within 5 working days of receipt of a request for a fair hearing, the agency (or MCO or other Contractor) will prepare a hearing summary and submit the summary to the Hearing Office.

2. Staff Ensure the Summary Contains Pertinent Information

   The hearing summary will contain enough information for the appellant to prepare his or her case. The summary must contain:

   A. Identifying information - Give the client's name, the client's address, and the DCIS identification number.

   B. Action taken – Indicate the basis of the client's appeal (rejection, reduction, closure, amount of benefits, etc.).

   C. Reason for action - Describe the specific action taken by the agency, as well as the factual basis for its decision.

   D. Has assistance continued? - Indicate whether or not the appellant's assistance was restored because the appellant filed a request for a hearing within the timely notice period.

   E. Policy basis - Cite the specific State and federal rules supporting the action taken.

   F. Persons expected to testify - This section lists the names and addresses (if any) of persons that the agency expects to call to testify.

3. The Hearing Office Notifies the Appellant

   Upon receipt of the hearing summary, the Hearing Office will:

   A. Set a prompt date for the hearing.

   B. Send a notice conforming to the requirements of §5311. The notice will include the hearing summary.

   C. Notify all parties, including witnesses, of the date, time, and place of the hearing.

DIVISION OF SOCIAL SERVICES

Statutory Authority: 31 Delaware Code, Section 512 (31 **Del.C.** §512)

PUBLIC NOTICE

Fair Hearing Provisions: DSSM; 5000, 5501, 5502, 5600, 5600.1, 5601, 5602, 5603, 5604, 5605, 5606 and 5607

In compliance with the State's Administrative Procedures Act (APA - Title 29, Chapter 101 of the Delaware Code) and under the authority of Title 31 of the Delaware Code, Chapter 5, Section 512, Delaware Health and Social Services (DHSS) / Division of Social Services is proposing to amend policies in the Division of Social Services Manual (DSSM) regarding various Fair Hearing provisions.

Any person who wishes to make written suggestions, compilations of data, testimony, briefs or other written materials concerning the proposed new regulations must submit same to Sharon L. Summers, Policy, Program & Development Unit, Division of Social Services, 1901 North DuPont Highway, P.O. Box 906, New Castle, Delaware 19720-0906 or by fax to (302) 255-4425 by January 31, 2012.

The action concerning the determination of whether to adopt the proposed regulation will be based upon the results of Department and Division staff analysis and the consideration of the comments and written materials filed by other interested persons.

Summary of Proposed Changes

The proposal described below amends policies in the Division of Social Services Manual (DSSM) regarding various Fair Hearing provisions, including *Definitions, Public Access to Hearing Records, Admissible Evidence, Official Notice, Protocol, and Request for Continuance*.

Statutory Authority

- Federal Rule of Evidence 803
- Delaware Uniform Rules of Evidence
- 31 Del.C. §1101, *Confidential character of public assistance records; penalties for violations*
- 7 CFR 272.1(c), *General Terms and Conditions, Disclosure*
- 7 CFR 273.15(c)(4), *Fair hearings, Timely action on hearings; household requests for postponement*
- 7 CFR 273.15(m), *Hearing official*
- 7 CFR 273.15(q)(5), *Hearing decisions*
- 7 CFR 273.15(s), *Implementation of final State agency decisions*
- 42 CFR 431.240(a)(3), *Conducting the hearing*
- 42 CFR 431.244(g), *Hearing decisions*
- 42 CFR 431.246, *Corrective action*
- 45 CFR 205.10(a)(9), 45 CFR 205.10(a)(14), 45 CFR 205.10(a)(16), 45 CFR 205.10(19), *Hearings, State plan requirements*
- 45 CFR 205.50, *Safeguarding information for the financial assistance programs*

Summary of Proposed Changes

The proposed changes reformat and clarify text for ease of readability. Additional changes include updating DSSM 5000; moving DSSM 5601 to *Definitions*; and, incorporating DSSM 5602, 5603, and 5607 into DSSM 5600.1. Also, section titles were renamed to more accurately reflect the section contents.

The proposed changes affect the following policy sections in the Division of Social Services Manual (DSSM):

DSSM 5000, *Definitions*

DSSM 5501, *Corrective Payments*

DSSM 5502, *Public Access to Hearing Decisions*

DSSM 5600, *Admission of Hearsay Evidence*

DSSM 5600.1, *Admissible Evidence*

DSSM 5601, *Rule of Legal Residuum*

DSSM 5602, *Exclusionary Rules of Evidence*

DSSM 5603, *Official Notice*

DSSM 5604, *Protocol*

DSSM 5605, *Requests for Continuance*

DSSM 5606, *Recusation*

DSSM 5607, *Demeanor Evidence*.

DSS PROPOSED REGULATION #11-53
REVISIONS:

5000 Definitions

~~Advance Notice Period or Timely Notice Period - Is the ten (10) day period between the date a notice is mailed to the date a proposed action is to take effect.~~

~~Appellant - Is a recipient who has requested a hearing.~~

~~Benefits - Are any kind of assistance, payments or benefits made by TANF, GA, Medicaid, Child Care or Food~~

~~Stamps.~~

~~Claimant - Is an applicant who has requested a hearing.~~

~~DHSS - Is the Department of Health and Social Services, including~~

~~1) the Division of Social Services ("DSS"), in connection with economic, medical, vocational or child care subsidy assistance;~~

~~2) the Division of Medicaid and Medical Assistance ("DMMA") or a managed care organization ("MCO") under contract with DHSS to manage an operation of the Medicaid Program, in connection with medical assistance;~~

~~3) the Division of State Service Centers ("DSSC") in connection with the Emergency Assistance Program;~~

~~4) the Division of Developmental Disabilities Services (DDDS) in connection with Medicaid Program services;~~

~~5) the Division of Public Health in connection with Medicaid Program services;~~

~~6) the Division of Services for the Aging and Adults with Physical Disabilities (DSAAPD) in connection with Medicaid Program services.~~

~~DSS - Is the Division of Social Services (or "the Division.")~~

~~Fair Hearing - Is an administrative hearing held in accordance with the principles of due process which include:~~

~~1) Timely and adequate notice;~~

~~2) The right to confront and cross- examine adverse witnesses;~~

~~3) The opportunity to be heard orally;~~

~~4) The right to an impartial decision maker;~~

~~5) The opportunity to obtain counsel.~~

~~Hearing Decision - Is the decision in a case appealed to the State hearing officer. The decision includes the substance of what transpired at the hearing and a summary of the case facts, supporting evidence, and pertinent State or federal regulations and gives the reason for the decision. In Food Stamp disqualification cases, the hearing decision must also respond to reasoned arguments by the appellant.~~

~~EXAMPLE: At a Food Stamp Program Intentional Program Violation Hearing involving a failure to report a change promptly, an appellant may argue that a failure to report does not constitute "clear and convincing evidence" of intent to defraud. The hearing officer's decision must respond to this argument.~~

~~Hearing Officer - Is the individual responsible for conducting the hearing and issuing a final decision on issues of fact and questions of law.~~

~~Hearing Record - Is a verbatim transcript of all evidence and other material introduced at the hearing, the hearing decision, and all other correspondence and other documents which are admitted as evidence or otherwise included for the hearing record by the hearing officer.~~

~~Hearing Summary - Is a document prepared by an agency stating the reason(s) the action under appeal was taken and the information upon which the reasons are based. The summary may include documents to be used to decide the issue in question. Its purpose is to provide an appellant with information to prepare his case for the hearing.~~

~~MCO - Means a Managed Care Organization offering or providing medical services to recipients of medical assistance from DHSS and individual medical service providers of an MCO panel.~~

~~Party - A party to a hearing is a person or an administrative agency or other entity who has taken part in or is concerned with an action under appeal. A party may be composed of one or more individuals.~~

~~Request for a Fair Hearing - Any clear expression (oral or written) by the appellant or his authorized agent that the individual wants to appeal a decision to a higher authority. Such request may be oral in the case of actions taken under the Food Stamp Program.~~

~~State Presenter - Is the agency employee advocating the State's case in a hearing.~~

"Abandonment"; When the claimant fails without good cause, to appear (by himself or by authorized representative) at his or her scheduled hearing.

"**Adequate Notice**"; A written notice that includes:

1. A statement of what action the agency intends to take
2. The reasons for the intended agency action
3. The specific regulations supporting such action
4. An explanation of the individual's right to request a State agency hearing
5. The circumstances under which assistance is continued if a hearing is requested

6. If the agency action is upheld, that such assistance must be repaid under title IV-A, and must also be repaid under titles I, X, XIV or XVI (AABD) if the State plan provides for recovery of such payments.

"**Advance Notice Period**"; The 10 day period between the date a notice is mailed to the date a proposed action is to take effect. (Also called Timely Notice Period.)

"**Appellant**"; Anyone who requests a hearing. (Also called Claimant.)

"**Benefits**"; Any kind of assistance, payments or benefits made by TANF, GA, Medicaid, Child Care, Refugee, Emergency Assistance or Food Supplement programs.

"**Claimant**"; Anyone who requests a hearing. (Also called Appellant.)

"**DSS**"; The Division of Social Services (or "the Division.")

"**DHSS**"; The Department of Health and Social Services, including:

1. The Division of Social Services (DSS), in connection with economic, medical, vocational or child care subsidy assistance
2. The Division of Medicaid & Medical Assistance (DMMA) or a managed care organization (MCO) under contract with DHSS to manage an operation of the Medicaid Program, in connection with medical assistance
3. The Division of State Service Centers (DSSC) in connection with the Emergency Assistance Program
4. The Division of Developmental Disabilities Services (DDDS) in connection with Medicaid Program services
5. The Division of Public Health in connection with Medicaid Program services
6. The Division of Services for the Aging and Adults with Physical Disabilities (DSAAPD) in connection with Medicaid Program services

"**Fair Hearing**"; An administrative hearing held in accordance with the principles of due process which include:

1. Timely and adequate notice
2. The right to confront and cross-examine adverse witnesses
3. The opportunity to be heard orally
4. The right to an impartial decision maker
5. The opportunity to obtain counsel

"**Fair Hearing Summary**"; A document prepared by the agency stating the factual and legal reason(s) for the action under appeal. The purpose of the hearing summary is to state the position of the agency/entity that initiated the action in order to provide the appellant with the necessary information to prepare his or her case.

"**Good Cause**"; May include, but is not limited to the following:

1. Death in the family
2. Personal injury or illness
3. Sudden and unexpected emergencies
4. Failure to receive the hearing notice

"**Group Hearing**"; A series of individual requests for a hearing consolidated into a single group hearing. A group hearing is appropriate when the sole issue involved is one of State or federal law, regulation, or policy. The policies governing hearings will be followed In all group hearings. The individual appellant in a group hearing is permitted to present his or her case or be represented by an authorized representative.

"**Hearing Decision**"; The decision in a case appealed to the State hearing officer. The decision includes:

1. The substance of what transpired at the hearing
2. A summary of the case facts
3. Supporting evidence
4. Pertinent State or federal regulations
5. The reason for the decision

In Food Supplement Program disqualification cases, the hearing decision must also respond to reasoned arguments by the appellant.

EXAMPLE: At a Food Supplement Program Intentional Program Violation Hearing involving a failure to report a change promptly, an appellant may argue that a failure to report does not constitute "clear and convincing evidence" of intent to defraud. The hearing officer's decision must respond to this argument.

"**Hearing Officer**"; The individual responsible for conducting the hearing and issuing a final decision on issues of fact and questions of law.

"**Hearing Record**"; A verbatim transcript of all evidence and other material introduced at the hearing, the hearing decision, and all other correspondence and documents which are admitted as evidence or otherwise included for the hearing record by the hearing officer.

"**Hearing Summary**"; A document prepared by an agency stating the reason(s) the action under appeal was taken and the information upon which the reasons are based. The summary may include documents to be used to decide the issue in question. Its purpose is to provide an appellant with information to prepare his or her case for the hearing.

"**Hearsay Evidence**"; Testimony about a statement made by a third party that is offered as fact without personal knowledge.

"**Individual Hearing**"; A hearing in which an individual client disagrees with the action taken by the Department on the facts of his or her case.

"**MCO**"; 1. A Managed Care Organization offering or providing medical services to recipients of medical assistance from the DHSS.

2. Individual medical service providers of an MCO panel.

"**Party**"; A party to a hearing is a person or an administrative agency or other entity who has taken part in or is concerned with an action under appeal. A party may be composed of one or more individuals.

"**Privilege**"; Appellants may decline to present testimony or evidence at a fair hearing under claim of privilege. Privilege may include the privilege against self- incrimination or communication to an attorney, a religious advisor, a physician, etc.

"**Request for a Fair Hearing**"; Any clear expression (oral or written) by the appellant or his authorized agent that the individual wants to appeal a decision to a higher authority. Such request may be oral in the case of actions taken under the Food Supplement Program.

"**Relevance**"; Refers to evidence. Evidence is relevant if an average person believes that the evidence makes a significant fact more probable.

"**Rule of Residuum**"; Findings of fact must be supported by at least some evidence which is admissible in a court of law.

"**State Presenter**"; The agency employee advocating the State's case in a hearing.

"**Timely Notice Period**"; The 10 day period between the date a notice is mailed to the date a proposed action is to take effect. (Also called Advance Notice Period.)

(Break in Continuity of Sections)

5501 ~~Corrective Payments~~ MAKING CORRECTIVE PAYMENTS OR ACTIONS

~~When the hearing decision is favorable to the appellant, or when the agency decides in favor of the appellant prior to the hearing, the agency will promptly make corrective payments (retroactive to the date incorrect action was taken). For the purpose of this section, "prompt" means action must be taken to initiate the corrective payments or other remedy within five (5) business days of the date of the hearing decision. Benefits will be restored to food stamp households which are leaving a project area before their departure, whenever possible. If benefits are not restored prior to the household's departure, the agency shall forward an authorization for benefits to the household or new project area if this information is known.~~

~~When the hearing decision upholds the agency's action, a claim against the household for any overissuance will be prepared.~~

7 CFR 273.15(s), 42 CFR 431.246, 45 CFR 205.10(a)(16)

This policy applies any time a hearing decision requires an adjustment in benefits. It also applies when an error that favors the appellant/claimant is discovered by the Division of Social Services (DSS) or the Division of Medicaid & Medical Assistance (DMMA).

1. The State Agency Initiates Corrective Actions

Staff will take corrective action (retroactive to the date an incorrect action was taken) when:

A. A hearing decision is favorable to the appellant

B. The agency decides in favor of the appellant prior to the hearing

Staff will take action to initiate the corrective payments or other remedy within 5 business days of the date of the hearing decision.

DSS or DMMA staff will restore benefits to food benefit households that are leaving the State before the household's departure, whenever possible.

NOTE: Staff must always prepare a claim against the household for any over-issuance when the hearing decision upholds the agency's action.

5502 ~~Public Access to Hearing Decisions~~ PROVIDING PUBLIC ACCESS TO HEARING DECISIONS

~~Decisions are accessible to the public subject to provisions for safeguarding public assistance information. Under 31 Delaware Code 1101, "no person may reveal information concerning applicants for or recipients of public assistance except for the purposes directly connected with the administration of the program."~~

7 CFR 272.1(c), 7 CFR 273.15(q)(5), 42 CFR 431.244(g), 45 CFR 205.10(19), 45 CFR 205.50, 31 **Del.C.** §1101

This policy applies to all hearing decisions made by the Division of Social Services (DSS) or the Division of Medicaid & Medical Assistance (DMMA).

1. Hearing Decisions are Available to The Public

Hearing decisions are available to the public on the Division of Social Services and Division of Medicaid & Medical Assistance websites.

DSS: (http://www.dhss.delaware.gov/dhss/dss/redactedfairhearings.html)

DMMA: (http://www.dhss.delaware.gov/dhss/dmma/fairhearings.html).

2. DSS and DMMA Take Steps to Keep Identities Confidential

DSS and DMMA remove information that might identify the appellant/claimant before the decision is made available.

No information concerning applicants or recipients of public assistance is revealed except for the purposes directly connected with the administration of the program.

(Break in Continuity of Sections)

5600 ~~Admission of Hearsay Evidence~~ ADMITTING HEARSAY EVIDENCE

~~1) Hearsay evidence is evidence of a statement made outside the hearing which is introduced at the hearing as proof of the truth of its content.~~

~~2) Hearsay evidence is not admissible over objection unless it meets one of the exceptions to the hearsay rule (evidence which, although it falls within definition of hearsay, is nevertheless admissible because of special necessity) listed in the Delaware Uniform Rules of Evidence. Admissible hearsay evidence includes:~~

~~a) Any statements where the claimant has had an opportunity to cross examine the witness at a prior proceeding or statements of agency staff who could be available as witnesses upon a claimant's request; and.~~

~~b) Evidence which falls within recognized hearing exceptions where cross- examination of the witness would not be meaningful, such as those enumerated in Federal Rule of Evidence 803. (See Ortiz v. Eichler, 794 F2d 889,896 (3rd Cir. 1986).~~

~~c) Official records of the Department of Health and Social Services and other official records when~~

~~authenticated by a custodian of the record.~~

~~d) Evidence recognized by official notice as an exception to the hearsay rule (see 5603).~~

~~Recognized exceptions to the hearsay rule include statements for purposes of medical diagnosis, records of regularly conducted activity (such as E&T logs), records of vital statistics, records of religious organizations, records of or statements in documents affecting an interest in property. For other exceptions, refer to 803 Delaware Uniform Rules of Evidence.~~

Federal Rule of Evidence 803, Delaware Uniform Rules of Evidence

This policy applies to applicants and recipients for any public assistance program administered by the Division of Social Services or the Division of Medicaid & Medical Assistance.

1. The Hearing Officer Decides if Hearsay Evidence is Admissible

Admissible hearsay evidence includes:

A. Statements where the claimant has had an opportunity to cross examine the witness at a prior proceeding

B. Statements of agency staff who could be available as witnesses upon a claimant's request

C. Evidence which falls within recognized hearing exceptions where cross-examination of the witness would not be meaningful

D. Official records of the Department of Health and Social Services and other official records when authenticated by a custodian of the record

E. Evidence recognized by official notice as an exception to the hearsay rule (see DSSM 5603)

Exception: Recognized exceptions to the hearsay rule include:
1. Statements for purposes of medical diagnosis
2. Records of regularly conducted activity (such as Employment and Training logs)
3. Records of vital statistics
4. Records of religious organizations
5. Records of or statements in documents affecting an interest in property
See Delaware Uniform Rules of Evidence §803 for more exceptions.

2. Hearsay Evidence is Not Admissible if There is an Objection

If a party to the hearing objects to the use of hearsay evidence, the evidence will not be admitted.

Exception: Hearsay evidence is admissible, regardless of objections, if it meets one of the exceptions to the hearsay rule listed in the Delaware Uniform Rules of Evidence.

5600.1 ~~Admissible Evidence~~ ADMITTING EVIDENCE

~~Evidence admitted at the hearing shall be limited to evidence having a bearing on the issue(s) on appeal. Such issues include those offered by the appellant at the time of his/her appeal and those offered by the State or other party as a basis for the action or inaction under appeal. No other evidence or issues shall be considered.~~

45 CFR 205.10(14)

This policy applies to applicants and recipients for any public assistance program administered by the Division of Social Services or the Division of Medicaid & Medical Assistance.

1. Hearing Officer Determines if Evidence is Admissible

Evidence must meet the following minimum criteria to be admissible.

A. Relevance - In order for evidence to be admissible in a fair hearing it must be relevant. Evidence is relevant if an average person believes that the evidence makes a significant fact more probable.

B. Reliability - In order for evidence to be admissible in a fair hearing it must be reliable.

C. Competence - In addition to relevance and reliability, evidence admitted at a hearing must be competent.

D. Privilege - Appellants may decline to present testimony or evidence at a fair hearing under claim of privilege.

The hearing officer may make a negative assumption when a party declines to give testimony under a claim of privilege.

Privilege may include the privilege against self-incrimination or communication to an attorney, a religious advisor, or doctor.

Exception: Privilege may not be disclosed without the consent of the person who sought the professional assistance unless:
1. It has been waived
2. The person attempting to claim it has put the subject of the privilege at issue in the fair hearing

1. Claimants or Witnesses May Waive Privilege

Privileges are waived by a claimant or witness if he or she testifies to some part of the privileged matter.

Privileges are waived by a claimant if the information is relevant to the defense of the action or inaction under appeal.

EXAMPLE: A person who makes his or her medical condition an issue may not use Doctor/ Patient privileges to exclude any information relating to his or her condition.

2. Hearing Officer Limits Admissible Evidence

Only evidence relating to the issue under appeal is admissible at the hearing. Issues under appeal include those offered by:

A. The appellant at the time of his or her appeal

B. The State as a basis for the action or inaction under appeal

C. Another party as a basis for the action or inaction under appeal

3. Hearing Officer May Admit Other Evidence

Information concerning matters of common knowledge and generally accepted as true may be relied on in a fair hearing whether or not it is introduced by evidence or testimony.

The behavior of a party to a hearing may be taken by a hearing officer into evidence only when the behavior has been noted in the hearing record.

5601 ~~Rule of Legal Residuum~~ RESERVED

~~Findings of fact must be supported by at least some evidence which is admissible in a court of law.~~

5602 ~~Exclusionary Rules of Evidence~~ RESERVED

~~1) Relevance - In order for evidence to be admissible in a fair hearing it must be relevant. Evidence is relevant if a reasonable person could feel that, assuming the evidence is true, it renders a significant fact more probable than it appeared before the introduction of the evidence.~~

~~2) Reliability - In order for evidence to be admissible in a fair hearing it must be reliable.~~

~~3) Competence - In addition to relevance and reliability, evidence admitted at a hearing must be competent.~~

~~4) Privilege - Appellants may decline to present testimony or evidence at a fair hearing under claim of privilege.~~

~~Privilege may include the privilege against self- incrimination or communication to an attorney, a religious advisor, or physician (and may not be disclosed without the consent of the person who sought the professional assistance unless it has been waived or the person attempting to claim it has put the subject of the privilege at issue in the fair hearing).~~

~~Privileges are waived by a claimant or witness if he/she testifies to some part of the privileged matter or, in the case of a claimant, the matter is relevant to a claim in defense that is the subject of the hearing.~~

~~EXAMPLE: A person who makes his/her medical condition an issue may not use Doctor/ Patient privileges to exclude any information relating to his/her condition), or~~

~~The hearing officer may take a negative inference when a party declines to give testimony under a claim of~~

~~privilege.~~

5603 ~~Official Notice~~ RESERVED

~~Information concerning matters of common knowledge and generally accepted as true may be relied on in a fair hearing whether or not it is introduced by evidence or testimony.~~

5604 ~~Protocol~~ DISCUSSING THE CASE

~~1) If a hearing is requested, a party to the hearing may not discuss the merits of the case with the hearing officer before the hearing.~~

~~2) Agency employees may not discuss the merits of the case with the hearing officer after the hearing is adjourned. However, after the hearing decision is made final, the parties may discuss the results of the hearing with the hearing officer. An exception to this is if the hearing officer has remanded or sent the case back with instructions for further action and the agency worker expects to receive another request for a fair hearing.~~

This policy applies to all parties involved with a hearing for any public assistance program administered by the Division of Social Services or the Division of Medicaid & Medical Assistance.

1. Discussions About the Case Are Prohibited

A. Before the Hearing:

A party to the hearing may not discuss the merits of the case with the hearing officer.

B. After the Hearing

Agency employees may not discuss the merits of the case with the hearing officer after the hearing is adjourned.

However, after the hearing decision is made final, the parties may discuss the results of the hearing with the hearing officer.

Exception: The parties may not discuss the results of the hearing with the hearing officer if the hearing officer sends the case back with instructions for further action and the agency worker expects to receive another request for a fair hearing.

5605 ~~Requests for Continuance~~ REQUESTING A CONTINUANCE

~~Either party to a hearing may request that the hearing officer continue the hearing on a different date.~~

~~A witness or party in interest to the hearing does not have standing to request that the date of a hearing be continued.~~

~~A request for a continuance must be made at least twenty- four (24) hours in advance of the hearing so that the other party may be notified.~~

~~The request for a continuance must specify the reason that a continuance is needed.~~

~~Examples of requests for which a continuance should be granted, include, but are not limited to:~~

~~1) Illness of a party or witness;~~

~~2) Extreme inclement weather;~~

~~3) Request for additional time to prepare for the hearing.~~

~~The hearing officer will respond to the request not later than ten (10) days after the request is received.~~

~~No continuance will be granted to the State or its agent if the continuance would result in the State exceeding the time limits specified in §5305 and §5309 or any statutory time limit.~~

7 CFR 273.15(c)(4)

This policy applies to every appellant, appellant's authorized agent, and agency staff involved in the hearing. It applies to any public assistance program administered by the Division of Social Services or the Division of Medicaid & Medical Assistance.

1. Either Party To A Hearing May Request A Continuance

Either party to a hearing may request that the hearing officer continue the hearing on a different date.

Exception: A witness or party in interest to the hearing may not request a continuance.

2. Requests For A Continuance Meet Specific Requirements

A request for a continuance must:

A. Be made at least 24 hours in advance of the hearing so that the other party may be notified

B. Specify the reason that a continuance is needed

Examples of requests for which a continuance should be granted, include, but are not limited to:

1. Illness of a party or witness
2. Extreme inclement weather
3. Request for additional time to prepare for the hearing

3. Hearing Officer Responds to Requests

The hearing officer will respond to the request not later than 10 days after the request is received.

No continuance will be granted to the State or its agent if the continuance would result in the State exceeding the time limits specified in DSSM 5305 and DSSM 5309 or any statutory time limit.

5606 ~~Recusation~~ DISQUALIFYING A HEARING OFFICER

~~Either party at a hearing may request that a hearing officer disqualify himself from hearing the issue for reasons of interest or prejudice. A hearing officer may disqualify himself sua sponte (on his own motion). If disqualified, a hearing officer will immediately notify the Director of the Division of Social Services who will promptly appoint a new hearing officer.~~

7 CFR 273.15(m), 42 CFR 431.240(a)(3), 45 CFR 205.10(a)(9)

This policy applies to every hearing officer, appellant, appellant's authorized agent, and agency staff involved in the hearing. It applies to any public assistance program administered by the Division of Social Services or the Division of Medicaid & Medical Assistance.

1. Hearing Officer Is Impartial

The hearing officer must be impartial with no personal stake or involvement in the case. The hearing officer is prohibited from having any involvement in the initial determination of the action in question.

2. Hearing Officer May Disqualify Himself

3. Either Party May Ask to Disqualify a Hearing Officer

The appellant, the appellant's authorized agent, or the agency employee may ask the hearing office to disqualify himself or herself from the hearing. This could happen if they believe the hearing officer has an interest in or prejudice against an issue of the hearing.

4. Hearing Officer Gives Notice of Disqualification

If a hearing officer is disqualified, the officer will immediately notify the Director of the Division of Social Services. The Director will promptly appoint a new hearing officer.

5607 ~~Demeanor Evidence~~ RESERVED

~~The behavior of a party to a hearing may be taken by a hearing officer into evidence only when the behavior has been noted in the hearing record.~~

DEPARTMENT OF STATE

DIVISION OF PROFESSIONAL REGULATION

Statutory Authority: 24 Delaware Code, Section 5206(1) (24 **Del.C.** §5206(1))
24 **DE Admin. Code** 5200

5200 Board of Examiners of Nursing Home Administrators

The Delaware Board of Examiners of Nursing Home Administrators pursuant to 24 **Del.C.** §5206(1) proposes to revise their rules and regulations. The proposed revision to the rules defines a Preceptor, adds pre-Approval of a direct supervisor for the Administrator in Training Program, changes the percentages of the type of work done for the Administrator in Training Program, changes the time periods for an expired license, and allows for continuing education credits for the appointees of the Board for their attendance at board meetings.

The Board will hold a public hearing on the proposed rule change on March 13, 2012 at 1.00 pm., Second floor Conference Room B, Cannon Office Building, 861 Silver Lake Blvd., Dover DE 19904. Written comments should be sent to Michele Howard, Administrator of the Delaware Board of Examiners of Nursing Home Administrators, Cannon Building, 861 Silver Lake Blvd., Dover DE 19904.

5200 Board of Examiners of Nursing Home Administrators

1.0 General Provisions

1.1 Words and terms defined in Title 24, Chapter 52 of the **Delaware Code** are applicable to these regulations.

1.2 The following additional words and terms, when used within these regulations, shall have the following meaning unless the context clearly indicates otherwise:

"**Direct Supervision** "means oversight on the premises of a nursing home by a preceptor.

"**Preceptor**" means an individual who currently has an active Delaware Nursing Home Administrator license and is employed in a Skilled Nursing Facility (SNF) or Assisted Living Facility (AL) and is approved by the Board to have oversight of an AIT candidate according to the rules of the AIT Program.

"**Sponsoring Facility**" means the nursing home facility at which candidates expect to conduct the majority of their AIT program, often their employer.

1.3 Licensees shall display their license in their office or other conspicuous place in their place of business or employment.

1.4 Upon receipt of satisfactory evidence that a license has been lost, mutilated, or destroyed, the Board may issue a duplicate license. The duplication fee is set by the Division of Professional Regulation (Division).

1.5 Licensee shall inform the Board of a change in address within 30 days.

2.0 Application for Licensure by Examination

2.1 Applications shall be made in writing on forms provided by the Board.

2.2 To obtain licensure, applicants must meet the educational and experience requirements and must pass the National Association of Boards ("NAB") examination.

2.3 Applicants must obtain Board approval before they may take the NAB examination. To obtain Board approval, applicants must:

2.3.1 Submit satisfactory evidence of having met one of the educational requirements under Section 5209(a)(1) of Title 24 of the **Delaware Code**, and

2.3.2 Submit a plan to complete the Administrator-In-Training ("AIT") program that corresponds with their education in accordance with regulation section 3.0, and

2.3.3 Identify the applicant's preferred Preceptors.

2.4 If the Board is satisfied that the applicant has completed the requisite education and approves the applicant's AIT plan and preferred Preceptors, the applicant shall be approved to begin their AIT program under the direct supervision of the approved Preceptors.

2.4.1 Approved applicants shall begin their AIT program immediately.

2.4.2 Applicants not approved by the Board may be given the opportunity to rectify deficiencies in their applications before denial of their application is proposed.

2.5 Applicants approved to take the examination will be granted licensure once the Board receives confirmation that the applicant has achieved a passing score of 75% or more on the National Association of Boards ("NAB") examination.

2.5.1 Applicants who do not pass the first examination may retake the examination within the following three months after the date of the exam without further Board approval.

2.5.2 Applicants who do not pass the second examination may retake the examination within the following six months after the date of the exam without further Board approval.

2.5.3 Applicants who do not pass the third examination must obtain Board approval each time they wish to retake the examination. The Board will approve these applicants to retake the examination only after they complete 40 additional hours working under the direct supervision of a Delaware-licensed nursing home administrator in a skilled nursing facility previously approved by the Board.

3.0 Administrator-In-Training ("AIT") Program

3.1 ~~AIT programs must be approved by the Board and conducted under the direct supervision of the Board approved Preceptors.~~ Every Administrator-In-Training (AIT) program shall be approved by the Board and shall be conducted under the direct supervision of the Pre-Approved Preceptor(s). The start date and expiration date of the approved AIT program shall be printed on the AIT license. AIT Progress Reports must be submitted to the Board by the AIT every three (3) months for the duration of the AIT program. Supervised training of the AIT must continue for the entire duration of the AIT program, regardless of whether or not the AIT outline has been fulfilled.

3.2 AIT programs must be split between a skilled nursing facility ("SNF") and an assisted living facility ("ALF"). If the Sponsoring Facility is an SNF, the Board will require that at least ~~5~~10% of the program be completed in an ALF. If the Sponsoring Facility is an ALF, the Board will require that at least ~~10~~25% of the program be completed in an SNF. The training for each subject of the program shall be conducted in the proper facility. Because the AIT program is split between an SNF and an ALF, a preceptor is required for each type of facility.

3.3 Its shall begin their program immediately after receiving notification of approval of their AIT plan and Preceptors.

3.4 Preceptors shall make themselves available to provide direction, observation, aid, training, and instruction to their AIT. Preceptors shall submit quarterly progress reports to the Board. AIT programs are expected to be an interactive process between the Preceptor and their AIT to ensure that the AIT fully experiences the nature and scope of a nursing home administrator's responsibilities.

3.5 AIT programs are expected to provide applicants with experience that will establish their suitability and fitness to practice as a nursing home administrator and their ability to perform the essential functions of a nursing home administrator. Examples of essential functions are:

- Understanding and communicating general and technical information that is necessary to the administration and operation of a nursing home with or without reasonable accommodation i.e., applicable health and safety regulations.
- Assuming responsibility for the administration of a nursing home.
- Relating the physical, psychological, spiritual, emotional, and social needs of ill or aged individuals to the administration of a nursing home and creating the compassionate climate necessary to meet the needs of the patients with or without reasonable accommodation.

3.6 AIT programs must be completed within the allotted time, including any extensions granted by the Board; otherwise the AIT license expires and the individual must submit a new application for licensure as an AIT.

3.7 Extensions may be granted at the sole discretion of the Board upon written request by an AIT or a Preceptor. Requests for extensions must be submitted before the expiration of the AIT licensing certificate and must provide a detailed explanation of the reason an extension is needed.

4.0 Application for Licensure by Reciprocity

4.1 Applicants must:

4.1.1 Submit a notarized statement listing all licensing jurisdictions in which a license was held, and

4.1.2 Cause a verification of licensure status to be submitted directly to the Board from all jurisdictions.

4.2 Determination of Substantial Similarity of Licensing Standards - The applicant must submit a copy of the laws and regulations governing licensure from the jurisdiction from which reciprocity is sought. The burden of proof is upon the applicant to demonstrate that the licensure standards are at least equivalent to those of this State. Based upon the information presented, the Board shall make a determination regarding substantial similarity.

5.0 Programs for Continuing Education Credits

5.1 Continuing education programs consisting of Board approved seminars, resident or extension courses, conferences and workshops totaling 48 classroom hours or more, on any of the subject areas enumerated in 5.2 below, are required for biennial licensure of a license as a Nursing Home Administrator. The following are requirements for license renewal:

5.1.1 For licenses initially authorized during the first six months of the biennial period, 36 credit hours will be required for renewal.

5.1.2 For licenses initially authorized during the second six months of the biennial period, 24 credit hours will be required for renewal.

5.1.3 For licenses initially authorized during the third six months of the biennial period, 12 credit hours will be required for renewal.

5.1.4 For licenses initially authorized during the fourth six months of the biennial period, no credit hours will be required for renewal.

5.1.5 When continuing education units are not met, there will be no extensions, absent showing hardship.

5.2 Content of programs of continuing education shall include one or more of the following general subject areas or their equivalents:

5.2.1 Applicable standards of environmental health and safety,

5.2.2 Local health and safety regulations,

5.2.3 General Administration,

5.2.4 Psychology of patient care,

5.2.5 Principles of medical care,

5.2.6 Personal and social care,

5.2.7 Therapeutic and supportive care and services in long-term care,

5.2.8 Department organization and management,

5.2.9 Community interrelationships, and,

5.2.10 Business or financial management.

5.3 Acceptable programs of continuing education are:

5.3.1 Those conducted solely by accredited educational institutions.

5.3.2 Those conducted jointly by accredited educational institutions and associations, professional societies, or organizations other than accredited colleges or universities.

5.3.3 Those conducted solely by associations, professional societies, and other professional organizations other than accredited educational institutions.

5.3.4 Those self-instruction or home study courses, videos, computer-assisted programs, and teleconferences pre-approved by the Board, may be accumulated at no more than 12 hours per renewal period.

5.3.5 Courses approved by the National Association of Boards (NAB).

5.4 Upon completion of an approved program of study, the sponsor or sponsors of the program shall issue certificates of attendance or other evidence of completion satisfactory to the Board.

5.5 Licensees appointed to the Delaware Board of Examiners of Nursing Home Adminstrators may receive 0.5 CE credits for every board meeting they attend, regardless of the length of the meeting. Members may be granted credit for a maximum of six meetings within a two-year licensure period, for a cap of 3.0 CE credits.

***Please Note: As the rest of the sections were not amended, they are not being published here. A complete copy of the final regulation is available at:**

5200 Board of Examiners of Nursing Home Administrators

DIVISION OF PROFESSIONAL REGULATION

8800 Boxing, Sparring Matches and Exhibitions

Statutory Authority: 28 Delaware Code, Chapter 1 (28 **Del.C.** Ch. 1)
28 **DE Admin. Code** 8800

PUBLIC NOTICE

8800 Boxing and Combative Sports Entertainment Rules and Regulations

The Department of State, in accordance with 28 **Del.C.** Chapter 1, is proposing to amend the regulations related to combative sports and combative sports entertainment.

Written comments should be submitted to James Collins, Director, Division of Professional Regulation, at the above address on or before February 4, 2012. Anyone wishing to obtain a copy of the proposed regulations or to submit written comments should contact Shauna Slaughter, Administrative Specialist, at the above address or by calling (302) 744-4502.

The Department through the Director may consider promulgating the proposed regulations immediately after closure of the public comment period.

8800 ~~Boxing and~~ Combative Sports Entertainment Rules and Regulations

(Break in Continuity of Sections)

Part C Professional Mixed Martial Arts

1.0 Weight Classes

1.1 Men's Division

1.1.1 Flyweight up to 125 lbs.

1.1.2 Bantamweight over 125 - 135 lbs.

1.1.3 Featherweight over 135 - 145 lbs.

1.1.4 Lightweight over 145 - 155 lbs.

1.1.5 Welterweight over 155 - 170 lbs.

1.1.6 Middleweight over 170 -185 lbs.

1.1.7 Light Heavyweight over 185 - 205 lbs.

1.1.8 Heavyweight over 205 -265 lbs. and
1.1.9 Super Heavyweight over 265 lbs.
1.2 Women's Division
1.2.1 Flyweight up to 105 lbs.
1.2.2 Bantamweight over 105-114~~0~~ lbs.
1.2.3 Featherweight over 114~~0~~-123~~0~~ lbs.
1.2.4 Lightweight over 123~~0~~-132~~0~~ lbs.
1.2.5 Welterweight over 132~~0~~-141~~0~~ lbs.
1.2.6 Middleweight over 141~~0~~-150 lbs.
1.2.7 Light Heavyweight over 150-159~~59~~60 lbs.
1.2.8 Cruiserweight over 15~~9~~60-16~~8~~70 lbs.
1.2.9 Heavyweight over 16~~8~~70 lbs.
1.3 Should a fighter be a no-show, that bout shall be canceled.
1.4 Should a fighter ~~not make weight~~ be over their weight class, they shall be given one (1) hour to ~~make~~ comply with their weight class but shall not be permitted to lose more than two (2) pounds in that time and shall be permitted to weigh-in a second time. There shall be a one (1) pound allowance in non-championship fights.
1.5 In some instances, fighters that are cleared for the same event may be approved to fight another fighter on the card pending approval of the Division or the Division's Designated Agent (hereafter referred to as the Division).
1.6 There shall be no allowances made for fighters being under their weight class. They will not be permitted to gain weight nor weigh-in a second time.
1.7 Fighters may fight up or down one Weight Division; however, weight differences between opposing fighters cannot exceed seven pounds, except for the following:
1.3~~7~~.1 Weight differences between men fighters weighing over 185 pounds, fighting up or down one Weight Division, shall not be more than 15 pounds.
1.3~~7~~.2 Weight differences between women fighters weighing over 16~~8~~70 pounds, fighting up or down one Weight Division, shall not be more than 15~~0~~ pounds.
1.8 Contestants shall be weighed in on scales approved by the Division at such a time and place as may be formally designated by the Division in advance of all scheduled bouts. Contestants must weigh in a maximum of 24 hours before the event. All contestants must attend the designated weigh-in proceedings unless otherwise excused by the Division. By special permission of the Division, contestants may be allowed to weigh-in no later than one hour but not greater than 24 hours before the scheduled time of the first match on the card. Contestants must weigh in on the same day as their opponent during the designated weigh-in period.
1.9 Attire for weigh-ins.
1.9.1 Male fighters shall wear no more than undergarments and light weight shorts only.
1.9.2 Female fighters shall wear no more than undergarments and light weight shorts and shirt only.

(Break in Continuity of Sections)

3.0 Equipment and Clothing

3.1 The promoter shall provide a r~~R~~ing stool for each contestant. An appropriate number of stools or chairs shall be available for each contestant's seconds. They shall be located near each contestant's corner.
3.2 For each bout, the promoter is to provide a clean water bucket and ~~clean plastic~~ bottled water ~~bottle in each corner~~ for each contestant and ice for each contestant's seconds.
3.3 Contestants shall wear mma shorts, biking shorts, boxing shorts, Muay Thai shorts or kick-boxing shorts.
3.4 Gi's or shirts are prohibited during competition.

3.5 Females shall wear rash guards.

3.6 Shoes are not permitted.

3.7 No clothing that is made of hard plastic or metallic surface or is deemed hazardous material is permitted.

3.8 No jewelry or piercing accessories is permitted during competition.

4.0 Bandage Wraps

4.1 Bandages shall be restricted to soft gauze cloth not more than 15 yards in length and two inches in width, held in place by not more than ~~6~~10 feet of surgeon's tape, one inch in width for each hand.

4.2 Surgeon's adhesive tape shall be placed directly on each hand for protection near the wrist. The tape may ~~cross the back of the hand twice and extend to cover and protect the knuckles~~ cover the hand but not extend within ¾ inch of the knuckles when the hand is clenched to make a fist.

4.3 The bandages and tape shall be placed on the contestant's hands in the ~~dressing room~~ designated area in the presence of the inspector. ~~and in the presence of the manager or chief second of his or her opponent.~~ It shall be signed off by the inspector with his/her initials and the date.

4.4 ~~Under no circumstances are gloves to be placed on the hands of the contestant without the approval of the inspector~~ Gloves are to be removed cage side after the fight in the presence of an inspector.

(Break in Continuity of Sections)

12.0 Warnings

12.1 The referee may issue a warning for the following infractions. After the initial warning, if the prohibited conduct persists, a penalty may be issued at the sole discretion of the referee. The penalty may result in a deduction of points or disqualification.

12.1.1 Holding or grabbing the fence or any part of the cage or ring;

12.1.2 Holding opponent's shorts or gloves; or one's own gloves or shorts.

12.1.3 The presence of more than two seconds on the fighting area perimeter.

13.0 Fouls and Violations:

13.1 If a fighter flagrantly breaks any rule, the official ring referee shall immediately disqualify him; however, if the foul is not severe or intentional, the referee may issue a warning or point deductions(s) from the offending fighter. The following are fouls and may result in penalties if committed:

13.1.1 Downward pointing elbow strikes;

13.1.2 Butting with the head;

13.1.3 Eye gouging of any kind;

13.1.4 Biting or spitting at an opponent;

13.1.5 Hair pulling;

13.1.6 Fish hooking;

13.1.7 Groin attacks of any kind;

13.1.8 Intentionally placing a finger in any opponent's orifice, cut or laceration;

13.1.9 Small joint manipulation;

13.1.10 Strikes to the spine or back of neck or back of the head or ~~back of neck~~ (defined as anywhere on the head behind the ears and behind the line that would extend from the back of one ear to the back of the other ear and across the top of the head);

13.1.11 Heel kicks to the kidney;

13.1.12 Attacking an opponent on or during the break;

13.1.13 Kicks to the head of a grounded fighter;

13.1.14 Kneeing the head of a grounded fighter;

13.1.15 Stomping of a grounded fighter;

13.1.16 Throat strikes of any kind;
13.1.17 Clawing, pinching, twisting the flesh or grabbing the clavicle;
13.1.18 The use of ~~abusive language~~ grossly offensive profanity or racist remarks in fighting area or in the fighters entrance or exit music;
13.1.19 Any unsportsmanlike conduct ~~that causes an injury to opponent~~ of any kind;
13.1.20 Attacking an opponent who is under the referee's care at the time;
13.1.21 Timidity (avoiding contact, or consistent dropping of mouthpiece, or faking an injury);
13.1.22 Interference from a mixed martial artists seconds;
13.1.23 Throwing an opponent out of the fighting area;
13.1.24 Flagrant disregard of the referee's instructions;
13.1.25 Spiking/slamming an opponent to the fighting surface on his or her head or neck;
13.1.26 Holding or grabbing the fence or any part of the ring or cage;
13.1.27 Any strikes to any joint.

13.2 Disqualification occurs after any combination of three of the fouls listed in 13.1 above. Disqualification will occur after a referee determines that a foul was intentional and flagrant.
13.3 Only a referee can assess a foul. If the referee does not call the foul, judges shall not make that assessment on their own and cannot factor such into their scoring calculations.
13.4 A fouled fighter has up to five minutes to recuperate.
13.5 If a foul is committed, the referee shall:
13.5.1 Call time;
13.5.2 Send the opponent to a neutral corner;
13.5.3 Check the fouled mixed martial artist's condition and safety; and
13.5.4 Assess the foul to the offending contestant, deduct points, and notify each corner's seconds, judges and the official scorekeeper.
13.6 If a bottom contestant commits a foul, unless the top contestant is injured, the fight shall continue, so as not to jeopardize the top contestant's superior positioning at the time.
13.6.1 The referee shall verbally notify the bottom contestant of the foul.
13.6.2 When the round is over, the referee shall assess the foul and notify both corners' seconds, the judges and the official scorekeeper.
13.6.3 The referee may terminate a bout based on the severity of a foul. For such a flagrant foul, a contestant shall lose by disqualification.
13.7 Any point or points to be deducted for any foul must be deducted in the round in which the foul occurred.
13.8 Fighters cannot win by intentionally or accidentally fouling another fighter.

14.0 Legal Strikes

14.1 While Standing
14.1.1 Closed hand strikes and elbows to the body, ~~and~~ head and legs.
14.1.2 Kicking techniques to body, legs and head.
14.1.3 Knees to the body, legs and head.
14.1.4 Takedowns, Throws and Sweeps.
14.1.5 Chokes, ~~Armbars~~ Armlocks and Shouldering.
14.1.6 Standing Submissions.
14.2 While on the Ground
14.2.1 Closed hand strikes and elbows to body, legs and head.
14.2.2 Submissions.

(Break in Continuity of Sections)

17.0 Matchmaking:

17.1 The matchmaking of the contestants is subject to the approval of the Division.

17.2 Matchmaker must present suitable evidence reflecting experience as a matchmaker. The final decision on suitability shall be made by the Division.

18.0 Physical Exams and Other Testing:

18.1 Contestants must complete and submit the ~~following~~ results ~~in~~ of the following tests in writing to the Division:

18.1.1 A physical completed within ~~six~~ three (3) months of the event. ~~HIV exam with negative results is required in order to compete in an event and test must be dated within six months of event.~~

18.1.2 HIV 1/2 qualitative test, c~~C~~omplete Hepatitis B Surface AG testing & Hepatitis C AB (must be tested within six months of event.) and lab results must be faxed from the lab to the Division.

18.1.3 Complete Blood Count (CBC) and Bleed & Coagulation (PT/PTT Pro Time) within four (4) years of the event.

18.1.4 Original EKG report, read by a physician (Dated within ~~six months~~ two (2) years of the event.) Fighters over the age of 35 years old, shall have their report dated within one (1) year of the event.

18.1.5 Original ~~CT/~~MRI Brain Scan report (without contrast), read by a physician (dated within three years of event.)

18.1.6 Original EYE examination by an ophthalmologist-ophthalmological dilation (dated within ~~six months~~ one (1) year of the event.)

18.1.7 ~~Serum Pregnancy test for female contestants (dated within 7 days of event.)~~ All female contestants must complete a pregnancy test the day of the event and the results must be negative. The pregnancy test kit shall be provided by the promoter.

18.1.8 ~~Annual Physical/clinical Gynecological and Breast Exam for female contestants.~~ A chemistry 14 test shall be completed within four (4) years of the event.

18.1.9 A urinalysis test shall be completed within four (4) years of the event.

18.1.~~9~~10 ~~If contestant's injuries result in broken bones or concussion, the contestant shall be suspended for the length of the recovery time according to physician's orders.~~ The ringside physician may place a contestant on a medical suspension for any injuries. The contestant is required to furnish a letter of clearance from the treating physician.

18.1.11 Any fighter 40 years or older may be required by the Division to present more current test results or additional test results.

18.1.~~10~~12 Based on the requirements set forth in Title 28 §105(a)(7), the following criteria for determining physical and mental fitness shall include but is not limited to: blood pressure, pulse, respiration, heart rhythm, heart murmurs, ears, nose, throat, extremities, medications taken, negative pregnancy test results, and mental assessment, which must meet acceptable standards as determined by the examining physician prior to the event.

18.1.13 Mandatory drug testing on the day of the event.

18.2 A fighter must receive clearance from his personal physician and the ringside physician in order to fight after the physicians have reviewed the required tests.

19.0 Requirements of the Division:

19.1 Promoter must present suitable evidence reflecting experience as a promoter. The final decision on suitability shall be made by the Division.

19.2 Matchmaker must present suitable evidence reflecting experience as a matchmaker. The final decision on suitability shall be made by the Division.

19.~~1~~3 Require promoter to provide proof of sufficient liability insurance for the officials.

19.~~2~~4 Require promoter to provide proof of sufficient medical insurance including Accidental Death and Dismemberment insurance for contestants including the deductibe amount as per application requirements.

19.~~3~~5 Require promoter to provide an ambulance with ~~life saving equipment and~~ with at least 2 EMTs ~~one of which is a~~ and 2 paramedics, to be present and on site at all times and have a Delaware licensed physician onsite and at ringside. The paramedics will maintain a supply of life saving medicines and equipment to be available as needed.

19.4~~6~~ Verify the matchmaking done by the promoter by confirming the fight records.

19.~~5~~7 The Division shall not have any direct or indirect interest of any kind in the fighters, the promoter or the event.

19.~~6~~8 Oversee the weigh-ins, the hand wrapping and glove placement after inspecting the gloves.

19.9 The Division shall provide a fighters' meeting to review the rules and regulations prior to the commencement of the fights.

19.~~7~~10 Must inspect and approve the fighting area prior to the start of the contests.

19.~~8~~11 Follow all Delaware laws and rules governing Professional Mixed Martial Arts Events.

19.~~9~~12 Report results of each bout and suspensions to the Association of Boxing Commissions data base within seven days of the event.

19.1~~0~~3 Agree not to hold the event if the promoter has not obtained adequate security to maintain control over the event and provide safety to the public during and after the event.

19.1~~1~~4 Oversee drug testing to be performed on the day of the event on all contestants for illegal drugs, banned substances and performance enhancers.

19.15 Oversee pregnancy tests by a female official only.

20.0 Responsibilities of the Promoter:

20.1 Follow all Delaware rules and laws governing Professional Mixed Martial Arts Events.

20.2 Promoter must present suitable evidence reflecting experience as a promoter. The final decision on suitability shall be made by the Division.

20.~~2~~3 Obtain verbal approval from the Division before applying in writing to the Division for the permit to hold a Mixed Martial Arts Event.

20.~~3~~4 Submit an application to the Division at least thirty days in advance of the event for a permit to hold an MMA event along with the required fee.

20.~~4~~5 Receive permit before holding the MMA event.

20.~~5~~6 Coordinate matchmaking to be approved by the Division.

20.~~6~~7 Cooperate fully with the Division:

20.~~6~~7.1 Fees

20.~~6~~7.2 Match Making approval of the Division.

20.~~6~~7.3 Engage services and provide evidence to the Division that an ambulance with ~~life saving equipment and~~ at least 2 EMTs ~~one of which is a~~ and 2 paramedics, will be on-site during competition. The paramedics will maintain a supply of life saving medicines and equipment to be available as needed.

20.~~6~~7.4 Engage services and provide evidence to the Division that a Delaware licensed physician will be on site during and directly after the competition.

20.~~6~~7.5 Engage contract and provide to the Division proof that medical insurance and an accidental death insurance policy has been purchased per application requirements, including all deductibles.

20.~~6~~7.6 Engage contract and provide to the Division proof that liability insurance has been purchased per the amount required by the venue.

20.~~7~~8 Agree to not officiate at their own events. Cannot have interest of any kind in the Division.

20.~~8~~9 Cannot be involved or interfere in the oversight of the referee, judging, weighing-in, drug testing, post and pre-fight physicals, and glove inspections.

20.~~9~~10 Provide the required gloves, gauze and adhesive tape for fighter wraps, duct tape, disposable gloves for corner persons, water for all fighters and officials, access to ice for corner persons, stools for each contestant, and clean water bucket.

20.1~~0~~1 Provide the fight card that indicates the weight of the fighters and the weight division that the fighters will be in as well as the complete fight records for each contestant, including records for other combative sports in which they were a participant.

20.1~~1~~2 Ensure that there will be NO exhibition bouts.

20.1~~2~~3 Provide hand sanitizer to the fighters to be kept at the equipment table.

20.1~~3~~4 Sanitize all equipment before and after each fight.

20.1~~4~~5 Provide adequate security personnel to maintain order and provide safety during and after the event.

20.1~~5~~6 Obtain a Delaware business license.

20.1~~6~~7 Execute and file a surety bond with the State of Delaware for not less than $10,000.

20.1~~7~~8 Pay for drug testing to be performed on day of event on all contestants for illegal drugs, banned substances and performance enhancers. The Division shall oversee the testing.

20.19 Pay for female pregnancy test kit to be performed on the day of the event.

21.0 Requirements of Fighter:

21.1 Attend pre-fight meeting. Failure to attend will result in disqualification of the fighter.

21.2 Be 18 years or older to participate.

21.3 Pass drug testing completed the day of the event and the pre-fight physical.

21.4 Agree not to use any illegal drug, narcotic, stimulant, depressant, analgesic of any description, or alcohol substance either before or during a match.

21.5 Obtain National MMA ID number prior to the event.

21.6 Follow all Delaware laws, Rules and Regulations and requirements of the Division.

21.7 Obtain a pre-fight and post-fight physical by the physician assigned to the event.

21.8 If fighter should be a no-show, that bout shall be canceled. ~~Under no circumstances shall a fighter be permitted to cut more than two pounds to make weight.~~

21.9 Fighter shall not fight a minimum of ten~~s~~ days from last fight.

21.10 Complete all forms and requirements of the Division.

22.0 Requirements of Seconds/Cornermen:

22.1 Each fighter may have three seconds, but only two seconds at a time are permitted in the fighting area and only when given permission by the referee. The Division may authorize an additional cornerman for championship fights at their discretion.

22.2 Permitted to use such general anti-coagulants such as Thrombin, Adrenaline Hydrochloride 1:1000 and Aventine ~~or any other first-aid medicine approved by the Division~~ to cuts that are in their original labeled containers.

22.3 Must dry the corner area before the next round continues.

22.4 Follow all Delaware laws, Rules and Regulations and requirements of the Division.

22.5 Attend pre-fight meeting. Failure to attend can result in disqualification of the non-compliant second.

Part D Amateur Mixed Martial Arts

1.0 Weight Classes:

1.1 Men's Division

1.1.1 Flyweight up to 1~~1~~2~~2~~5 lbs.

1.1.2 Bantamweight over 1~~1~~2~~2~~5-1~~1~~8~~3~~5 lbs.

~~1.1.3 Super Bantamweight over 118-122 lbs.~~

1.1.4~~2~~3 Featherweight over 1~~22~~35-1~~26~~45 lbs.

~~1.1.5 Super Featherweight over 126-130 lbs.~~

1.1.6~~3~~4 Lightweight over 1~~30~~45-1~~35~~55 lbs.

~~1.1.7 Super Lightweight over 135-140 lbs.~~

1.1.8~~4~~5 Welterweight over 1~~40~~55-1~~47~~0 lbs.

~~1.1.9 Super Welterweight over 147-154 lbs.~~

1.1.~~10~~6 Middleweight over 1~~54~~70-1~~60~~85 lbs.

~~1.1.11 Super Middleweight over 160-167 lbs.~~

1.1.~~12~~7 Light Heavyweight over 1~~67~~85-~~175~~205 lbs.

~~1.1.13 Super Lt. Heavyweight over 175-183 lbs.~~

~~1.1.14 Cruiserweight over 183-190 lbs.~~

~~1.1.15 Super Cruiserweight over 190-195 lbs.~~

1.1.~~16~~8 Heavyweight over ~~195~~205-2~~10~~65 lbs.

1.1.~~17~~9Super Heavyweight over 2~~10~~65 lbs.

1.2 Women's Division

1.2.1 Flyweight up to 105 lbs.

1.2.2 Bantamweight over 105-11~~4~~0 lbs.

1.2.3 Featherweight over 11~~4~~0-12~~3~~0 lbs.

1.2.4 Lightweight over 12~~3~~0-13~~2~~0 lbs.

1.2.5 Welterweight over 13~~2~~0-14~~1~~0 lbs.

1.2.6 Middleweight over 14~~1~~0-150 lbs.

1.2.7 Light Heavyweight over 150-1~~59~~60 lbs.

1.2.8 Cruiserweight over 1~~59~~60-1~~68~~70 lbs.

1.2.9 Heavyweight over 1~~68~~70 lbs.

1.3 Contestants shall be weighed in on scales approved by the sanctioning body at such a time and place as may be formally designated by the sanctioning body in advance of all scheduled bouts. Contestants must weigh in a maximum of 24 hours before the event. All contestants must attend the designated weigh-in proceedings unless otherwise excused by the sanctioning body. By special permission of the sanctioning body, contestants may be allowed to weigh-in no later than one hour but not greater than 24 hours before the scheduled time of the first match on the card. Contestants must weigh in on the same day as their opponent during the designated weigh-in period.

1.4 Attire for weigh-ins.

1.4.1 Male fighters shall wear no more than undergarments and light weight shorts only.

1.4.2 Female fighters shall wear no more than undergarments and light weight shorts and shirt only.

1.~~3~~5 Should a fighter be a no-show, that bout shall be canceled.

1.6 In some instances, fighters that are cleared for the same event may be approved to fight another fighter on the card pending approval of the sanctioning body.

1.7 Should a fighter ~~not make~~ be over their weight class, they shall be given one (1) hour to ~~make~~ comply with their weight class but shall not be permitted to lose more than two (2) pounds in that time and shall be permitted to weigh-in a second time. There shall be a one (1) pound allowance in non-championship fights. ~~In some instances, fighters that are cleared for the same event may be approved to fight another fighter on the card pending approval of the sanctioning body.~~

1.8 There shall be no allowances made for fighters being under their weight class. They will not be permitted to gain weight nor weigh-in a second time.

1.9 Fighters may fight up or down one Weight Division; however, weight differences between opposing fighters cannot exceed seven pounds, except for the following:

1.~~3~~9.1 Weight differences between men fighters weighing over 210 pounds, fighting up or down one Weight Division, shall not be more than 15 pounds.

1.~~3~~9.2 Weight differences between women fighters weighing over 1~~68~~70 pounds, fighting up or down one Weight Division, shall not be more than 1~~5~~0 pounds.

(Break in Continuity of Sections)

3.0 Equipment and Clothing:

3.1 The Promoter shall provide a r~~R~~ing stool for each contestant and an appropriate number of stools or chairs shall be available for each contestant's seconds. They shall be located near each contestant's corner.

3.2 For each bout, the promoter is to provide a clean water bucket and ~~clean plastic water~~ bottled water ~~in each corner~~ for each contestant and access to ice for each contestant's seconds.

3.3 Contestants shall wear mma shorts, biking shorts, boxing shorts, Muay Thai shorts or kick-boxing shorts.

3.4 Gi's or shirts are prohibited during competition.

3.5 Females shall wear rash guards.

3.6 Shoes are not permitted.

3.7 No clothing that is made of hard plastic, ~~or~~ metal~~lic surface~~ or hazardous material is permitted.

3.8 No jewelry or piercing accessories is permitted during competition.

4.0 Bandage Wraps:

4.1 Bandages shall be restricted to soft gauze cloth not more than 1~~3~~0 yards in length and two inches in width, held in place by not more than 10 feet of surgeon's tape, one inch in width for each hand.

4.2 Surgeon's adhesive tape shall be placed directly on each hand for protection near the wrist. The tape may ~~cross the back of the hand twice and extend to cover and protect the knuckles~~ cover the hand but not extend within ¾ inch of the knuckles when the hand is clenched to make a fist.

4.3 The bandages and tape shall be placed on the contestant's hands in the ~~dressing room in the presence of the~~ designated area and inspected by an inspector. ~~and in the presence of the manager or chief second of his or her opponent.~~ It shall be signed off by the inspector with his/her initials and the date.

4.4 ~~Under no circumstances are gloves to be placed on the hands of the contestant without the approval of the inspector.~~ Gloves are to be removed cage side after fight in the presence of an inspector.

(Break in Continuity of Sections)

6.0 Protective Equipment:

6.1 Male mixed martial artists shall wear a foul proof groin protector of their own selection.

6.2 Shin/instep protectors, provided by the promoter are required and should be new or like new and should be the same type for opponent.

6.3 Female mixed martial artists shall wear a foul proof chest protector during competition.

7.0 Gloves:

7.1 The gloves shall be ~~new~~ sanitized and in good condition for all bouts except championship bouts. New or like new gloves shall be provided for all championship bouts.

7.2 All contestants shall wear open finger minimum 7 ounce gloves and shall be supplied by the promoter. No contestant shall supply their own gloves. All gloves are subject to the approval of the sanctioning body.

(Break in Continuity of Sections)

12.0 Warnings:

12.1 The referee may issue a warning for the following infractions. After the initial warning, if the prohibited conduct persists, a penalty may be issued at the sole discretion of the referee. The penalty may result in a deduction of points or disqualification.

12.1.1 Holding or grabbing the fence;

12.1.2 Holding or grabbing any part of the cage or ring;

12.1.~~2~~3 Holding opponent's shorts or gloves; or holding one's own shorts or gloves;

12.1.~~3~~4 The presence of more than two seconds on the fighting area perimeter.

13.0 Fouls And Violations:

13.1 If a fighter flagrantly breaks any rule, the official ring referee shall immediately disqualify him; however, if the foul is not severe or intentional, the referee may issue a warning or point deductions(s) from the offending fighter. The following are fouls and may result in penalties if committed:

13.1.1 No elbows of any kind to the head;

13.1.2 No downward pointing elbows;

13.1.~~2~~3 Butting with the head;

13.1.~~3~~4 Eye gouging of any kind;

13.1.4~~5~~ Biting or spitting at an opponent;

13.1.~~5~~6Hair pulling;

13.1.~~6~~7 Fish hooking;

13.1.~~7~~8 Heel hooks;

13.1.~~8~~9 Finger locks;

13.1.~~9~~10Toe locks;

13.1.1~~0~~1Spine locks;

13.1.1~~1~~2~~Hammer locks to grounded opponent~~ Strikes to any joint;

13.1.1~~2~~3Smothering of grounded opponent (hand over mouth);

13.1.1~~3~~4Groin attacks of any kind;

13.1.14~~5~~Intentionally placing a finger in any opponent's orifice, cut or laceration;

13.1.1~~5~~6Small joint manipulation;

13.1.1~~6~~7Strikes to the spine or back of neck or back of the head ~~or back of neck~~ (defined as anywhere on the head behind the ears and behind the line that would extend from the back of one ear to the back of the other ear and across the top of the head);

~~13.1.17 Any striking to head of grounded opponent;~~

13.1.18 Heel kicks to the kidney;

13.1.19 Throat strikes of any kind;

13.1.20 One or two-handed chokes applied directly to the throat/windpipe;

13.1.21 Clawing, pinching, twisting the flesh or grabbing the clavicle;

13.1.22 Kicking the head of a grounded fighter;

~~13.1.23 Kicks to the head of a standing fighter;~~

13.1.24~~3~~Knees to head of standing opponent;

13.1.2~~5~~4Kneeing the head of a grounded fighter;

13.1.2~~6~~5Stomping of a grounded fighter;

13.1.2~~7~~6The use of ~~abusive language~~ grossly offensive profanity or racist remarks in fighting area or in fighters entry or exit music;

13.1.2~~8~~7Any unsportsmanlike conduct ~~that causes an injury to opponent~~;

13.1.2~~9~~8Attacking an opponent on or during the break;

13.1.~~30~~29Attacking an opponent who is under the referee's care at the time;
13.1.3~~1~~0Timidity (avoiding contact, or consistent dropping of mouthpiece, or faking an injury);
13.1.3~~2~~1Interference from a mixed martial artists seconds;
13.1.3~~3~~2Throwing an opponent out of the fighting area;
13.1.3~~4~~3Flagrant disregard of the referee's instructions;
13.1.3~~5~~4Spiking/slamming an opponent to the fighting surface on his or her head or neck;
13.1.3~~6~~5Neck cranks;
13.1.36 Holding or grabbing the fence or any part of the ring or cage.

13.2 Disqualification occurs after any combination of three of the fouls listed in 13.1 above. Disqualification will occur after a referee determines that a foul was intentional and flagrant.

13.3 Only a referee can assess a foul. If the referee does not call the foul, judges shall not make that assessment on their own and cannot factor such into their scoring calculations.

13.4 A fouled fighter has up to five minutes to recuperate.

13.5 If a foul is committed, the referee shall:

13.5.1 Call Time;

13.5.2 Send the opponent to a neutral corner;

13.5.3 Check the fouled mixed martial artist's condition and safety; and

13.5.4 Assess the foul to the offending contestant, deduct points, and notify each corner's seconds, judges and the official scorekeeper.

13.6 If a bottom contestant commits a foul, unless the top contestant is injured, the fight shall continue, so as not to jeopardize the top contestant's superior positioning at the time.

13.6.1 The referee shall verbally notify the bottom contestant of the foul.

13.6.2 When the round is over, the referee shall assess the foul and notify both corners' seconds, the judges and the official scorekeeper.

13.6.3 The referee may terminate a bout based on the severity of a foul. For such a flagrant foul, a contestant shall lose by disqualification.

13.7 Any point or points to be deducted for any foul must be deducted in the round in which the foul occurred.

13.8 Fighters cannot win by intentionally or accidentally fouling another fighter.

14.0 Legal Strikes:

14.1 While Standing

14.1.1 Closed hand strikes to the body and head.

14.1.2 Elbows to the body.

14.1.~~2~~3 Kicking techniques to body, legs and head.

14.1.~~3~~4 Knees to the body and legs.

14.1.4~~5~~ Takedowns, Throws and Sweeps.

14.1.~~5~~6 Chokes, ~~Armbars~~ Armlocks and Shouldering.

14.1.~~6~~7 Standing Submissions.

14.2 While on the Ground

14.2.1 Closed hand strikes to body, head and legs.

14.2.2 Submissions (chokes, ~~armbars~~ armlocks, straight leg locks only).

14.2.3 Hammer locks.

(Break in Continuity of Sections)

17.0 Matchmaking:

17.1 The matchmaking of the contestants is subject to the approval of the approved sanctioning body.

17.2 Matchmaker must present suitable evidence reflecting experience as a matchmaker. The final decision on suitability shall be made by the Sanctioning Body.

18.0 Physical Exams and other Testing

18.1 All Contestants must complete a physical within 90 days of the event. ~~and~~ They must submit completed physical form to the sanctioning body including negative blood results from a lab that has consulted with a physician for HIV, Hepatitis B and C tests. The results shall be faxed from the lab to the sanctioning body. The lab results must be within 180 days of the enent.

18.2 All contestants are subject to pre-fight and post-fight physicals. Failure to have a Pre-Fight physical will result in disqualification. Failure to have a Post-Fight Medical will result in a minimum 90 day suspension of contestant.

18.3 ~~If contestant's injuries result in broken bones or concussion, the contestant shall be suspended for the length of the recovery time according to physician's orders.~~ The ringside physician may place a contestant on medical suspension for any injuries. The contestant is required to furnish a letter of clearance from the treating physician.

18.4 All female contestants must complete a pregnancy test the day of the event at the event and the results must be negative. The promoter shall provide the pregnancy test kit.

18.5 Based on the requirements set forth in Title 28 §105 (b) (5), the following criteria for determining physical and mental fitness shall include but is not limited to: blood pressure, pulse, respiration, heart rhythm, heart murmurs, ears, nose, throat, extremities, medications taken, negative pregnancy test results, and mental assessment, which must meet acceptable standards as determined by the examining physician prior to the event.

18.6 Any fighter 40 years or older may be required by the Division to present more current test results or additional test results.

19.0 Requirements Of The Sanctioning Body:

19.1 Require promoter to provide proof of sufficient liability insurance for the officials.

19.2 Require promoter to provide proof of sufficient medical insurance including Accidental Death and Dismemberment insurance for contestants including a cap on the deductible amount as per application requirements.

19.3 Require promoter to provide an ambulance ~~with life saving equipment and~~ with at least 2 EMTs, ~~one of which is a~~ and 2 paramedics, to be present and on site at all times and have a Delaware licensed physician onsite and at ringside.The paramedics will maintain a supply of life saving medicines and life saving equipment available as needed.

19.4 Verify the matchmaking done by the ~~promoter~~ matchmaker by confirming the fight records.

19.5 Matchmaker must present suitable evidence reflecting experience as a matchmaker. The final decision on suitability shall be made by the Sanctioning Body.

19.6 Promoter must present suitable evidence reflecting experience as a promoter. The final decision on suitability shall be made by the Sanctioning Body.

19.~~5~~7 Sanctioning body shall not have any direct or indirect interest of any kind in the fighters, the promoter or the event.

19.~~6~~8 Oversee the weigh-ins, the hand wrapping and glove placement after inspecting the gloves.

19.9 The Sanctioning body shall provide a fighters' meeting to review the rules and regulations prior to the commencement of the fights.

19.~~7~~10 Must inspect and approve the fighting area prior to the start of the contests.

19.~~8~~11 Follow all Delaware laws and rules governing Amateur Mixed Martial Arts Events.

19.~~9~~12 Report results of each bout and suspensions to the Association of Boxing Commissions data base within seven days of the event.

19.1~~0~~3 Agree not to hold the event if the promoter has not obtained adequate security to maintain control over the event and provide safety to the public during and after the event.

19.1~~1~~4 Oversee random drug testing to be performed on the day of the event on randomly selected contestants, if deemed necessary for illegal drugs, banned substances and performance enhancers.

19.15 Oversee pregnancy tests by a female official.

20.0 Responsibilities of the Promoter:

20.1 Follow all Delaware rules and laws governing Amateur Mixed Martial Arts Events.

20.2 Promoter must present suitable evidence reflecting experience as a promoter. The final decision on suitability shall be made by the Sanctioning Body.

20.~~2~~3 Obtain approval from a sanctioning body approved by the Director before applying to the State of Delaware for the permit to hold a Mixed Martial Arts Event.

20.~~3~~4 Submit an application to the State of Delaware at least thirty days in advance of the event for a permit to hold an MMA event along with the required fee.

20.~~4~~5 Receive permit before holding the MMA event.

20.~~5~~6 Coordinate matchmaking to be approved by the approved sanctioning body.

20.7 Prior to submitting card to the sanctioning body, the promoter must search the official website mixedmartialarts.com or other site designated by the Division for any participants who are under current suspension in any jurisdiction. The Promoter shall review the website again, the day prior to the event.

20.~~6~~8 Cooperate fully with the approved Sanctioning Body:

20.~~6~~8.1 Fees

20.~~6~~8.2 Match Making approval of the sanctioning body.

20.~~6~~8.3 Engage services and provide evidence to the sanctioning body that an ambulance ~~with life saving equipment and~~ with at least 2 EMTs, ~~one of which is a~~ and 2 paramedics, will be on-site during competition. The paramedics will maintain a supply of life saving medicines and live saving equipment to be available as needed.

20.~~6~~8.4 Engage services and provide evidence to the sanctioning body that a Delaware licensed physician will be on site during and directly after the competition.

20.~~6~~8.5 Engage contract and provide to the sanctioning body proof that medical insurance and an accidental death insurance policy has been purchased per application requirements, including all deductibles.

20.~~6~~8.6 Engage contract and provide to the sanctioning body proof that liability insurance has been purchased per the amount required by the venue.

20.~~7~~9 Agree to not officiate at their own events. Cannot have interest of any kind in the sanctioning organization.

20.~~8~~10 Cannot be involved or interfere in the oversight of the referee, judging, weighing-in, drug testing, post and pre-fight physicals, and glove inspections.

20.~~9~~11 Provide the required gloves, shin/instep guards, ~~grey/silver~~ duct tape, gauze and adhesive tape for fighter wraps, disposable gloves for corner persons, water for all fighters and officials, access to ice for corner person, stools for each contestant, and clean water bucket.

20.1~~0~~2 Provide the fight card that indicates the weight of the fighters and the weight division that the fighters will be in as well as the complete fight records for each contestant, including records for other combative sports in which they were a participant.

20.1~~1~~3 Agree that there will be NO exhibition bouts.

20.1~~2~~4 Provide hand sanitizer to be kept at the equipment table.

20.1~~3~~5 Sanitize all equipment before and after each fight.

20.1~~4~~6 Provide adequate security personnel to maintain order and provide safety during and after the event.

20.1~~5~~7 Obtain a Delaware business license.

20.16~~8~~ Execute and file a surety bond with the State of Delaware for not less than $5,000.

20.17~~9~~ Pay for random drug testing to be performed on day of event on randomly selected contestants, if deemed necessary, for illegal drugs, banned substances and performance enhancers. The sanctioning body shall oversee the testing.

20.20 Pay for pregnancy testing to be performed on the day of event. The sanctioning body shall oversee the testing.

21.0 Requirements of Fighter

21.1 Attend pre-fight meeting. Failure to attend will result in disqualification of the fighter.

21.2 Be 18 years or older to participate.

21.3 Pass the pre-fight physical.

21.4 Agree not to use any illegal drug, narcotic, stimulant, depressant, analgesic of any description, or alcohol substance either before or during a match. A random drug test may be performed on the day of the event if deemed necessary. Any positive results ~~with~~ will disqualify the contestant and may subject contestant to a suspension by the Division or sanctioning body.

21.5 ~~Obtain National MMA ID number prior to the event~~ Complete all forms and requirements of the sanctioning body.

21.6 Follow all Delaware laws, Rules and Regulations and requirements of the sanctioning body.

21.7 Contestants must provide a signed statement to the sanctioning body that they have never engaged in a professional style MMA event or any other professional martial arts sports and have never accepted payment for their participation in any combative sports event or fighting art. The contestant's trainer must attest in writing to the contestant's skill.

21.8 Obtain a pre-fight and post-fight physical by the physician assigned to the event.

21.9 If fighter should be a no-show, that bout shall be canceled. ~~Under no circumstances shall a fighter be permitted to cut more than two pounds to make weight.~~

21.10 Fighter shall not fight a minimum of ten~~s~~ days from last fight.

21.11 No fighter shall be permitted to participate in any event if he/she is currently under suspension in any jurisdiction/venue.

22.0 Requirements of Seconds/Cornermen

22.1 Each fighter may have three seconds, but only two seconds at a time are permitted in the fighting area and only when given permission by the referee. The Sanctioning Body may authorize an additional cornerman at their discretion for championship fights.

22.2 Permitted to use such general anti-coagulants such as Thrombin, Adrenaline Hydrochloride and Aventine ~~or any other first aid medicine approved by the sanctioning body~~ to cuts that are in their original labeled containers.

22.3 Must dry the corner area before the next round continues.

22.4 Follow all Delaware laws, Rules and Regulations and requirements of the sanctioning body.

22.5 Wear protective gloves as provided by the promoter during fighter's match.

22.6 Attend the pre-fight meeting. Failure to attend will result in disqualification of the non-compliant second.

12 DE Reg. 1435 (05/01/09)

Part E Combative Sports Entertainment

1.0 Fighting Area

A marked barrier, separating the audience from the fighting area by no less than six feet shall be placed around the outside of the fighting area.

2.0 Safety

2.1 Should the referee notice any blood (excluding fake blood) in the fighting area or on the fighter's body, he shall halt the contest until the area is cleaned and sanitized. An exception will be made for those promoters who require blood testing of its fighters.

2.2 If the promoter chooses to allow real blood in the fight area, his fighters will be subject to the following blood test requirements:

2.2.1 HIV exam with negative results is required in order to compete in an event and test must be dated within six months of event.

2.2.2 Complete Hepatitis B Surface AG testing & Hepatitis C AB (must be tested within six months of event.)

2.3 The referee is required to wear protective gloves at all times while in the fighting area.

2.4 The Division may require additional presence of law enforcement and/or medical personnel as deemed necessary to conduct an orderly event.

3.0 Stopping a Contest

The referee shall halt any contest where it appears that the contestant is engaging in prohibited activities. The referee shall stop a contest if directed by the Division.

4.0 Prohibited Acts

4.1 The following acts are prohibited and will result in the contest being terminated:

4.1.1 Grossly offensive profanity by any contestant, referee or in any music.

4.1.2 Racist remarks by any contestant, referee or in any music.

4.1.3 Sexually explicit remarks by any contestant, referee or in any music.

4.1.4 Offensive or obscene naming of a contestant.

4.1.5 Deliberately lacerating oneself or one's opponent, or by any other means, introducing human or animal blood into the ring with the exception being those promoters that require blood tests. See 2.0 of these Rules and Regulations.

5.0 Legal Simulated Strikes

5.1 Elbow strikes.

5.2 Kicks or stomps to the head.

5.3 Striking an opponent with a fist or using the knuckles.

5.4 Neck cranks.

5.5 Strikes to the spine or back of the head or back of neck.

5.6 Scratching or gouging an opponent.

5.7 Butting an opponent.

5.8 Slamming an opponent.

5.9 Stranglehold.

5.10 Inhibiting breathing by covering the nose and mouth at the same time.

5.11 Unsportsmanlike or physically dangerous contact.

5.12 Pile driving.

6.0 Responsibility of the Promoter

6.1 Shall be responsible to the Division for the conduct of its representatives and employees including the following:

6.1.1 Prohibit any alcohol or illegal drugs back stage or in locker rooms.

6.1.2 Prohibit any and all discriminatory practices.

6.1.3 Review safety rules immediately prior to the event to include:

6.1.3.1 Ensure that no objects fly out of the fighting area and injure others.

6.1.3.2 Make sure all equipment is in good working order.

6.1.3.3 Ensure that security personnel are standing by the audience when a contestant is in the six foot barrier area.

6.1.4 Ensure that adequate security personnel are in attendance at all times during the event.

6.2 Maintain a first aid kit that contains an adequate amount of up-to-date medicine and supplies which shall be immediately available at all times during the event.

7.0 Responsibility of the contestants.

7.1 Agree not to use any illegal drugs, narcotics, stimulants, depressants, analgesics of any description or alcohol substance either before or during the match.

7.2 Abide by all Delaware Laws, Rules and Regulations governing Combative Sports Events.

7.3 Agree not to participate in any Combative Sports Entertainment Event if diagnosed with any contagious blood disorder.

7.4 Agree not to participate in any Combative Sports Entertainment Event if pregnant.

12 DE Reg. 1435 (05/01/09)

***Please Note: As the rest of the sections were not amended, they are not being published here. A complete copy of the final regulation is available at:**

8800 Boxing and Combative Sports Entertainment Rules and Regulations

Symbol Key

Arial type indicates the text existing prior to the regulation being promulgated. Underlined text indicates new text added at the time of the proposed action. Language which is ~~stricken~~ through indicates text being deleted. **[Bracketed Bold language]** indicates text added at the time the final order was issued. **[~~Bracketed bold stricken through~~]** indicates language deleted at the time the final order was issued.

Final Regulations

The opportunity for public comment shall be held open for a minimum of 30 days after the proposal is published in the ***Register of Regulations***. At the conclusion of all hearings and after receipt within the time allowed of all written materials, upon all the testimonial and written evidence and information submitted, together with summaries of the evidence and information by subordinates, the agency shall determine whether a regulation should be adopted, amended or repealed and shall issue its conclusion in an order which shall include: (1) A brief summary of the evidence and information submitted; (2) A brief summary of its findings of fact with respect to the evidence and information, except where a rule of procedure is being adopted or amended; (3) A decision to adopt, amend or repeal a regulation or to take no action and the decision shall be supported by its findings on the evidence and information received; (4) The exact text and citation of such regulation adopted, amended or repealed; (5) The effective date of the order; (6) Any other findings or conclusions required by the law under which the agency has authority to act; and (7) The signature of at least a quorum of the agency members.

The effective date of an order which adopts, amends or repeals a regulation shall be not less than 10 days from the date the order adopting, amending or repealing a regulation has been published in its final form in the ***Register of Regulations***, unless such adoption, amendment or repeal qualifies as an emergency under §10119.

DEPARTMENT OF EDUCATION

OFFICE OF THE SECRETARY

Statutory Authority: 14 Delaware Code, Section 122(d) (14 **Del.C.** §122(d))
14 **DE Admin. Code** 885

REGULATORY IMPLEMENTING ORDER

885 Safe Management and Disposal of Chemicals in the Delaware Public School System

I. Summary of the Evidence and Information Submitted

The Secretary of Education intends to amend 14 **DE Admin. Code** 885 Safe Management and Disposal of Chemicals in the Delaware Public School System. The amendments include, but are not limited to, the following: 1) a purpose statement; 2) addition of definitions: 3) explicit delineation of the areas the regulation applies; 4) requirements for a Chemical Safety Plan; 5) requirements for chemicals with special conditions; 6) expansion of the requirements around the storage, management and disposal of chemicals; and 7) requirements for instructional area(s) where chemicals are used.

Notice of the proposed regulation was published in the *News Journal* and the *Delaware State News* on **October 3, 2011,** in the form hereto attached as *Exhibit "A"*. The Department did not receive comments on the amendments to this regulation. Additionally, the Department has published the companion "Safety First" manual.

II. Findings of Facts

The Secretary finds that it is appropriate to amend 14 **DE Admin. Code** 885 Safe Management and Disposal of Chemicals in the Delaware Public School System in order to ensure all students' health and safety are adequately protected in regard to the safe management and disposal of chemicals in the schools.

III. Decision to Amend the Regulation

For the foregoing reasons, the Secretary concludes that it is appropriate to amend 14 **DE Admin. Code** 885 Safe Management and Disposal of Chemicals in the Delaware Public School System. Therefore, pursuant to 14 **Del.C.** §122, 14 **DE Admin. Code** 885 Safe Management and Disposal of Chemicals in the Delaware Public School System. attached hereto as *Exhibit "B"* is hereby amended. Pursuant to the provision of 14 **Del.C.** §122(e), 14 **DE Admin. Code** 885 Safe Management and Disposal of Chemicals in the Delaware Public School System hereby amended shall be in effect for a period of five years from the effective date of this order as set forth in Section V. below.

IV. Text and Citation

The text of 14 **DE Admin. Code** 885 Safe Management and Disposal of Chemicals in the Delaware Public School System. amended hereby shall be in the form attached hereto as *Exhibit "B"*, and said regulation shall be cited as 14 **DE Admin. Code** 885 Safe Management and Disposal of Chemicals in the Delaware Public School System in the *Administrative Code of Regulations* for the Department of Education.

V. Effective Date of Order

The actions hereinabove referred to were taken by the Secretary pursuant to 14 **Del.C.** §122 on **December 15, 2011.** The effective date of this Order shall be ten (10) days from the date this Order is published in the *Delaware Register of Regulations.*

IT IS SO ORDERED the 15th day of December 2011.
DEPARTMENT OF EDUCATION
Lillian M. Lowery, Ed.D., Secretary of Education
Approved this 15th day of December 2011

885 Safe Management and Disposal of Chemicals in the Delaware Public School System

1.0 Mercury and Mercury Compounds

~~1.1 Mercury and mercury compounds, both organic and inorganic, shall not be used in the science classrooms in the public schools in Delaware later than January 1, 2005. Instruments which contain mercury such as thermometers, hydrometers, barometers, etc. shall be replaced at all grade levels in order to guard against spillage.~~

2.0 Storage of Chemicals

~~2.1 The storage of all chemicals shall conform to the specifications stated in *Safety First: Guidelines for Safety in the Science or Science Related Classrooms.*~~

3.0 Inventory of Chemicals, Hazardous and Non Hazardous

~~3.1 All laboratories and science storage in the Delaware public schools shall be inventoried each year during the month of September. The list of the chemicals shall be kept by the school principal. The inventory of chemicals both hazardous and nonhazardous shall contain the following information:~~

~~3.2 Who may handle the chemical and use it;~~

~~3.3 The name of the chemical;~~

~~3.4 The amount on hand;~~

~~3.5 The location where the chemical is stored;~~

~~3.6 The date purchased; and~~

~~3.7 The date discarded.~~

4.0 Inventory of Surplus Chemicals

~~4.1 For purposes of this regulation, surplus shall refer to chemicals which are no longer usable or needed.~~

~~4.2 Each district and charter school shall prepare a list of surplus chemicals and send a copy to the Education Associate, Science Environmental Education by October 15 of each year. The Department shall duplicate and disseminate these lists to school districts and charter schools so that they may negotiate, trade or exchange their surplus chemicals.~~

5.0 Disposal of Surplus Non Hazardous Chemicals

~~5.1 Disposal of surplus nonhazardous chemicals shall be carried out by the school district and charter school in accordance with procedures outlined in the Flinn Chemical Catalog Reference Manual, using trained staff.~~

6.0 Disposal of Non Surplus Transportable Hazardous Chemicals

~~6.1 Surplus hazardous chemicals such as diethyl ether, picric acid, benzoyl peroxide and other materials that are listed in *Safety First: Guidelines for Safety in the Science or Science Related Classrooms,* must be disposed of through the use of a licensed waste hauler.~~

~~6.1.1 Each district and charter school shall prepare a list of surplus hazardous chemicals and submit it to the Education Associate for Science and Environmental Education by November 15 of each year. The Department shall arrange for a licensed waste hauler to take the chemicals to a proper waste facility for disposal. The cost of disposal shall be prorated among the districts and charter schools based upon the weight of the hazardous materials.~~

~~8 DE Reg. 346 (8/1/04)~~
~~10 DE Reg. 1432 (03/01/07)~~

1.0 Purpose

The purpose of this regulation in to outline the criteria and processes for Chemical Storage and for Chemical use in the classroom, laboratory, or other Instructional Areas in Delaware public schools. This regulation sets forth the requirements for the safe management, storage, and disposal of chemicals. Additional information may be found in the *Safety First: Safe Instructional Practices in the Classroom and Laboratory* manual.

2.0 Definitions:

The following words and terms, when used in this regulation, shall have the following meaning unless the context clearly states otherwise:

"**Carcinogen**" means any Chemical that can cause cancer. Included are known or suspected. Carcinogens such as formaldehyde, benzene, carbon tetrachloride, nickel salts, sodium dichromate and sodium chromate.

"**Chemical**" means any element, compound, or mixture of elements and/or compounds.

"Chemical Name" means the scientific designation of a Chemical in accordance with the nomenclature system developed by the International Union of Pure and Applied Chemistry (IUPAC) or the Chemical Abstracts Service (CAS) rules of nomenclature, or a name which will clearly identify the Chemical for the purpose of conducting a hazard evaluation.

"Common Name" means any designation or identification such as a code name, code number, trade name, brand name, or generic name used to identify a Chemical other than its Chemical name.

"Corrosive" means a Chemical that causes visible destruction of or irreversible alterations in, living tissue by Chemical action at the site of contact.

"**Explosive**" means a Chemical that causes a sudden, almost instantaneous release of pressure, gas, and heat when subjected to sudden shock, pressure, or high temperature.

"**Expose or Exposure**" means an instance where an individual is subjected to a Hazardous Chemical through any route of entry (inhalation, ingestion, skin contact or absorption, etc.) and includes potential (e.g., accidental or possible) Exposure.

"**Hazardous Chemical**" means any element, compound or mixture of elements and/or compounds which presents a Physical Hazard or Health Hazard.

"**Health Hazard**" means a Chemical for which there is statistically significant evidence based on at least one study conducted in accordance with established scientific principles that acute or chronic health effects may occur in exposed employees. The term "Health Hazard" includes Chemicals which are Carcinogens, toxic or highly toxic agents, reproductive toxins, irritants, Corrosives, sensitizers, hepatotoxins, nephrotoxins, neurotoxins, agents which act on the hematopoietic system, and agents which damage the lungs, skin, eyes, or mucous membranes. The Material Safety Data Sheet (MSDS) will provide information to determine whether or not the Chemical is a Health Hazard.

"**Instructional Area**" means a room or defined space used for an educational activity. An Instructional Area may be a classroom, a laboratory, a field, a special building such as a greenhouse, or any other space where educational activities may take place.

"**Long-Term Storage**" means the storage of any Chemical for a time period past the end of the school day.

"**Material Safety Data Sheet (MSDS)**" means a document that contains information on the potential health effects of exposure to Chemicals, or other potentially dangerous substances, and on safe working procedures when handling Chemical products. It contains hazard evaluations on the use, Storage, handling and emergency procedures related to that material. The Material Safety Data Sheet (MSDS) contains much more information about the material than the label and is prepared by the supplier. It is intended to tell what the hazards of the product are, how to use the product safely, what to expect if the recommendations are not followed, what to do if accidents occur, how to recognize symptoms of overexposure, and what to do if such incidents occur.

"**Non-hazardous Chemical**" means any element, compound or mixture of elements and/or compounds which do not present a Physical Hazard or Health Hazard.

"**Occupational Safety and Health Administration (OSHA)**" means the government agency in the Department of Labor that develops guidelines to maintain a healthy and safe working environment.

"**Physical Hazard**" means a Chemical for which there is scientifically valid evidence that it is a combustible liquid, a compressed gas, Explosive, flammable, an organic peroxide, an oxidizer, pyrophoric, unstable (reactive) or water-reactive. The Material Safety Data Sheet (MSDS) will provide information to determine whether or not the Chemical is a Physical Hazard.

"***Safety First: Safe Instructional Practices in the Classroom and Laboratory* Manual**" means the collection of documents that outline the mandatory safety procedures regarding the safe management, storage, and disposal of chemicals for Instructional Areas in Delaware public schools and which may be amended from time to time as published in the Delaware Registrar of Regulations. The manual also provides safety practices that are governed by this regulation. This document is available on the Delaware Department of Education Website (www.doe.k12.de.us).

"**Short-Term Storage**" means the storage of any Chemical for a time period before the end of the school day.

"**Storage**" means a space for the containment of Chemicals or other materials.

"**Surplus Chemical**" means any Chemical that is no longer Useable or needed.

"**Useable**" means that the Chemical or other material has not surpassed its expiration date.

3.0 Applicable Areas

This regulation is applicable to all public schools, including charter schools and all programs they offer, not already regulated by OSHA standards, including but not limited to science education (including classrooms, laboratories, combination classroom and laboratory settings, and outdoor education settings); Career and Technical Education; Technology and Engineering Education; Agricultural Education; Family and Consumer Science Education, Art Education; and Athletics/Athletic Training.

4.0 Chemical Safety Plan

4.1 All Delaware public schools shall have a Chemical Safety Plan that outlines specific district or charter school procedures in the area of staff and student Chemical safety. The plan shall include at least the following:

4.1.1 Identification of at least one Chemical Safety Officer for the district or charter school who shall:

4.1.1.1 Act as liaison between teachers, building and administration, and facilities staff regarding Chemical safety issues;

4.1.1.2 Maintain the Chemical inventory for the school(s);

4.1.1.3 Approve all Chemical orders by the district or charter school,

4.1.1.4 Maintain a supply of Material Safety Data Sheets (MSDS) for all Chemicals in the Chemical inventory;

4.1.1.5 Assist with maintenance requests related to safety equipment; and

4.1.1.6 Identify and coordinate disposal of Hazardous Chemical wastes.

4.1.2 Standard operating procedures associated with Chemical use, Chemical Storage, Chemical disposal (both Hazardous and Non-hazardous), and the handling of Chemical spills.

5.0 Inventory of Chemicals, Hazardous and Non-Hazardous

5.1 Each district and charter school shall prepare an inventory of Chemicals by September 15 of each year. A copy of this inventory of Chemicals, along with the respective Material Safety Data Sheet (MSDS), shall be maintained by the school principal, chief custodian, and the Chemical Safety Officer. Additionally, copies shall be maintained in the Chemical Storage area and with the school nurse or school health manager. The inventory of Chemicals, both Hazardous and Non-hazardous, shall contain at least the following information:

5.1.1 The name of the Chemical;

5.1.2 The amount of the Chemical (in appropriate measurement units);

5.1.3 The location where the Chemical is stored; and

5.1.4 The date of purchase.

6.0 Chemicals with Special Conditions

6.1 Mercury and mercury compounds, both organic and inorganic, shall not be present in or used in public schools in Delaware. Schools may continue to use mercury discharge tubes and fluorescent lights even though they contain a small amount of mercury gas because the mercury is enclosed in the glass container.

6.2 Known Carcinogens shall not be present in or used in public schools in Delaware. A listing of known Carcinogens can be found in *Safety First: Safe Instructional Practices in the Classroom and Laboratory.*

6.3 All schools shall comply with current Environmental Protection Agency (EPA) regulations regarding regulated refrigerants.

7.0 Storage of Chemicals

7.1 The Storage of all Chemicals shall conform to the mandatory specifications stated in *Safety First: Safe Instructional Practices in the Classroom and Laboratory.*

7.2 Chemicals in the Instructional Area shall be for immediate use only (Short-Term Storage). All Long-Term Storage of Chemicals shall be in a properly equipped Chemical Storage room.

7.3 Pressurized Storage of liquids and gases shall conform to OSHA Storage and handling regulations.

8.0 Management of Chemicals

8.1 Instructional staff shall provide training in the safe management of Chemicals to all students in Instructional Areas that use Chemicals annually. All students shall sign a student safety contract at the conclusion of this training. The training shall include at least the following:

8.1.1 An overview of the school safety program;

8.1.2 The location of all Hazardous Chemical containers in the Instructional Area;

8.1.3 An explanation of how to read labels on containers;

8.1.4 The location, availability and content of Material Safety Data Sheets (MSDS) and an explanation of how they are used;

8.1.5 An explanation of the nature of Health Hazards and Physical Hazards associated with the use of all Hazardous Chemicals (regardless of quantity) to which they may be exposed;

8.1.6 An explanation of the proper handling, Storage and disposal methods for each of the Hazardous Chemicals present in the Instructional Area; and

8.1.7 Measures taken by the instructional staff and school personnel to prevent or control Exposure such as engineering controls, personal protective equipment, and emergency procedures for spills or leaks.

9.0 Disposal of Surplus Chemicals

9.1 Disposal of Surplus Non-hazardous Chemicals shall be carried out by the school district or charter school in accordance with procedures outlined in the Material Safety Data Sheet (MSDS).

9.2 Disposal of Surplus Chemicals, that meet the definition of Hazardous Chemical, shall only be disposed of through the use of a licensed waste hauler.

9.2.1 Each district and charter school shall prepare a list of Surplus Hazardous Chemicals and submit it to the Education Associate, Science by November 15 of each year. The Department of Education shall arrange for a licensed waste hauler to take the Chemicals to a proper waste facility for disposal. The cost of disposal shall be prorated among the participating schools. Alternatively, a school district or charter school may independently contract with a licensed waste hauler. An official letter shall be sent to the Education Associate, Science describing the school's intentions and naming the licensed waste hauler.

10.0 Facility Requirements for Instructional Areas that use Hazardous Chemicals

10.1 Basic safety equipment shall be installed in all Instructional Areas that use Hazardous Chemicals and shall conform to the requirements outlined in *Safety First: Safe Instructional Practices in the Classroom and Laboratory*. Non-traditional instructional areas such as an outdoor classroom or an agricultural field shall include all of the safety equipment as warranted and deemed necessary based on the hazard level of the lesson and materials being used in the instruction of students. Basic safety equipment shall include at least the following items:

10.1.1 Eyewash (running water, continuous flow style)

10.1.2 Acid/Chemical shower (continuous flow style)

10.1.3 Eye protection (wrap-around, splash-shield style goggles)

10.1.4 Fire extinguisher

10.1.5 Fire blanket

10.1.6 Chemical spill equipment

10.2 A properly functioning fume hood and/or other industry-standard ventilation system shall be used when mixing Chemicals, using Chemicals, and/or for Short-term Storage of Chemicals that release hazardous fumes. The determination that hazardous fumes may be released is determined by a hazard analysis and a review of the MSDS document(s). Fume hoods and other ventilation systems shall conform to the requirements outlined in *Safety First: Safe Instructional Practices in the Classroom and Laboratory*.

10.3 All Instructional Areas that use Hazardous Chemicals which are constructed, reconfigured, or renovated after September 1, 2011 shall provide adequate space for student work at a minimum of 50 square feet per student.

10.4 All Instructional Areas that use Hazardous Chemicals shall have at least two means of egress. The second exit may pass through another room and/or a Non-Chemical Storage room if it is used only as an emergency exit.

8 DE Reg. 346 (8/1/04)
10 DE Reg. 1432 (03/01/07)

A copy of the 2011 Safety First Manual is located here:
885 Safe Management and Disposal of Chemicals in the Delaware Public School System

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OFFICE OF THE SECRETARY

Statutory Authority: 14 Delaware Code, Section 122(d) (14 **Del.C.** §122(d))
14 **DE Admin. Code** 910

Education Impact Analysis Pursuant To 14 Del.C. Section 122(d)

910 Delaware General Educational Development (GED) Endorsement

I. Summary of the Evidence and Information Submitted

The Secretary of Education seeks the consent of the State Board of Education to amend 14 **DE Admin. Code** 910 Delaware General Educational Development (GED) Endorsement. This regulation has been reviewed as part of the five year cycle and changes were made to the title and references to the test to be consistent with the American Council of Education's titling of the test and other GED® brand usage guidelines. The GED® is a brand name and registered trademark of the American Council on Education (ACE). GED® and GED Testing Service® are registered trademarks of the American Council on Education (ACE). They may not be used or reproduced without the express written permission of ACE or GED Testing Service. The GED® and GED Testing Service® brands are administered by GED testing Service LLC under license from the American Council on Education. The following highlights are from the ACE website:

- GED® tests are designed to measure the skills and knowledge equivalent to a high school course of study.
- The GED® test battery comprises five content area assessments:
  - Language Arts, Reading
  - Language Arts, Writing
  - (including an essay)
  - Mathematics
  - Science
  - Social Studies
- The GED® tests are currently offered only in a paper-pencil format at Official GED Testing Centers ™ - they cannot be taken online.

Notice of the proposed regulation was published in the *News Journal* and the *Delaware State News* on November 19, 2011**,** in the form hereto attached as *Exhibit "A"*. The Department did not receive comments on the amendments.

II. Findings of Facts

The Secretary finds that it is appropriate to amend 14 **DE Admin. Code** 910 Delaware General Educational Development (GED) Endorsement in order to be consistent with the American Council of Education's titling of the test and other GED® brand usage guidelines.

III. Decision to Amend the Regulation

For the foregoing reasons, the Secretary concludes that it is appropriate to amend 14 **DE Admin. Code** 910

Delaware General Educational Development (GED) Endorsement. Therefore, pursuant to 14 **Del.C.** §122, 14 **DE Admin. Code** 910 Delaware General Educational Development (GED) Endorsement attached hereto as *Exhibit "B"* is hereby amended. Pursuant to the provision of 14 **Del.C.** §122(e), 14 **DE Admin. Code** 910 Delaware General Educational Development (GED) Endorsement hereby amended shall be in effect for a period of five years from the effective date of this order as set forth in Section V. below.

IV. Text and Citation

The text of 14 **DE Admin. Code** 910 Delaware General Educational Development (GED) Endorsement amended hereby shall be in the form attached hereto as *Exhibit "B"*, and said regulation shall be cited as 14 **DE Admin. Code** 910 Delaware General Educational Development (GED) Endorsement in the *Administrative Code of Regulations* for the Department of Education.

V. Effective Date of Order

The actions hereinabove referred to were taken by the Secretary pursuant to 14 **Del.C.** §122 on December 15, 2011**.** The effective date of this Order shall be ten (10) days from the date this Order is published in the *Delaware Register of Regulations.*

IT IS SO ORDERED the 15th day of December 2011.
DEPARTMENT OF EDUCATION
Lillian M. Lowery, Ed.D., Secretary of Education
Approved this 15th day of December 2011

STATE BOARD OF EDUCATION

Teri Quinn Gray, Ph.D., President	Gregory Coverdale
Jorge L. Melendez, Vice President	Terry M. Whittaker, Ed.D.
G. Patrick Heffernan	James L. Wilson, Ed.D.
Barbara B. Rutt	

910 Delaware ~~General Educational Development (GED) Endorsement~~ Requirements for issuance of the GED® Test Credential

The Delaware ~~General Educational Development (GED) Endorsement~~ GED® test credential is given to persons who satisfactorily pass the ~~General Educational Development (GED)~~ GED® Test.

1.0 For a person 18 years of age or older to be eligible to take the ~~GED Test~~ GED® test an applicant shall:

1.1 Be a resident of Delaware or, if a resident of another state, be currently employed in Delaware and have been so employed for a minimum of six months prior to taking the test; and

1.2 Certify under his or her signature on the GED® application form that he or she is not enrolled in a public or non public school program; and

1.3 Provide ~~an official~~ a verified copy of the Official GED ~~p~~Practice ~~t~~Test® indicating the applicant has passed the Official GED Practice Test™ with a score of 2450 or better and not less than 470 on each of the 5 sub test areas.

2.0 For a person 16 or 17 years of age to be eligible to take the ~~GED Test~~ GED® test an applicant shall:

2.1 Seek a waiver of the 18 years of age requirement by completing a written application to the Delaware Department of Education that includes showing good cause for taking the test early and designating where the test will be taken; and

2.2 Be a resident of the State of Delaware; and

2.3 Verify that they are at least 16 years of age at the time of the application for the waiver of the age requirement using a birth certificate, drivers license, a State of Delaware Identification Card or other comparable and reliable documentation of age; and

2.4 Provide verification of withdrawal from the applicant's public or non public school program; and

2.5 Provide a transcript from the applicant's public or non public school program; and

2.6 Provide ~~an official~~ a verified copy of the ~~GED practice test~~ Official GED Practice Test™ indicating the applicant has passed the Official GED Practice Test™ with a score of 2450 or better and not less than 470 on each of the 5 sub test areas.

3.0 Scores Required for the Delaware ~~General Educational Development (GED) Endorsement~~ GED® test Credential

An individual shall have a standard score of not less than 410 on each of the five tests with an average standard score of not less than 450 for all five tests and a total standard score of not less than 2250 in order to be issued a ~~GED Endorsement~~ GED® test credential.

4.0 Retesting

Forty five days shall lapse prior to retesting and instruction is recommended before retesting.

2 DE Reg. 375 (09/01/98
5 DE Reg. 1285 (12/01/01)
10 DE Reg. 862 (11/01/06)

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF LONG TERM CARE RESIDENTS PROTECTION

Statutory Authority: 29 Delaware Code, Section 7903(10) (29 **Del.C.** §7903(10))
16 **DE Admin. Code** 3220

ORDER

3220 Training and Qualifications for Nursing Assistants and Certified Nursing Assistants

NATURE OF THE PROCEEDINGS:

The Department of Health and Social Services ("Department") / Division of Long Term Care Residents Protection (DLTCRP) initiated proceedings to amend Regulation 3220 Training and Qualifications for Nursing Assistants and Certified Nursing Assistants. The Department's proceedings to amend its regulations were initiated pursuant to 29 **Delaware Code**, Section 10114 and its authority as prescribed by 29 **Delaware Code**, Section 7903, (10) and Section 7971(15)(e).

The Department published its notice of proposed regulation changes pursuant to 29 **Delaware Code** Section 10115 in the September 2011 Delaware *Register of Regulations*, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by October 3, 2011 at which time the Department would receive information, factual evidence and public comment to the said proposed changes to the regulations.

SUMMARY OF PROPOSED AMENDMENT

The proposal amends the existing Regulation 3220 Training and Qualifications for Nursing Assistants and Certified Nursing Assistants. The proposed change will amend the regulation to incorporate updates deemed necessary by DLTCRP.

Statutory Authority

29 **Del.C.** Ch. 79, § 7903(10) and 29 **Del.C.** Ch. 79, §7971(15)(e), "Department of Health and Social Services."

Background

DLCTRP identified the need to update the Training and Qualifications for Nursing Assistants and Certified Nursing Assistants regulation in order to incorporate federal and state requirements for continuing education of Nursing Assistants and Certified Nursing Assistants.

Summary of Proposed Amendment

This regulatory change updates the regulation in the following areas:

The proposal amends policies regarding Long Term Care Residents Protection to require certain persons to receive dementia specific training as required by the amendment to 29 **Del.C.** §7903 which added a paragraph (10) directing the DHSS Secretary to adopt regulations which require dementia specific training each year for persons who are certified, licensed, or registered by the State, and/or who are partially or fully funded by the State, to provide direct healthcare services to persons diagnosed as having Alzheimer's disease or other forms of dementia. The revision also requires prevention if patient abuse training.

The proposed changes affect the following policy sections:

3220 Training and Qualifications for Nursing Assistants and Certified Nursing Assistants

SUMMARY OF COMMENTS RECEIVED WITH AGENCY RESPONSE AND EXPLANATION OF CHANGES

The Governor's Advisory Council for Exceptional Citizens ("GACEC") and the State Council for Persons with Disabilities (SCPD) endorsed the proposed regulations and offered comments. Two private individual also offered comments on the number of hours and one individual offered suggestions on the content of the training. DLTCRP has not included comments that merely endorsed the proposed changes. DLTCRP has considered each comment and responds as follows:

Comments: Both individuals suggested increasing the number of hours of dementia training from the 6 hours in each twenty-four month certification period that is proposed. One suggested doubling it to 6 hours every twelve months.

Agency Response: The Division acknowledges that increased training is desirable, but recognizes that facilities must routinely train staff on many topics in the remaining 18 hours every 24 months. Additionally, they must have the flexibility to present ad hoc training as situations demand. Lastly, the required 6 hours is a minimum, facilities can add additional hours if they so choose.

Revised language: N/A

Comment: One individual suggested all caregivers across the professional spectrum staff receive this mandatory training.

Agency Response: While 29 **Del.C.** Ch. 79, §7903(10) does require dementia training for all person certified, licensed or registered by the State however these regulations apply only to Nursing Assistants and Certified Nursing Assistants therefore they do not include other licensed or certified professions.

Revised language: N/A

FINDINGS OF FACT:

The Department finds that the proposed changes as set forth in the September 2011 *Register of Regulations* should be adopted.

THEREFORE, IT IS ORDERED, that the proposed changes to Regulation 3220 -Training and Qualification for Nursing Assistants and Certified Nursing Assistants, with the modification indicated herein, is adopted and shall be final effective January 1, 2012.

Rita M. Landgraf, Secretary, DHSS

3220 Training and Qualifications for Nursing Assistants and Certified Nursing Assistants

(Break in Continuity of Sections)

2.0 General Training Requirements And Competency Test

Each Nursing Assistant/Certified Nursing Assistant employed by any nursing facility either as contract/ agency or facility staff shall be required to meet the following:

2.1 An individual shall complete a nursing assistant training course approved by the Department on the recommendation of the CNA Training Curriculum Committee. The Committee shall consist of individuals with experience in the knowledge and skills required of CNAs.

2.2 Nursing Assistants are required to pass a competency test provided by the Department or by a contractor approved by the Department.

2.3 Nursing Assistants shall take the competency test within 30 days of completion of an approved program. Nursing assistants who fail to obtain a passing score may repeat the test two additional times. Nursing assistants who fail to obtain a passing score after testing three times must repeat the CNA training program before retaking the test. The certificate of completion of an approved program, a prerequisite to testing, must be dated within 24 months of the available testing date. Nursing assistants who are trained in a facility and are counted for staffing purposes pursuant to 16 **Del.C.** §1162(f) must pass the test within 90 days of completion of the facility program to continue to be counted in staffing calculations.

2.4 In order to qualify for recertification, a CNA must, during each 24 month certification period: (1) complete 24 hours of approved continuing education education including 6 hours of dementia training and 2 hours of patient abuse prevention training and (2) perform at least 64 hours of nursing related services for pay under the supervision of a licensed nurse or physician. A CNA who does not perform at least 64 hours of nursing related services in a certification period or fails to complete the required continuing education must pass the competency test again. Nursing assistants who fail to obtain a passing score after testing three times must repeat the CNA training program before additional testing will be permitted.

2.4.1 ~~A CNA who provides direct healthcare services to persons diagnosed as having Alzheimer's disease or other forms of dementia shall annually receive dementia specific training that must include: communicating with persons diagnosed as having Alzheimer's disease or other forms of dementia; the psychological, social, and physical needs of those persons; and safety measures which need to be taken with those persons.~~ All CNAs shall receive dementia specific training that shall include: communicating with persons diagnosed as having Alzheimer's disease or other forms of dementia; the psychological, social, and physical needs of those persons; and safety measures which need to be taken with those persons. All CNAs shall also receive training in the prevention of patient abuse that shall include: definitions and signs and symptoms of abuse and neglect, reporting requirements and prevention strategies.

2.5 A Certified Nursing Assistant trained and certified outside the State of Delaware in a program that equals or exceeds the federal nurse aide training program requirements in the Code of Federal Regulations §483.152 cannot work in Delaware without a Delaware certificate. Delaware certification is required prior to being employed as a CNA. The Department will grant reciprocity if the following conditions are met:

2.5.1 The CNA must have a current certificate from the jurisdiction where he or she currently practices, except that candidates from the State of Maryland must hold a current Geriatric Nursing Assistant certificate.

2.5.2 The CNA must have 3 months of full-time experience as a CNA performing nursing related services for pay under the supervision of a licensed nurse or physician, or have completed a training and competency evaluation program with the number of hours at least equal to that required by the State of Delaware.

2.5.3 The CNA must be in good standing in the jurisdiction where he/she is currently certified.

2.5.4 The CNA submits $30 to the Department to cover the costs associated with granting the reciprocity.

2.6 Nursing students who are currently enrolled in a nursing program and have satisfactorily completed a Fundamentals/Basic Nursing course with a 75 hour clinical component in a long term care setting will be deemed to meet the training requirements. These individuals will be approved to take the competency test upon submission of a letter from their school of nursing attesting to current enrollment status and satisfactory course completion as described.

2.7 Nursing students who have graduated from an RN or LPN program within 24 months prior to application for certification are deemed qualified to meet the Department's nurse aide training and competency evaluation program requirements and are eligible for certification upon submission of a sealed copy of their diploma. Individuals who have graduated from an RN or LPN program more than 24 months prior to application for certification are deemed qualified to meet the Department's nurse aide training program requirements and are eligible to take the competency test upon submission of a sealed copy of their diploma.

2.8 For the purpose of calculating minimum staffing levels, any individual who has completed all of the classroom training and half of the clinical training in a facility sponsored training program may be considered as a member of such facility's staff while undergoing the last 37.5 hours of clinical training at such facility.

2.9 A nursing assistant who is employed by, or who has received an offer of employment from, a federally certified nursing facility on the date on which the aide begins a nurse aide training and competency evaluation program may not be charged for any portion of the program including tuition, any tests taken and fees for textbooks or other required course materials.

2.10 If a Certified Nursing Assistant who is not employed, or does not have an offer to be employed as a nurse aide becomes employed by, or receives an offer of employment from, a federally certified nursing facility not later than 12 months after completing a nurse aide training and competency evaluation program, the federally certified nursing facility shall reimburse all documented personally incurred costs in completing the program. Facilities shall accept as documentation canceled checks, paid receipts, written verification from a training program or other written evidence which reasonably establishes the CNA's personally incurred costs. Such costs include tuition, tests taken and fees for textbooks or other required course materials. Such costs shall be reimbursed in equal quarterly payments with full reimbursement to coincide with the CNA's completion of one year of employment including the orientation period.

2.11 Any nursing facility which reimburses a Certified Nursing Assistant for documented personally incurred costs of a nurse aide training and competency evaluation program shall notify the Division of Long Term Care Residents Protection of such reimbursement. Notice of such reimbursement shall be entered in the CNA Registry database and information regarding such reimbursement shall be available to facilities upon request.

6 DE Reg. 1505 (5/1/03)
8 DE Reg. 1014 (1/1/05)
14 DE Reg. 169 (09/01/10)

***Please Note: As the rest of the sections were not amended, they are not being published here. A complete copy of the final regulation is available at:**

3220 Training and Qualifications for Nursing Assistants and Certified Nursing Assistants

DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

Statutory Authority: 31 Delaware Code, Section 512 (31 **Del.C.** §512)

ORDER

Qualified Long-Term Care Insurance Partnership Program

NATURE OF THE PROCEEDINGS:

Delaware Health and Social Services ("Department") / Division of Medicaid and Medical Assistance (DMMA) initiated proceedings to amend the Delaware Title XIX Medicaid State Plan and the Division of Social Services Manual regarding the *Qualified Long Term Care Insurance Partnership Program*. The Department's proceedings to amend its regulations were initiated pursuant to 29 **Delaware Code** Section 10114 and its authority as prescribed by 31 **Delaware Code** Section 512.

The Department published its notice of proposed regulation changes pursuant to 29 Delaware Code Section 10115 in the November 2011 Delaware *Register of Regulations*, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by November 30, 2011 at which time the Department would receive information, factual evidence and public comment to the said proposed changes to the regulations.

SUMMARY OF PROPOSAL

The proposed amends the Delaware Title XIX Medicaid State Plan and the Division of Social Services Manual regarding implementation of a *Qualified State Long-Term Care Insurance Partnership Program.*

Statutory Authority

Deficit Reduction Act of 2005 (Public Law 109-171), enacted on February 8, 2006

Background

Section 6021 amends section 1917(b) of the Social Security Act (the Act) to provide for Qualified State Long-Term Care (LTC) Insurance Partnership programs, and permits an exception to estate recovery provisions with respect to individuals who receive benefits under LTC insurance policies sold in States that implement a Partnership program.

Section 6021(a)(1)(A)(iii) defines the term "Qualified State LTC Partnership" to mean an approved State plan amendment (SPA) that provides for the disregard of resources, when determining estate recovery obligations, in an amount equal to the LTC insurance benefits paid to, or on behalf of, an individual who has received medical assistance. A policy that meets all of the requirements specified in a Qualified State LTC Partnership SPA is referred to as a "Partnership policy."

Summary of Proposal

The proposed amendment provides incentive to individuals who purchase a Qualified Long-Term Care Insurance Partnership Policy by allowing the policyholder a disregard of assets or resources in an amount equal to the insurance benefit payments paid for the beneficiary**[. ~~once the policy holder has exhausted their long-term care benefits.~~]** The dollar amount paid by the policy for their care is also exempt from the recovery of medical assistance received by the participant (Estate Recovery).

[Individuals will not be eligible for Medicaid to meet their long-term care needs until the policyholder has exhausted the long-term care benefits provided by their Qualified LTC Partnership Policy.]

Delaware's Department of Insurance would approve long-term care insurance policies and ensure that insurance agents are trained and certified. Insurers authorized to offer long-term care insurance will be obligated to disclose the existence of the *Qualified Long-Term Care Insurance Partnership Program*.

This amendment provides for the disregard of resources in an amount equal to the insurance benefit payments made to or on behalf of an individual who is a beneficiary under a long-term care insurance policy, in accordance with the provisions of Section 6021 of the Deficit Reduction Act of 2005. The disregard will be in the form of one

dollar of assets retainable for every dollar in benefits paid under a long-term care insurance policy if the policyholder received Medicaid benefits while or after accessing the long-term care insurance benefits.

The provisions of these amendments are subject to approval by the Centers for Medicare and Medicaid Services (CMS).

Fiscal Impact Statement

The intent of a *Qualified Long-Term Care Insurance Partnership Program (QLTCIP)* is to reduce the burden of long-term expenses on Medicaid by providing incentives to purchase long-term care insurance. The fiscal impact of implementation is an indeterminable decrease in expenditures. There may be costs associated with the establishment of the QLTCIP program, such as: developing training programs; preparation of annual reports; and, potential reduction in Medicaid estate recovery proceeds. However, these costs are expected to be more than offset by the fact that long-term care insurance policies will initially be paying for services rather than Medicaid. Exact dollar amounts are indeterminable because the number of people who will participate in the Program is unknown.

SUMMARY OF COMMENTS RECEIVED WITH AGENCY RESPONSE AND EXPLANATION OF CHANGES

American Council of Life Insurers (ACLI) and America's Health Insurance Plans (AHIP), the Delaware Developmental Disabilities Council (DDDC), the Governor's Advisory Council for Exceptional Citizens (GACEC) and, the State Council for Persons with Disabilities (SCPD) offered the following observations and recommendations summarized below. The Division of Medicaid and Medical Assistance (DMMA) has considered each comment and responds as follows.

ACLI and AHIP

As we understand it, the Delaware Division of Medicaid and Medical Services is proposing to prohibit policyholders of a Qualified Long-Term Care Partnership Policy from being eligible for asset disregard or eligible for Medicaid until the policyholder has exhausted the long term care benefits provided by the qualified LTC partnership policy.

The Deficit Reduction Act of 2005 (Pub.L 109-171) did not require exhaustion of private long term care coverage before one can apply for Medicaid. The reason that an exhaustion of benefits requirement is not a sensible approach is because the person with private insurance would only be allowed to apply after he has exhausted his private coverage. Since the Medicaid application process may take several days/months, the person would be liable to pay his own expenses for some time.

For the reasons stated, we strongly encourage the Department to not move forward with the current draft proposal to amend the regulation.

Agency Response: The phrase and sentence referenced in your comment have been deleted from the above "Summary of Proposal" (indicated by bracketed, bold type). An individual does not need to 'exhaust' the Long-Term Care Insurance (LTCi) benefits in order to be eligible for LTC Medicaid. Medicaid will disregard an amount of resources equal to the amount of LTCi benefits paid at the time of the Medicaid application. The individual could be eligible for Medicaid (as the payor of last resort).

DDDC, GACEC and SCPD

The program is authorized by federal law to provide an incentive to individuals to purchase a qualifying long-term care insurance. Under this scheme, an individual with a QLTCIP policy can enroll in Medicaid without having to exhaust policy benefits. The policy would then pay the authorized policy amount towards long-term care and Medicaid could cover the balance. Id. Both nursing home and home-health services would be eligible. There is no "grandfather" provision, i.e., this program is available only to individuals purchasing a QLTCIP policy after November 1, 2011 in Delaware or another state with a QLTCIP. Individuals taking advantage of this program qualify for a disregard of resources in an amount equal to LTC insurance benefits paid. Participating insurers would be required to report benefits paid under covered policies.

The Councils endorse the concept of implementing this federal option. However, we would like to also remind DMMA of concerns shared with the Department in the attached August 23, 2010 memo. See also attached Dept of Insurance commentary at 14 DE Reg. 316 (October 1, 2010). In a nutshell, the Department of Insurance allows LTC insurers to offer highly-constrictive policies which: 1) only authorize nursing home payments if an insured has

limits in 3 ADLs; 2) ignore limits in IADLs; and 3) allow only ½ benefit payments for individuals opting for home health care versus institutional care. Delaware Medicaid covers both home health and nursing home services based on a deficit in 1 ADL. Effective April 2012, the DSHP Plus program will authorize home health services based on a deficit in 1 ADL and authorize nursing home coverage based on a deficit in 2 ADLs. Thus, Medicaid will be paying for both nursing home and home health services with 0 contribution by insurers since the "disability" threshold triggering insurance payment is higher. The "bottom line" is that DMMA may not realize anticipated cost savings, i.e., the expectation "that long-term care insurance policies will initially be paying for services rather than Medicaid." At p. 622, Fiscal Impact Statement.

DMMA would be well advised to collaborate with the Department of Insurance to ensure that qualifying QLTCIP policies provide nursing home benefits based on more liberal standards than limits in 3 ADLs. Moreover, the DSHP Plus program is attempting to promote home health services versus nursing home services by establishing a higher requirement for nursing home eligibility (limits in 2 ADLs) than home health care (limit of 1 ADL). This incentive is undermined by insurance policies which pay only ½ benefits for home health services. DMMA should consult the Department of Insurance to assess prospects for requiring a QLTCIP policy to pay equal benefits for home health and nursing facility care.

Agency Response: DMMA intends continued collaboration with the Department of Insurance, as required by the State plan amendment. Your comments will be considered as we move forward with implementation of the QLTCIP program in Delaware. Thank you for the endorsement.

Further analysis by Division staff resulted in the insertion of language to further clarify eligibility requirements in the Division of Social Services Manual (DSSM). Specifically, policy number DSSM 20345 is inserted; and, the policy is renumbered to add new text at number 7, *Disregarded assets may be transferred without penalty*. Also, to increase clarity, numbered headings are changed to appear in bold type face. **[Bracketed, Bold type]** indicates added text/changes made at the time the final order is issued.

FINDINGS OF FACT:

The Department finds that the proposed changes as set forth in the November 2011 Register of Regulations should be adopted.

THEREFORE, IT IS ORDERED, that the proposed regulation to amend Delaware Title XIX Medicaid State Plan and the Division of Social Services Manual regarding implementation of a *Qualified Long Term Care Insurance Partnership Program* is adopted and shall be final effective January 10, 2012.

Date of Signature

Rita M. Landgraf, Secretary, DHSS

DMMA FINAL ORDER REGULATION #11-62a
REVISION:

Page 53b

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: DELAWARE

1917(b)(1)(C)	(4)	X	If an individual covered under a long-term care insurance policy received benefits for which assets or resources were disregarded as provided for in Attachment 2.6-A, Supplement 8c (State Long-Term Care Insurance Partnership) the State does not seek adjustment or recovery from the individual's estate for the amount of assets or resources disregarded.

(Break in Continuity of Sections)

REVISION:

Supplement 8b to ATTACHMENT 2.6-A
Page 1

STATE PLAN UNDER TITLE OF THE SOCIAL SECURITY ACT
State: DELAWARE
MORE LIBERAL METHODS OF TREATING RESOURCES
UNDER SECTION 1902 (r) (2) OF THE ACT

/ / Section 1902(f) State / X / Non-Section 1902 (f) State

D. Qualified State Long-Term Care Insurance Partnership

1. A resource disregard is given to an individual who has purchased a qualified long-term care insurance policy and has used such policy to pay for certain medical costs as approved or covered under Delaware Medicaid as follows:
   a. Long-term nursing care in nursing facilities. 42 CFR 440.40
   b. Home and community-based services (HCBS) as defined in the Delaware HCBS Waiver for the elderly and disabled (Elderly & Disabled Waiver DE.0136).
2. The amount of the disregard is equal to the dollar amount of insurance benefits that have been paid by the long- term care insurance company in accordance with the provisions of Section 6021 of the Deficit Reduction Act of 2005.
3. Such disregard is in effect for the lifetime of the individual who has purchased the long-term care insurance policy and used the policy to pay for long-term careservices.
4. Persons eligible for a resource disregard are categorically needy individuals in nursing facilities and home and community-based waiver programs under the special income level (250%) defined at 1902(a)(10)(A)(ii)(V).
5. Effective November 1, 2011, Delaware shall accept all of the reciprocity standards as promulgated pursuant to Section 6201(b) of Public Law 109-171 with respect to all other states agreeing to participate under such reciprocity standards.
6. Resources disregarded under this provision are not subject to recovery of medical payments made on behalf of the individual.

NEW:

Supplement 8c to ATTACHMENT 2.6-A
Page 1

STATE PLAN UNDER TITLE OF THE SOCIAL SECURITY ACT
State: DELAWARE
STATE LONG-TERM CARE INSURANCE PARTNERSHIP

1902(r)(2)
1917(b)(1)(C)

The following more liberal methodology applies to individuals who are eligible for medical assistance under one of the following eligibility groups:

Individuals who meet the requirements under the following sections of the Social Security Act:

Categorically needy individuals in nursing facilities and home and community-based waiver programs under the special income level (250%) defined at 1902 (a)(10)(A)(ii)(V).

An individual who is a beneficiary under a long-term care insurance policy that meets the requirements of a “qualified State long-term care insurance partnership” policy (partnership policy) as set forth below, is given a resource disregard as described in this amendment. The amount of the disregard is equal to the amount of the insurance benefit payments made to or on behalf of the individual. The term “long-term care insurance policy” includes a certificate issued under a group insurance contract.

X The State Medicaid Agency (Agency) stipulates that the following requirements will be satisfied in order for a long-term care policy to qualify for a disregard. Where appropriate, the Agency relies on attestations by the State Insurance Commissioner

(Commissioner) or other State official charged with regulation and oversight of insurance policies sold in the state, regarding information within the expertise of the State's Insurance Department.

- The policy is a qualified long-term care insurance policy as defined in section 7702B(b) of the Internal Revenue Code of 1986.
- The policy meets the requirements of the long-term care insurance model regulation and long-term care insurance model Act promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000) as those requirements are set forth in section 1917(b)(5)(A) of the Social Security Act.
- The policy was issued no earlier than the effective date of this State plan amendment.
- The insured individual was a resident of a Partnership State when coverage first became effective under the policy. If the policy is later exchanged for a different long-term care policy, the individual was a resident of a Partnership State when coverage under the earliest policy became effective.
- The policy meets the inflation protection requirements set forth in section 1917(b)(1)(C)(iii)(IV) of the Social Security Act.

NEW:

Supplement 8c to ATTACHMENT 2.6-A
Page 2

STATE PLAN UNDER TITLE OF THE SOCIAL SECURITY ACT
State: DELAWARE
STATE LONG-TERM CARE INSURANCE PARTNERSHIP CONTINUED

- The Commissioner requires the issuer of the policy to make regular reports to the Secretary that include notification regarding when benefits provided under the policy have been paid and the amount of such benefits paid, notification regarding when the policy otherwise terminates, and such other information as the Secretary determines may be appropriate to the administration of such partnerships.
- The State does not impose any requirement affecting the terms or benefits of a partnership policy that the state does not also impose on non-partnership policies.
- The State Insurance Department assures that any individual who sells a partnership policy receives training, and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care.
- The Agency provides information and technical assistance to the Insurance Department regarding the training described above.

DMMA FINAL ORDER REGULATION #11-62b
REVISION:

[~~(Policy Number Pending~~ DSSM 20345]) **Qualified State Long-Term Care Insurance Partnership Program**

This policy applies to Long-Term Care Insurance Partnership policies purchased on or after November 1, 2011.

1. Defining a Qualified State Long-Term Care Insurance Partnership.

The Delaware Qualified State Long-Term Care (LTC) Insurance Partnership is a partnership between States that implement a Partnership program, private insurance companies that offer long term care insurance policies and State insurance departments. The term "Qualified State Long-Term Care Insurance Partnership" means an approved State plan amendment (SPA) that provides for the disregard of any assets or resources from Medicaid estate recovery in an amount equal to the insurance benefits paid by certain LTC insurance policies, where those benefits were disregarded in determining an individual's Medicaid eligibility. The term "long-term care insurance policy" includes a certificate issued under agroup insurance contract.

Purchasing or owning a Qualified State Long-Term Care Insurance Partnership policy does not guarantee Medicaid eligibility. All other financial, non-financial and medical eligibility requirements must be met.

Policies must meet specific conditions and the State Insurance Commissioner must certify that a policy meets those conditions, in order for the State to apply the disregard from estate recovery.

The long-term care partnership policy is designed to do all of the following:

a. Provide incentives for individuals to insure against the costs of providing for their long-term care needs.

b. Provide a mechanism for individuals to qualify for coverage of the cost of their long-term care needs under Medicaid without first being required to substantially exhaust their resources.

c. Reduce Medicaid expenditures by delaying or eliminating the need for Long-Term Care Medicaid.

2. Long-term care insurance policies purchased prior to November 1, 2011 are not Partnership policies.

3. Long-term care insurance policies purchased on or after November 1, 2011 may or may not be Partnership policies.

A long-term care partnership program policy means a policy that must meet all of the following requirements:

a. The policy must have been issued on or after November 1, 2011.

b. The covered individual must be a resident of a Qualified Partnership State when coverage first becomes effective. If a policy is exchanged for another policy, the residency rule applies to the issuance date of the original policy.

c. The policy must meet the definition of a "qualified long-term care insurance policy" as stated in section 7702B(b) of the Internal Revenue Code of 1986.

d. The policy must meet specific requirement of the National Association of Insurance Commissioners (NAIC) Long Term Care Insurance Model Regulations Act and Model Act.

e. The policy must include inflation protection.

i. For purchasers under 61 years of age, compound annual inflation protection.

ii. For purchasers 61 to 76 years of age, some level of inflation protection; or

iii. For purchasers 76 years of age or older, inflation protection may be offered, but is not required.

4. A Partnership policy allows for assets to be disregarded from eligibility.

The amount of the disregard is equal to the dollar amount of insurance benefits that have been paid to or on behalf of the individual.

This amount is limited to the amount paid as of the month of application, even if additional benefits are available under the terms of the policy.

5. Assets are also protected from the Medicaid Estate Recovery Program.

The amount of the assets disregarded in the eligibility process is not recoverable under the Medicaid estate recovery program.

6. Disregarded assets are counted in the Spousal Resource Assessment.

The disregarded assets are included in determining the amount of the community spouse resource allowance in a Spousal Impoverishment case.

However, the disregarded asset is not counted in determining the individual's eligibility.

[7. Disregarded assets may be transferred without penalty.

If an individual becomes eligible for Medicaid through the application of a QLTCP disregard, then transfers all or part of the disregarded resources that would otherwise be considered an improper transfer, no restricted Medicaid coverage period applies. The disregarded value of the transferred resource continues to be considered part of the individual's QLTCP disregard.

If an individual becomes eligible for Medicaid through the application of a QLTCP disregard after making a

transfer that would otherwise be considered an improper transfer:

a. If the individual's QLTCP disregard plus resource limit equals or exceeds the individual's countable resources plus the value of the transferred resource, no penalty period applies. The disregarded value of the transferred resource is considered part of the individual's QLTCP disregard.

b. If the individual's QLTCP disregard plus resource limit is less than the individual's countable resources plus the value of the transferred resource:

i. Determine the individual's available QLTCP disregard by adding the individual's QLTCP disregard to the individual's resource limit, then subtracting the individual's current countable resources and any amounts that have previously been transferred without a restricted Medicaid coverage period as a result of a QLTCP disregard.

ii. Subtract the individual' available QLTCP disregard from the amount that would otherwise have been considered improperly transferred. The remainder is the amount improperly transferred; a restricted Medicaid coverage period is calculated for the remainder.]

[~~7~~8].Reciprocity with other states.

DMMA will accept partnership policies issued in other States with qualified long-term care insurance partnership programs.

[~~8~~9].Exhaustion of Benefits.

An individual who owns a Qualified State Long-Term Care Insurance Partnership policy can apply for Medicaid before exhausting policy benefits.

The partnership policy is treated as a third party liability and Medicaid will pay for services not covered. Medicaid will be payor of last resort.

[~~9~~10].Verification of the Partnership policy.

A Qualified State Long-Term Care Insurance Partnership policy must meet all relevant requirements of federal and state law. Qualified partnership policies are certified by the Delaware Department of Insurance (DOI).

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

Statutory Authority: 16 Delaware Code, Section 512 (16 **Del.C.** §512)

ORDER

Payment Error Rate Measurement (PERM)

NATURE OF THE PROCEEDINGS:

Delaware Health and Social Services ("Department") / Division of Medicaid and Medical Assistance (DMMA) initiated proceedings to amend the Title XIX Medicaid State Plan regarding *Payment Error Rate Measurement (PERM)*. The Department's proceedings to amend its regulations were initiated pursuant to 29 **Delaware Code** Section 10114 and its authority as prescribed by 31 **Delaware Code** Section 512.

The Department published its notice of proposed regulation changes pursuant to 29 **Delaware Code** Section 10115 in the October 2011 Delaware *Register of Regulations*, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by October 31, 2011 at which time the Department would receive information, factual evidence and public comment to the said proposed changes to the regulations.

SUMMARY OF PROPOSAL

The proposal serves as notice of intent of the Division of Medicaid and Medical Assistance (DMMA) to submit a State Plan Amendment (SPA) to elect the option to substitute the Payment Error Rate Measurement (PERM) eligibility process for the traditional Medicaid Eligibility Quality Control reviews.

Statutory Authority

- Improper Payments Information Act of 2002 (IPIA), amended in July 2010 by the Improper Payments Elimination and Recovery Act of 2010 (IPERA), Public Law 111-204;
- Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Public Law 111-3;
- 42 CFR §431.806(b), *State plan requirements; Use of PERM data*

Background

To implement the requirements of the Improper Payments Information Act of 2002 (IPIA), amended in July 2010 by the Improper Payments Elimination and Recovery Act of 2010 (IPERA), Public Law 111-204, the Centers for Medicare and Medicaid Services (CMS) developed the Payment Error Rate Measurement (PERM) program. Under PERM, reviews are conducted in three areas for both the Medicaid and CHIP programs: 1) Fee-for-Service, 2) Managed Care and 3) Program Eligibility. Under the eligibility component, States draw monthly samples of cases and verify eligibility for each case based on State and Federal policies. These reviews result in an eligibility error rate that is included in the national payment error rates for Medicaid and CHIP.

The Medicaid Eligibility Quality Control (MEQC) program is set forth in Section 1903(u) of the Social Security Act. This is an annual eligibility measurement that is similar to the PERM eligibility review, but has its own requirements under a separate regulation. PERM and MEQC have been a longstanding issue between CMS and the States, essentially because every three years the States must administer two parallel eligibility reviews while participating in PERM. The States have requested for many years that CMS implement ways to reduce the duplication of effort between the two programs. Attempts to coordinate PERM and MEQC in previous years through a "substitution" strategy were unsuccessful. The programs are authorized under two different statutes and two separate regulations and could not be supplanted. With the enactment of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), CMS was able to again attempt to implement a substitution strategy for PERM and MEQC. CHIPRA at Section 603(e) requires that CMS review PERM and MEQC policies and coordinate the requirements of both programs in an effort to harmonize the programs.

On August 11, 2010, CMS issued a final rule outlining its planned implementation of provisions from CHIPRA with regard to harmonizing the MEQC and PERM programs. The final rule is available at http://www.gpo.gov/fdsys/pkg/FR-2010-08-11/pdf/2010-18582.pdf. The rule allows the States the option to use data resulting from the MEQC reviews to complete the requirements for the PERM eligibility reviews. States also have the option to use data resulting from the PERM eligibility reviews to complete the requirements for the MEQC reviews.

Because States administer Medicaid and CHIP according to each State's unique program, the States necessarily need to be participants in the measurement process. CMS use PERM to measure Medicaid and CHIP improper payments in a subset of States each year. States are reviewed on a rotating basis, so States are measured in a 17-State, three year rotation. States selected for Medicaid and CHIP improper payments measurements in Federal Fiscal Year 2012 include Delaware. States sample and conduct eligibility reviews of Medicaid and CHIP cases. CMS' Statistical Contractor calculates and combines the State eligibility error rates to develop national eligibility error rates for Medicaid and CHIP.

States that elect the option to substitute PERM data for MEQC data in a State's PERM cycle need to submit a State plan amendment referencing the PERM rule.

Summary of Proposal

The Medicaid state plan will be amended at General Program Administration, 4.4 Medicaid Quality Control to identify the State's election to substitute PERM reviews (active and negative) for the State's MEQC traditional reviews during the State's PERM cycle year. The regulation at 42 CFR §431.806(b) authorizes this substitution.

Fiscal Impact Statement

These revisions impose no increase in cost on the General Fund.

SUMMARY OF COMMENTS RECEIVED WITH AGENCY RESPONSE

The Governor's Advisory Council for Exceptional Citizens (GACEC) and the State Council for Persons with Disabilities (SCPD) offered the following observations and recommendations summarized below. The Division of Medicaid and Medical Assistance (DMMA) has considered each comment and responds as follows.

As background, under a Medicaid Eligibility Quality Control ("MEQC") program, states generally review

samples of Medicaid cases to assess excess payment error rates. CMS is authorized to withhold payments to states based on the amount of improper payments which exceed a 3% threshold. See attached 75 Fed Reg. 48816 (August 11, 2010). A second, overlapping payment error system is also operating pursuant to another federal law. The second system is the "Payment Error Rate Measurement (PERM) Program. States have been critical of the overlapping systems based on perceived duplication of effort. See discussion at 15 DE Reg. 449.

In 2010, CMS issued a 36-page regulation [75 Fed Reg. 48816 (August 11, 2010)] offering states some relief, i.e., states may opt to substitute PERM reviews for the MEQC reviews every 3 years (conforming to the 3-year review cycle). Delaware DMMA is now proposing a Medicaid State Plan Amendment electing this option consistent with the federal regulatory amendments reflected in the attached 75 Fed Reg. 48847.

The GACEC and the SCPD endorse the concept underlying the DMMA regulation since it should reduce administrative costs. Councils' only concern is that the proposed revision to the State Plan is somewhat vague and does not explicitly mention acceptance of the option to substitute PERM reviews for the MEQC reviews during Delaware's PERM review cycle. Perhaps CMS has provided states with a somewhat vague template and DMMA is simply adopting that template. We respectfully requests clarification on this issue.

Agency Response: CMS provided the draft State plan amendment (SPA) preprint to authorize this substitution. State Medicaid agencies are instructed to submit this template to CMS for review and approval. Thank you for the endorsement.

FINDINGS OF FACT:

The Department finds that the proposed changes as set forth in the October 2011 *Register of Regulations* should be adopted.

THEREFORE, IT IS ORDERED, that the proposed regulation to regarding *Payment Error Rate Measurement (PERM)* is adopted and shall be final effective January 10, 2012.

Rita M. Landgraf, Secretary, DHSS

DMMA FINAL ORDER REGULATION #11-55
REVISION:

35

Revision:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: DELAWARE

Citation		
42 CFR 431 Subpart P 50 FR 21839 75 FR 48847 1903(u) of of the Act, P.L. 99-509 (Section 9407) P.L. 107-300 P.L. 111-3	4.4	Medicaid Eligibility Quality Control (MEQC) (a) A system of quality control is implemented in accordance with 42 CFR Part 431, Subpart P. (b) In accordance with 431.806(c), the State operates a Medicaid quality control claims processing assessment system that meets the requirements of ~~431.800(e), (g), (h), and (k)~~ 431.830 – 431.836 ☒ ☐ Yes.

☐ ☒ Not applicable. The State has an approved Medicaid Management Information System (MMIS).

(c) In accordance with 431.806(b), Payment Error Rate Measurement (PERM) is implemented in accordance with 42 CFR Part 431, Subpart Q, in substitution to meet the statutory and regulatory ("traditional") Medicaid Eligibility Quality Control (MEQC) review during the State's PERM cycle.

☒ Yes.

☐ Not applicable. The State operates an approved MEQC Pilot.

DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

Statutory Authority: 31 Delaware Code, Section 512 (31 **Del.C.** §512)

ORDER

DSSM: 14370 Coverage of Emergency Services and Labor and Delivery

NATURE OF THE PROCEEDINGS:

Delaware Health and Social Services ("Department") / Division of Medicaid and Medical Assistance (DMMA) initiated proceedings to amend the Division of Social Services Manual regarding *Coverage of Emergency Services and Labor and Delivery Only*. The Department's proceedings to amend its regulations were initiated pursuant to 29 **Delaware Code** Section 10114 and its authority as prescribed by 31 **Delaware Code** Section 512.

The Department published its notice of proposed regulation changes pursuant to 29 **Delaware Code** Section 10115 in the November 2011 Delaware *Register of Regulations*, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by November 30, 2011 at which time the Department would receive information, factual evidence and public comment to the said proposed changes to the regulations.

SUMMARY OF PROPOSAL

The proposed amends the Division of Social Services Manual regarding *Coverage of Emergency Services and Labor and Delivery Only.*

Statutory Authority

42 CFR §440.255, *Limited services available to certain aliens*

Background

Aliens who are not otherwise eligible for full Medicaid because of immigration status may be eligible for emergency services and labor and delivery only.

For the purposes of emergency services and labor and delivery only, federal Medicaid regulations define emergency services (including labor and delivery) as a sudden onset of a physical or mental condition which

causes acute symptoms, including severe pain, where the absence of immediate medical attention could reasonably be expected to:

- Place the person's health in serious jeopardy, or
- Cause serious impairment to bodily function, or
- Cause serious dysfunction of any bodily organ or part.

Summary of Proposal

DSSM 14370, *Coverage of Emergency Services and Labor and Delivery Only*: The Division of Medicaid and Medical Assistance (DMMA) is proposing a change to the Medicaid emergency services for undocumented aliens' benefit. The primary change is to include birthing centers as a place of service for emergency labor and delivery services, effective November 1, 2011.

Fiscal Impact Statement

The proposed revision imposes no increase in cost on the General Fund.

SUMMARY OF COMMENTS RECEIVED WITH AGENCY RESPONSE

The Governor's Advisory Council for Exceptional Citizens (GACEC) and the State Council for Persons with Disabilities (SCPD) offered the following observations and recommendations summarized below. The Division of Medicaid and Medical Assistance (DMMA) has considered each comment and responds as follows.

In June 2011, DMMA adopted a regulation limiting Medicaid services eligibility of qualifying legally residing noncitizens to "emergency services and labor and delivery only." [14 DE Reg. 998 (April 1, 2011) (proposed); 14 DE Reg. 1361 (June 1, 2011)] The Division now proposes to adopt a regulation clarifying that labor and delivery services may be rendered not only in a hospital, but in a birthing center as well. The Councils endorse this clarification, but has the following observations on the proposed regulation.

Agency Response: Thank you for the endorsement.

The current regulation categorically limits emergency services to those "rendered in an acute care emergency room or in an acute care inpatient hospital". [Section 14370] Since DMMA is not limiting labor and delivery to hospital sites, it should consider whether covered emergency services can only be provided in a hospital. The DMAP definition of "emergency" includes a "severe acute illness or accidental injury that demands immediate medical attention or surgical attention" which, "without the treatment a person's life could be threatened or he or she could suffer serious long lasting disability." At 621.

There are free-standing emergency or urgent care centers which treat conditions covered by this standard. See attachments. For example, the Newark Emergency Center treats pneumonia, asthma, and fractures. If a patient presented with acute shortness of breath due to asthma and was treated with a nebulizer and concomitant treatment, that should be covered as a life-threatening emergency. Similarly, the fracture of three fingers could be treated in the Center which would meet the standard of an accidental injury" which could result in "serious long-lasting disability." Consistent with the attachment, the Silverside Medical Aid Network similarly covers broken bones, asthma, and pneumonia. It would be preferable for DMMA to expand the sites in which compensable emergency services can be provided. If free-standing center costs are less than hospital costs, such a change could also result in cost saving to the State.

Agency Response: Urgent care is the delivery of ambulatory medical care outside of a hospital emergency department on a walk-in basis without a scheduled appointment. Urgent care centers provide immediate care for acute, non-life threatening illnesses and injuries. Urgent care medicine differs from emergency medicine in that its primary focus is on acute medical problems at the lower end of the severity spectrum. Individuals who present to an urgent care center and are judged to need emergency care are transferred to a hospital emergency department. The subsequent triage and treatment costs in the hospital emergency room would incur more costs. No change will be made to the regulation as a result of this comment.

FINDINGS OF FACT:

The Department finds that the proposed changes as set forth in the November 2011 *Register of Regulations* should be adopted.

THEREFORE, IT IS ORDERED, that the proposed regulation to amend the Division of Social Services Manual

regarding *Coverage of Emergency Services and Labor and Delivery Only* is adopted and shall be final effective January 10, 2012.

Rita M. Landgraf, Secretary, DHSS

DMMA FINAL ORDER REGULATION #11-63
REVISION:

14370 Coverage of Emergency Services and Labor and Delivery Only

~~These~~ Emergency services must be rendered in an acute care hospital emergency room or in an acute care inpatient hospital. Labor and delivery only services must be rendered in an acute care hospital emergency room, an acute care inpatient hospital, or a birthing center.The DMAP defines an emergency as:

- a sudden serious medical situation that is life threatening; or
- a severe acute illness or accidental injury that demands immediate medical attention or surgical attention; and
- without the treatment a person's life could be threatened or he or she could suffer serious long lasting disability.

Medically necessary physician (surgeon, pathologist, anesthesiologist, emergency room physician, internist, etc.) or midwife services rendered during an emergency service that meets the above criteria are covered. Ancillary services (lab, x-ray, pharmacy, etc.) rendered during an emergency service that meets the above criteria are also covered. Emergency ambulance services to transport these individuals to and from the services defined above are also covered.

Services not covered for aliens who are determined to be eligible for emergency services and labor and delivery only include but are not limited to:

- any service delivered in a setting other than an acute care hospital emergency room or an acute care inpatient hospital. Exception: labor and delivery services may be rendered in a birthing center.
- any service (such as pharmacy, transportation, office visit, lab or x-ray, home health) that precedes or is subsequent to a covered emergency service. Exception: ambulance transportation that is directly related to the emergency is covered.
- organ transplants
- long term care or rehabilitation care
- routine prenatal and post partum care

13 DE Reg. 1540 (06/01/10)

DIVISION OF SOCIAL SERVICES

Statutory Authority: 16 Delaware Code, Section 512 (16 **Del.C.** §512)
16 **DE Admin. Code** 2000

ORDER

Food Supplement Program; Issuing Benefit Restorations

NATURE OF THE PROCEEDINGS:

Delaware Health and Social Services ("Department") / Division of Social Services initiated proceedings to amend the Division of Social Services Manual (DSSM) regarding the Food Supplement Program, specifically, *Issuing Benefit Restorations*. The Department's proceedings to amend its regulations were initiated pursuant to 29 **Delaware Code** Section 10114 and its authority as prescribed by 31 **Delaware Code** Section 512.

The Department published its notice of proposed regulation changes pursuant to 29 **Delaware Code Section** 10115 in the October 2011 Delaware *Register of Regulations*, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by October 31, 2011 at which time the Department

would receive information, factual evidence and public comment to the said proposed changes to the regulations.

SUMMARY OF PROPOSAL

The proposal described below amends policies in the Division of Social Services Manual (DSSM) regarding the Food Supplement Program, specifically, *Issuing Benefit Restorations*.

Statutory Authority

- 7 CFR §273.17, *Restoration of lost benefits*
- 45 CFR §233.20(a)(12), *Recoupment of overpayments and correction of underpayments for programs other than AFDC*

Summary of Proposed Changes

DSSM 2011, ~~*Benefit Restorations for Cash Assistance and Food Stamps*~~ *Issuing Benefit Restorations*: The name of the section is being changed to more clearly indicate the content of the policy. Policy is being reformatted for clarity and ease of readability. Federal citations are also added to the policy section.

SUMMARY OF COMMENTS RECEIVED WITH AGENCY RESPONSE AND EXPLANATION OF CHANGE(S)

The Governor's Advisory Council for Exceptional Citizens (GACEC) and the State Council for Persons with Disabilities (SCPD) offered the following observations and recommendations summarized below. The Division of Social Services (DSS) has considered the comment and responds as follows:

The attached federal regulation (7 C.F.R. §273.17) contains the following provision:

> (g) *Changes in household composition*. Whenever lost benefits are due a household and the household's membership has changed, the State agency shall restore the lost benefits to the household containing a majority of the individuals who were household members at the time the loss occurred. If the State agency cannot locate or determine the household which contains a majority of household members the State agency shall restore the lost benefits to the household containing the head of the household at the time the loss occurred.

This concept is not included in the State regulation. DSS may wish to consider its inclusion since household composition of Food Supplement Program participants may change on a relatively frequent basis.

Agency Response: The policy is revised by adding item 4 as follows:

> 4. DHSS Issues Restorations When the Household Composition Changes
>
> Issue benefit restorations even if a household's membership has changed. In this instance issue the restoration to the household containing a majority of the individuals who were household members at the time the loss occurred. If the agency cannot locate or determine the household which contains a majority of household members, the agency will issue the restoration to the household containing the head of the household at the time the loss occurred.

FINDINGS OF FACT:

The Department finds that the proposed changes as set forth in the October 2011 *Register of Regulations* should be adopted.

THEREFORE, IT IS ORDERED, that the proposed regulation to amend the Division of Social Services Manual (DSSM) regarding the Food Supplement Program (FSP), specifically, *Issuing Benefit Restorations* is adopted and shall be final effective January 10, 2012.

Rita M. Landgraf, Secretary, DHSS

DSS FINAL ORDER REGULATION #11-59
REVISIONS:

2011 ~~Benefit Restorations for Cash Assistance and Food Stamps~~ Issuing Benefit Restorations

~~Benefit restorations must be made to correct an underpayment resulting from the Division's failure to act or to take appropriate action on available information. Requests for benefit restorations for one to three months must be approved and countersigned by the Operations Administrator. Requests for benefit restorations for more than three months from the date of the incorrect action must be approved and countersigned by the Chief Operations Administrator. Requests for benefit restorations beyond a period of one year require a fair hearing decision or court hearing. Benefit restorations are always subject to available funds. Benefit restorations are also subject to offsetting overpayments and claims owed by the family or household per DSSM 7002.1 and DSSM 7004.3~~

7 CFR 273.17, 45 CFR 233.20(a)(12)

This policy applies to cash assistance and food benefit applicants and recipients that received less benefits than they were eligible to receive. The need for restoration may be identified by the client or DHSS. Eligibility for restoration may also be determined by a court or administrative hearing decision or a change in law.

1. DSS Must Correct All Under-issuances

An under-issuance occurs when the amount of benefit that the household received was less than the benefit the household was entitled to receive. In these instances DSS will issue a benefit equal to the difference between what was received and what should have been received. This is called a restoration.

Exception: Restorations are not issued when funding is not available.

2. Restorations Must Be Approved

Benefit restorations must be approved by a designated authority. The following are authorized to approve restorations as indicated.

A. Operations Administrator: approves 1 to 3 months of benefits.
B. Chief Administrator: approves 4 to 12 months of benefits.
C. Fair hearing or court decision: required for 13 or more months of benefits.

3. DHSS Applies Restorations to Unpaid Overpayments and Claims

If the client has an unpaid overpayment or claim, the agency will first use the restoration to reduce the overpayment or claim. Any remaining funds are sent to the client. See DSSM 7002.1 and DSSM 9011.1.

[4. DHSS Issues Restorations When the Household Composition Changes

Issue benefit restorations even if a household's membership has changed. In this instance issue the restoration to the household containing a majority of the individuals who were household members at the time the loss occurred. If the agency cannot locate or determine the household which contains a majority of household members, the agency will issue the restoration to the household containing the head of the household at the time the loss occurred.]

DIVISION OF SOCIAL SERVICES

Statutory Authority: 16 Delaware Code, Section 512 (16 **Del.C.** §512)
16 **DE Admin. Code** 9076

ORDER

Food Supplement Program; Treatment of Income and Resources of Certain Non-Household Members

NATURE OF THE PROCEEDINGS:

Delaware Health and Social Services ("Department") / Division of Social Services initiated proceedings to amend the Division of Social Services Manual (DSSM) regarding the Food Supplement Program, specifically, *Treatment of Income and Resources of Certain Non-Household Members*. The Department's proceedings to amend its regulations were initiated pursuant to 29 **Delaware Code** Section 10114 and its authority as prescribed

by 31 **Delaware Code** Section 512.

The Department published its notice of proposed regulation changes pursuant to 29 **Delaware Code** Section 10115 in the October 2011 Delaware *Register of Regulations*, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by October 31, 2011 at which time the Department would receive information, factual evidence and public comment to the said proposed changes to the regulations.

SUMMARY OF PROPOSAL

The proposal described below amends policies in the Division of Social Services Manual (DSSM) regarding the Food Supplement Program, specifically, *Treatment of Income and Resources of Certain Non-Household Members*.

Statutory Authority

7 CFR §273.11(c), *Treatment of Income and Resources of Certain Non-Household Members*

Summary of Proposed Changes

DSSM 9076, *Treatment of Income and Resources of Certain Non-Household Members* **and DSSM 9076.1**, *Intentional Program Violation, Felony Drug Conviction or Fleeing Felon Disqualifications ~~or~~ and Work Requirement Sanctions*: Senate Bill (SB) 12 of the 146th General Assembly eliminated the bar to receipt of food benefits for those convicted of a felony drug conviction. This policy change removes text from the policy manual that says individuals convicted of a felony drug conviction are ineligible for food benefits. SB 12 was effective upon the Governor's signature on June 22, 2011 and affects benefits beginning July 1, 2011.

SUMMARY OF COMMENTS RECEIVED WITH AGENCY RESPONSE AND EXPLANATION OF CHANGE(S)

The Governor's Advisory Council for Exceptional Citizens (GACEC) and the State Council for Persons with Disabilities (SCPD) offered the following observations and recommendations summarized below. The Division of Social Services (DSS) has considered each comment and responds as follows:

First, the Governor signed the attached S.B. 12 on June 22, 2011. The bill removes the bar on Food Supplement Program eligibility of convicted drug felons. The DSS regulation implements the legislation by removing an ineligibility reference in §9076.1 based on a drug related felony conviction. However, the title to §9076.1 still contains a reference to "Felony Drug Conviction" which should be deleted.

Agency Response: Correction made and the text "Felony Drug Conviction or" is removed.

Second, the attached 16 **DE Admin. Code** 2027 still contains a bar on Food Supplement Program eligibility for convicted drug felons. DSS should consider proposing an amendment to this regulation to conform to S.B. 12.

Agency Response: The correction will be made.

Third, revised §9076.1 otherwise conforms to the attached corresponding federal regulation, 7 C.F.R. §273.11(c)(1).

Agency Response: Thank you.

FINDINGS OF FACT:

The Department finds that the proposed changes as set forth in the October 2011 Register of Regulations should be adopted.

THEREFORE, IT IS ORDERED, that the proposed regulation to amend the Division of Social Services Manual (DSSM) regarding the Food Supplement Program (FSP), specifically, *Treatment of Income and Resources of Certain Non-Household Members* is adopted and shall be final effective January 10, 2012.

Rita M. Landgraf, Secretary, DHSS

DSS FINAL ORDER REGULATION #11-57
REVISIONS:

9076 Treatment of Income and Resources of Certain Non-Household Members

~~[273.11(c)]~~

~~During the period of time that a household member cannot participate because (s)he:~~

~~Is an ineligible alien;~~

~~Is ineligible because of disqualification for an intentional Program violation;~~

~~Is ineligible because of disqualification for or refusal to obtain or provide an SSN; or~~

~~Is ineligible for failing to sign the application attesting to his/her citizenship or alien status.~~

~~Is ineligible because of having made a fraudulent statement or misrepresentation to the identity and/or place of residence in order to receive multiple benefits at the same time per DSSM 2024;~~

~~Is ineligible for being a fleeing felon or probation/parole violator per DSSM 2025.~~

~~Is ineligible for being convicted of trafficking food stamps of $500 or more per DSSM 2026.~~

~~Is ineligible due to work requirements per DSSM 9018.~~

~~Determine the eligibility and benefit level of any remaining household members in accordance with the procedures outlined in this section.~~

7 CFR 273.11(c)

During the period of time that a household member cannot participate for the reasons below, determine the eligibility and benefit level of any remaining household members in accordance with sections 9076.1 through 9076.4.

The household member cannot participate because he or she is:

1. An ineligible alien.
2. Disqualified for an intentional Program violation.
3. Disqualified for or refusal to obtain or provide an SSN.
4. Ineligible for failing to sign the application attesting to his/her citizenship or alien status.
5. Ineligible because of having made a fraudulent statement or misrepresentation of his or her identity in order to receive multiple benefits at the same time per DSSM 2024.
6. Ineligible because of having made a fraudulent statement or misrepresentation about his or her place of residence in order to receive multiple benefits at the same time per DSSM 2024.
7. Ineligible for being a fleeing felon or probation/parole violator per DSSM 2025.
8. Ineligible for being convicted of trafficking food benefits of $500 or more per DSSM 2026.
9. Ineligible due to work requirements per DSSM 9018.
10. Ineligible due to the time limit for Able-bodied Adults without Dependents per DSSM 9018.2.

9076.1 Intentional Program Violation, [~~Felony Drug Conviction or~~] Fleeing Felon Disqualifications ~~or~~ and Work Requirement Sanctions

~~Determine as follows the eligibility and benefit level of any remaining household members of a household containing individuals determined ineligible because of the disqualifications or sanctions listed below:~~

~~Is ineligible because of disqualifications for an intentional Program violation;~~

~~Is ineligible because of having made a fraudulent statement or misrepresentation to the identity and/or place of residence in order to receive multiple benefits at the same time;~~

~~Is ineligible for being a fleeing felon or probation/ parole violator;~~

~~Individuals who are ineligible because of a drug related felony conviction per DSSM 2027;~~

~~Is ineligible for being convicted of trafficking food stamps of $500 or more.~~

~~1) Income, resources and deductible expenses - the income and resources of the ineligible household member(s) continue to count in their entirety, and the entire household's allowable earned income, standard, medical, dependent care, child support payment, and excess shelter deductions continue to apply to the remaining household members.~~

~~2) Eligibility and benefit level - the ineligible member is not included when determining the household's size for the purpose of:~~

~~a) Assigning a benefit level to the household;~~

~~b) Comparing the household's monthly income with the income eligibility standards; or~~

~~c) Comparing the household's resources with the resource eligibility limits. Ensure that no household's~~

~~food stamp allotment is increased as a result of the exclusion of one or more household members.~~

7 CFR 273.11(c)

For households containing individuals determined ineligible because of the disqualifications or sanctions listed below, determine the eligibility and benefit level of any remaining household members as follows:

Disqualifications or Sanctions

1. Disqualified for an intentional Program violation.
2. Ineligible because of having made a fraudulent statement or misrepresentation of his or her identity in order to receive multiple benefits at the same time.
3. Ineligible because of having made a fraudulent statement or misrepresentation about his or her place of residence in order to receive multiple benefits at the same time.
4. Ineligible for being a fleeing felon or probation/ parole violator.
5. Ineligible for being convicted of trafficking food benefits of $500 or more.

Eligibility and Benefit Determination

1. Income, resources and deductible expenses
   A. Count all the income and resources of the ineligible household member(s) in the eligibility and benefit determination.
   B. Apply all allowable earned income and deductions to the entire household. Include all deductions the ineligible household member would receive if he or she was included in the household size. Count the following deductions:
      1. Standard
      2. Medical
      3. Dependent care
      4. Child support payment
      5. Excess shelter
2. Eligibility and benefit level
   Do not include the ineligible member when determining the household's size when:
   A. Assigning a benefit level to the household.
   B. Comparing the household's monthly income with the income eligibility standards.
   C. Comparing the household's resources with the resource eligibility limits. Ensure that no household's food benefit is increased as a result of the exclusion of one or more household members.

DIVISION OF SOCIAL SERVICES

Statutory Authority: 16 Delaware Code, Section 512 (16 **Del.C.** §512)
16 **DE Admin. Code** 9093

ORDER

Food Supplement Program; Electronic Benefit Transfer

NATURE OF THE PROCEEDINGS:

Delaware Health and Social Services ("Department") / Division of Social Services initiated proceedings to amend the Division of Social Services Manual (DSSM) regarding the Food Supplement Program, specifically, *Electronic Benefit Transfer*. The Department's proceedings to amend its regulations were initiated pursuant to 29 **Delaware Code** Section 10114 and its authority as prescribed by 31 **Delaware Code** Section 512.

The Department published its notice of proposed regulation changes pursuant to 29 **Delaware Code** Section 10115 in the October 2011 Delaware *Register of Regulations*, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by October 31, 2011 at which time the Department would receive information, factual evidence and public comment to the said proposed changes to the regulations.

SUMMARY OF PROPOSAL

The proposal described below amends policies in the Division of Social Services Manual (DSSM) regarding the Food Supplement Program, specifically, *Electronic Benefit Transfer*.

Statutory Authority

- 7 CFR §271.2, *Definitions*
- 7 CFR §273.18(g)(2), *Benefits from EBT accounts*
- 7 CFR §274.2, *Providing benefits to participants*
- 7 CFR §274.4, *Reconciliation and reporting*
- 7 CFR §274.8(d), *Re-presentation*

Summary of Proposed Changes

The below referenced policy sections are being changed to bring the policy manual up to date regarding the current Electronic Benefit Transfer (EBT) vendor. Other technical changes were made to update language, e.g., food stamps to food benefits. Additional changes made to improve readability; clarify and reformat text; add federal citations; remove the name of the previous EBT vendor and replace it with a generic indicator; replace all instances of food stamps with food benefits; and, remove the duplicative and incomplete definitions section at 9093.1.

The proposed changes affect the following policy sections:

DSSM 9093, *Electronic Benefit Transfer (EBT)*

DSSM 9093.1, ~~*Definitions/Acronyms*~~ *RESERVED*

DSSM 9093.2, *Using EBT for Food ~~Stamp~~ Benefits*

DSSM 9093.3, *Food ~~Stamp~~ Benefit EBT Adjustments*

DSSM 9093.4, *Account Balances*

DSSM 9093.5, *Manual Transactions*

DSSM 9093.6, *Manual Vouchers*

DSSM 9093.7, *EBT and Timely Application Processing*

DSSM 9093.8, *EBT Benefits and Claim Issues*

DSSM 9093.9, *Aging Periods and Expungement Process*

DSSM 9094, *Definitions*

SUMMARY OF COMMENTS RECEIVED WITH AGENCY RESPONSE AND EXPLANATION OF CHANGE(S)

The Governor's Advisory Council for Exceptional Citizens (GACEC) and the State Council for Persons with Disabilities (SCPD) offered the following observations and recommendations summarized below. The Division of Social Services (DSS) has considered each comment and responds as follows:

First, there are many references to "store" or "stores". See, e.g., §§9093.2, 9093.3, and 9093.5. In other instances, DSS often refers to "retailer" or retailers". See, e.g., §§9093.3 and 9093.6. DSS describes eligible vendors as including a "farmers market" (§§9093.2 and 9093.6); "street or route vendor" (§9093.6); and providers such as soup kitchens, shelters, communal living arrangements, and home delivered meals (definition of "eligible foods" at p. 466). The term "retailer" would be preferable to "store" since it would cover farmers' markets and street vendors. However, the term would not "capture" soup kitchens, shelters, home delivered meal providers. DSS should consider adopting a uniform term (e.g. "supplier") with a definition which encompasses the expected provider network.

Agency Response: After careful consideration DSS decides to retain the language as is. Though it is often preferable to use consistent terms throughout, the verbiage used in the selected sections is used appropriately. The use of a term like "supplier" has a very different connotation than retailer or store and might create confusion on the part of the end user.

Second, in §9093.2, first line, substitute "farmers'" for "farmers". Compare reference in §9093.6, second paragraph.

Agency Response: The text is corrected.

Third, in §9093.3, second paragraph, consider substituting "DSS will emphasize" for "Emphasize". Compare references at end of this section (e.g. "DSS must act..."; DSS will send a notice..."; "DSS will make a provisional credit...").

Agency Response: The text is changed as suggested.

Fourth, in §9093.3, second last paragraph, the "notice" provision would benefit from embellishment since it does not indicate how households would be alerted to the 10-day deadline on requesting provisional credit. One option would be to amend the initial sentence as follows:

DSS will send a notice to the household informing it of the account adjustment and appeal rights, including the timetable for requesting a provisional credit.

Alternatively, DSS could insert the following based on the definition of "adequate notice" at p. 463:

DSS will send an adequate notice as defined in §9094 to the household informing it of the account adjustment.

Agency Response: The text is changed to read "DHSS will send an adequate notice as defined in DSSM 9094 to the household informing it of the account adjustment."

Fifth, in §9093.7, first sentence, consider the following revision: "~~Regulations say we~~ DSS must provide..."

Agency Response: The text is changed to read "DHSS must provide…"

Sixth, in §9093.8, second sentence, substitute "it was" for "they were" since the antecedent ("household") is singular. Similarly, in §9094, definition of "Notice of Expiration", substitute "it needs" for "they need". Compare similar reference in §9093.3, second last paragraph.

Agency Response: The text is changed as suggested.

Seventh, in §9094, definition of "Elderly or disabled member", the period is missing at the end of Par. "A".

Agency Response: Correction made.

Eighth, in §9094, definition of "Eligible foods", Par. C, DSS may wish to consider substituting "benefits" for "coupons".

Agency Response: The referenced text is changed from "coupons" to "EBT benefits".

Ninth, the regulation contains pejorative and outdated references. See, e.g., the following: A. reference to "physically or mentally handicapped" in §9094, definition of "Meal Delivery Service"; B. reference to "Disabled member" in §9094, definition of "elderly or disabled member" and definition of "group living arrangement"; and C. inclusion of the following reference in §9094, definition of "homeless" - "a halfway house or similar institution that provides temporary accommodations for individuals intended to be institutionalized". The Governor signed H.B. 91 in August, 2011 which includes the following admonition:

> (b) From the effective date of this section, all new and revised statutes, administrative rules, local laws, ordinances, charters or regulations promulgated or any publications published by the state or any political subdivision that refers to persons with disabilities shall:
>
> (1) Avoid language that:
>
> (A) implies that a person as a whole is disabled, such as the "mentally ill", "retarded", or the "learning disabled", or
>
> (B) equates persons with their conditions, such as "epileptics", "autistics", or quadriplegics", and
>
> (2) Replace non-respectful language by referring to persons with disabilities as persons first; for example, persons with disabilities, persons with developmental disabilities, persons with mental illness, persons with autism, or person with cognitive disabilities.

DMMA implemented this law in August by issuing a comprehensive regulation amending many of its regulations to conform to the directive and spirit of H.B. 91. See 15 DE Reg. 202 (August 1, 2011). DSS should likewise consider reviewing this regulation to ensure conformity with H.B. 91.

Agency Response: The phrase "the physically or mentally handicapped" is changed to "persons with physical or mental disabilities". Other similar references to obsolete terminology is changed to more respectful language.

FINDINGS OF FACT:

The Department finds that the proposed changes as set forth in the October 2011 *Register of Regulations* should be adopted.

THEREFORE, IT IS ORDERED, that the proposed regulation to amend the Division of Social Services Manual (DSSM) regarding the Food Supplement Program (FSP), specifically, *Electronic Benefit Transfer* is adopted and shall be final effective January 10, 2012.

Rita M. Landgraf, Secretary, DHSS

DSS FINAL ORDER REGULATION #11-58
REVISIONS:

9093 Electronic Benefit Transfer (EBT)

Electronic Benefit Transfer (EBT) is the method by which Delaware **[~~Division of Social Services (DSS)~~ Department of Health and Social Services (DHSS)]** issues food ~~stamp~~ benefits to participants. The EBT card is a plastic card called the Delaware Food First Card. The card is used with a Personal Identification Number (PIN) at grocery retailers to purchase food.

~~eFunds Government Systems (eFunds) is Delaware's contractor for EBT.~~ Delaware uses an EBT contractor to manage the EBT cards. Client/case file and benefit information are transmitted through an interface between ~~eFunds~~ the EBT contractor and the Division's data processing systems.

EBT did not change the way that eligibility determinations are made for food ~~stamps~~ benefits. EBT affected the way that food benefits are delivered to participants. EBT provides greater privacy and security for those receiving food ~~stamp~~ benefits.

9093.1 ~~Definitions/Acronyms~~ RESERVED

~~**Administrative Terminal**: This is the eFunds system through which DSS staff can obtain EBT card and account information.~~

~~**Authorized Representative**: This is an individual outside the household designated to have access to the household's benefit account. This can also be a household member, like a spouse, who is a secondary card holder.~~

~~**Benefit Status**: This is a code which indicates the current status of the benefit in the Administrative Terminal.~~

~~**Card Number**: The card number is printed on the front of the EBT card. The first six digits are the same for all of Delaware's cards. This is known as the Primary Account Number (PAN).~~

~~**Card Status**: An EBT card may be active or inactive. The card status for a replacement card can indicate stolen, lost, payee changed, name changed, damaged, undelivered, deactivated/cancelled or bad address.~~

~~**Date Available**: Benefits are available at 6:00 a.m. on the date specified in the Administrative Terminal. Regular monthly food supplement benefits are available according to a seven day staggered schedule based on the last name. Benefits start staggering on the fifth calendar day of each month.~~

~~**eFunds Customer Support**: The Customer Support Unit receives phone calls from participants to check balances, report lost or stolen cards, report problems with a retailer, and request new PINs. The CSU number is 1-800-526-9099.~~

~~**Expunged Benefits**: Benefits in client accounts not used for 365 days are expunged (removed) from the account forever.~~

~~**FNS Number:** A unique number assigned to retailers by FNS indicating that the retailer is eligible to accept FSP benefits.~~

~~**Hold Amount:** When an EBT manual voucher transaction is used, the retailer obtains an authorization number from eFunds. eFunds puts a hold on the participant's food benefit account. Once an accept reason is assigned to the voucher, the hold amount is deducted from the participant's benefit balance and this field becomes blank.~~

~~**Manual Entries:** If an EBT card or POS machine is damaged, the card number can be keyed manually to complete the transaction.~~

~~**Manual Voucher:** Retailers use paper vouchers when the eFunds system is not available. Retailers who are not eligible to have POS terminals also use these vouchers. A voucher has a unique number which identifies the voucher. This field is completed only if the transaction displayed in the Administrative Terminal is an off line voucher.~~

~~**PAN:** The Primary Account Number is the 16 digit number on the EBT card, also called the card number.~~

~~**PIN (Personal Identification Number):** A PIN is a four digit secret code that must be used when the EBT card is used. No one can use the card but the participant as long as the participant does not give the PIN to anyone.~~

~~**PIN Info:** The Card Maintenance screen in the Administrative Terminal displays whether or not a PIN has been selected and the method. Yes indicates that a PIN has been selected. Fails is the number of times the PIN entered has failed that day. Chg Count is the number of times the PIN has been changed. Method is how the PIN was selected.~~

~~**Point-of-Sale (POS) Terminal:** A POS is the device on which transactions are made by the food stamp participant. The POS machine reads the card and allows the participant to buy food with the food stamp benefits.~~

~~**Stale Benefits**: Benefits not used by a household within 60, 90 or 230 days.~~

9093.2 Using EBT for Food ~~Stamp~~ Benefits

7 CFR 274.4

The household may use its EBT card in any grocery store, convenience store, farmers' market, etc., anywhere in the United States, authorized by FNS to accept ~~them~~ the card. The benefits may be used the same as cash to purchase any food or food product prepared for human consumption. Households cannot use benefits to purchase alcoholic beverages, tobacco, soap and paper products, and hot foods or hot foods prepared for immediate consumption. Households can use benefits to buy seeds and plants for use in gardens to produce food for personal consumption by the eligible household.

EBT benefits are available 24 hours a day, seven days per week including weekends and holidays. **[~~DSS~~ DHSS]** issues benefits on a daily and monthly basis. **[~~DSS~~ DHSS]** issues monthly benefits on the same day each month for each household based on a staggered issuance schedule. ~~eFunds~~ The EBT contractor posts benefits in the household's account by 6 a.m. the day after benefits are approved in DCIS II.

There is no minimum dollar amount per transaction. There is no maximum limit on the number of transactions a household can make. Stores cannot impose transaction fees on food ~~stamp~~ benefit households using their EBT card ~~at grocery stores~~.

Households can check their food ~~stamp~~ benefit account balances without making a purchase or standing in a checkout line.

Households receive printed receipts at the time of transactions.

When transacting food ~~stamp~~ benefits by EBT, the household cannot receive change. When a household returns food to a ~~grocery~~ store, the store will credit the household's EBT account with the amount of the refund. The household cannot receive a cash refund for returned food.

9093.3 Food ~~Stamp~~ Benefit EBT Adjustments

7 CFR 274.2

~~eFunds~~ The EBT contractor makes adjustments to EBT accounts to correct system errors. A system error is an error resulting from a malfunction at any point in the redemption process, for example, errors made at the grocery store. Adjustments are initiated by the client or store and may result in a debit or credit to the household.

[~~Emphasize~~ DHSS will emphasize] to clients that they should review their transaction slips before leaving the store. If there is a mistake, the client should discuss the problem with the store clerk or manager before leaving the store. Problems discovered later must be resolved through the ~~eFunds~~ EBT contractor Customer Service Unit.

Client-Initiated Adjustments

An EBT credit adjustment occurs when ~~eFunds~~ the EBT contractor returns benefits to a household's account after the store deducted the benefits in error.

For example, a household member uses an EBT card to purchase groceries. Due to a system error, the store debited the purchase amount from the household's EBT account twice.

The household has 90 days from the date of the problem transaction to contact ~~eFunds~~ the EBT contractor Customer Service at 1-800-526-9099 and inform the customer service representative that a problem has occurred. The household will need to tell the customer service representative the date, time and location of the transaction and the amount of food ~~stamp~~ benefits that were debited in error.

If the request is a legitimate request, ~~eFunds~~ the EBT contractor will return the funds to the household's EBT account within 10 business days from the date the household filed the report with the ~~eFunds~~ EBT contractor Customer Service Unit. A business day is any calendar day other than a Saturday, a Sunday or a federal holiday.

If the household's request is not legitimate, ~~eFunds~~ the EBT contractor will deny the credit adjustment. The household may request a fair hearing. ~~eFunds~~ The EBT contractor will take no action to credit the household's EBT

account unless the hearing decision is in the household's favor.

Retailer-Initiated Adjustments

A retailer-initiated adjustment occurs when the retailer does not receive a credit for an EBT purchase amount when the household made the purchase. The store needs the adjustment to get credit for the purchase made by the household.

For example, a household uses the EBT card to purchase $200 worth of groceries. The credit to the store's account does not go through and the $200 remains in the household's account.

[~~DSS~~ DHSS] must act upon all adjustments to debit a household's account no later than 10 business days from the date the error occurred, by placing a hold on the adjusted amount in the household's account. If there are insufficient benefits to cover the entire adjustment, **[~~DSS shall~~ DHSS will]** place a hold on any remaining balance that exists and the whole amount will be debited from the household's account when the next month's benefits become available.

[~~DSS~~ DHSS] will send a**[n adequate]** notice **[as defined in DSSM 9094]** to the household informing ~~them~~ it of the account adjustment. The household has 90 days from the date of the notice to request a fair hearing.

If the household disputes the adjustment and requests a hearing within 10 days of the notice, **[~~DSS~~ DHSS]** will make a provisional credit to the household's account by releasing the hold on the adjustment balance within 48 hours of the request by the household, pending resolution of the fair hearing. If the household does not request ~~for~~ a hearing within 10 days of the notice, **[~~DSS~~ DHSS]** will release the hold on the adjustment balance, and credit this amount to the retailer's account.

9093.4 Account Balances

An EBT food ~~stamp~~ benefit account does not close when a food ~~stamp~~ benefit DCIS case closes. The former recipient remains entitled to the account balance. As long as benefits remain in the EBT food ~~stamp~~ benefit account, the former recipient may ~~still~~ have cards issued or reissued and be able to select or change PINs.

9093.5 Manual Transactions

7 CFR 274.8(d)

Sometimes circumstances cause the client or store clerk to enter the transaction manually instead of swiping the EBT card through the POS machine. This happens when the card's magnetic stripe becomes scratched, worn or demagnetized.

Until the client can get a new card issued, the client can still use the card at a retailer. The clerk keys the card number in manually to complete the transaction. Only the client should enter his/her PIN. The client should never reveal the PIN to a store clerk when entering a manual transaction.

9093.6 Manual Vouchers

7 CFR 274.8(d)

Retailers use a manual voucher process when the ~~eFunds~~ EBT contractor system or the terminals are not working and cannot accept the EBT card for a food ~~stamp~~ benefit purchase. Retailers do not have to use the manual process, but most will not turn away a sale.

Retailers that do not have POS terminals, for example, farmers' markets, and street or route vendors also use manual vouchers.

The manual voucher is a paper form on which the retailer writes the card number, the cardholder's name, the store FNS number, and the dollar amount of the sale. The client must sign the voucher. The retailer must call in manual vouchers to ~~eFunds~~ the EBT contractor to get an authorization for the amount of the transaction. The retailer calls in to make sure that the money is in the client's account. If the client has enough funds in the account to cover the transaction, the retailer subtracts the whole amount of the transaction from the client's account.

Retailers use manual vouchers when the ~~eFunds~~ EBT contractor system is down. Since the retailer cannot confirm whether the client has an available balance, the client is limited to a $40.00 purchase.

9093.7 EBT & Timely Application Processing

7 CFR 274.2(b)

[~~Regulations say we~~ DHSS] must provide eligible households that complete the initial application process an opportunity to participate as soon as possible, but no later than 30 calendar days following the date the household filed the application. With EBT, FNS has issued guidelines saying that the opportunity to participate is the date the

money is posted to the account **plus** two days when mailing the EBT card. ~~DSS mails EBT cards for hardship cases.~~ **[~~DSS~~ DHSS]** mails most EBT cards. Clients may pick up a card at the local office after notifying the worker not to have the card mailed. To avoid these timeliness errors, staff will need to take the action to approve a case on or before the 26th day at the latest.

When it is not possible to process the case on or before the 28th day because the client did not turn in the verifications or worker time constraints, document the case record. The error may still count but the explanation will be there.

9093.8 EBT Benefits and Claim Issues

7 CFR 273.18(g)(2)

When ~~eFunds~~ the EBT contractor posts the EBT benefits to the household's account, the household is considered in receipt of those benefits. If the household receives benefits **[~~they were~~ it was]** not entitled to, **[~~DSS~~ DHSS]**/ARMS will establish a claim. **[~~DSS~~ DHSS]**/ARMS establishes a claim even if the household has not used the benefits in the EBT account. As long as the benefits are in the account, the household has access to those benefits and owes the State the amount of the claim.

ARMS must allow a household to pay its claim using benefits from its EBT benefit account according to DSSM 9095.13.

Benefits not used for 230 days are stale and ARMS can use the stale benefits to credit a household's claim with the consent of the household.

~~eFunds~~ The EBT contractor will expunge benefits not used for 365 days from the household's account and credit the amount to a household's outstanding claim.

9093.9 Aging Periods and Expungement Process

7 CFR 274.2(h)(2)

Benefits remain available to the household for 365 days from the date of availability.

~~eFunds~~ The EBT contractor sends reports to **[~~DSS~~ DHSS]** that show accounts with no activity. ~~eFunds~~ The EBT contractor provides **[~~DSS~~ DHSS]** with a report for the following periods of time:

- Period 1: 60 days
- Period 2: 90 days
- Period 3: 230 days
- Period 4: 365 days

A household will get a notice at Periods 1, 2 and 3 if the household has not used benefits for 60, 90 or 230 days. Stale benefits are benefits not used by these time periods. The notice will tell the household the following information:

The account has not been used in the past 60, 90 or 230 days~~;~~

- To call the ~~eFunds~~ EBT contractor customer service unit to get the balance on the account~~;~~
- Stale food benefits not used for 230 days can be applied to any existing claim with the client's permission~~;~~
- Food benefits that are not used by day 365 will be removed from the account forever~~; and~~
- Food benefits removed from the account on day 365 will be applied to any remaining food benefit claim~~.~~"

On day 230, **[~~DSS~~ DHSS]** will generate notices to clients with outstanding claims. The notice tells the household that ARMS will apply benefits not used for 230 days to the outstanding claim unless the household contacts ARMS within ~~ten~~ 10 days.

On day 250, households ~~who~~ that do not contact ARMS to stop the repayment will have their stale benefits applied to the outstanding claim. On day 365, the ~~eFunds~~ EBT contractor system will expunge (remove from the account) any remaining stale benefits and send **[~~DSS~~ DHSS]** a report of those benefits expunged.

DCIS II and ARMS accounting systems will credit any expunged benefits to household accounts with an outstanding claim. ARMS and the Payments Unit will receive a report of benefits posted to household's claims so ARMS can update the benefit recovery screens. ARMS will send the client a credit slip indicating the credit made on ~~their~~ his or her claim and the existing balance.

(Break in Continuity of Sections)

9094 Definitions

[7 CFR 271.2]

The following terms are used in the Food Supplement Program (FSP).

Able-bodied Adults Without Dependent Children (ABAWD) are individuals without children in their FSP household who must work and/or comply with certain work requirements for 20 hours a week in order to get food benefits.

Adequate notice means a written notice that includes:

A. a statement of the action the agency has taken or intends to take;

B. the reason for the intended action;

C. the household's right to request a fair hearing;

D. the name of the person to contact for additional information;

E. the availability of continued benefits; and

F. the liability of the household for any overissuances received while awaiting a fair hearing if the hearing official's decision is adverse to the household.

Administrative Terminal is the eFunds system through which DSS staff can obtain EBT card and account information.

Alien Status Verification Index (ASVI) is the automated database used by States to verify immigration statuses from the Immigration and Naturalization Service (INS).

Allotment is the total dollar value of food benefits a household receives each month.

Application is the form completed by a household member or authorized representative to apply for food benefits, cash assistance, child care or medical assistance programs.

ASSIST is Delaware's electronic application. The acronym stands for Application for Social Services and Internet Screening Tool.

Authorized Representative is an individual the household authorizes to act on behalf of the household in the application process, in obtaining food benefits, and in using the EBT card. This individual has access to the household's EBT benefit account. This individual can be a nonhousehold member or a household member, like a spouse, who is a secondary cardholder.

Benefit Status: This is a code that indicates the status of the benefit in the Administrative Terminal.

Boarders: Individuals or groups of individuals residing with others and paying reasonable compensation to the others for lodging and meals.

Card Number: The card number is on the front of the EBT card. The first six digits are the same for all of Delaware's cards. This number is called the Primary Account Number (PAN).

Card Status: An EBT card may be active or inactive. The card status for a replacement card can indicate stolen, lost, payee changed, name changed, damaged, undelivered, deactivated/cancelled or bad address.

Categorically Eligible Household is any household where all members receive or are authorized to receive TANF/GA/RCA and/or SSI benefits, or the household income is at or under 200% of the FPL for their household size. The household is considered categorically eligible for food stamps. These households meet the resource test.

Certification period means the period of time in which a household is eligible to receive benefits.

Claim is the amount owed due to an over issuance of food benefits.

Date Available: Benefits are available at 6:00 a.m. on the date specified in the Administrative Terminal. Regular monthly food benefits are available according to a seven day staggered schedule based on the case head's last name. Benefits start staggering on the fifth calendar day of each month.

Date of Entry (Date of admission) means the date established by the Immigration and Naturalization Service as the date the sponsored alien was admitted for permanent residence.

Deeming means using a portion of an ineligible household member's income or resources for the remaining household members.

Destitute Households - Migrant or seasonal farm worker households that have little or no income at the time of application and are in need of immediate food assistance.

Disaster (for Assistance) - A major disaster is any natural catastrophe such as a hurricane or drought, fire, flood, or explosion, which the President declares the severity and magnitude warrants disaster assistance.

Drug addiction or alcoholic treatment and rehabilitation program means any drug addiction or alcoholic treatment and rehabilitation program conducted by a private, nonprofit organization or institution, or a publicly operated community mental health center, licenses by DHSS.

eFunds Customer Support: The Customer Support Unit receives phone calls from participants to check balances, report lost or stolen cards, report problems with a retailer, and request new PINs. The CSU number is 1-800-526-9099.

Elderly or disabled member means a member of a household who:

A. Is 60 years of age or older;

B. Receives Supplemental Security Income (SSI) benefits under title XVI of the Social Security Act or disability or blindness payments under titles I, II, X, XIV, or XVI of the Social Security Act;

C. Receives federally or State-administered supplemental benefits under section 1616(a) of the Social Security Act provided that the eligibility to receive the benefits is based upon the disability or blindness criteria used under title XVI of the Social Security Act;

D. Receives federally or State-administered supplemental benefits under section 212(a) of Pub. L. 93-66;

E. Receives disability retirement benefits from a governmental agency because of a disability considered permanent under section 221(i) of the Social Security Act.

F. Is a veteran with a service-connected or non service-connected disability rated by the Veteran's Administration (VA) as total or paid as total by the VA under title 38 of the United States Code;

G. Is a veteran considered by the VA to be in need of regular aid and attendance or permanently housebound under title 38 of the United States Code;

H. Is a surviving spouse of a veteran and considered by the VA to be in need of regular aid and attendance or permanently housebound or a surviving child of a veteran and considered by the VA to be permanently incapable of self support under title 38 of the United States Code;

I. Is a surviving spouse or surviving child of a veteran and considered by the VA to be entitled to compensation for a service-connected death or pension benefits for a non service-connected death under title 38 of the United States Code and has a disability considered permanent under section 221(i) of the Social Security Act. "Entitled" as used in this definition refers to those veterans' surviving spouses and surviving children who are receiving the compensation or pension benefits stated or have been approved for such payments, but are not yet receiving them; or

J. Receives an annuity payment under: section 2(a)(1)(iv) of the Railroad Retirement Act of 1974 and is determined to be eligible to receive Medicare by the Railroad Retirement Board; or section 2(a)(1)(v) of the Railroad Retirement Act of 1974 and is determined to be disabled based upon the criteria used under title XVI of the Social Security Act.

K. Is a recipient of interim assistance benefits pending the receipt of Supplemented Security Income, a recipient of disability related medical assistance under title XIX of the Social Security Act, or a recipient of disability-based State general assistance benefits provided that the eligibility to receive any of these benefits is based upon disability or blindness criteria established by the State agency which are at least as stringent as those used under title XVI of the Social Security Act (as set forth at 20 CFR part 416, subpart I, Determining Disability and Blindness as defined in Title XVI).

Electronic Benefit Transfer (EBT) is the method used for issuing and accessing FSP benefits through the use of a card similar to a debit card.

Eligible foods mean:

A. Any food or food product intended for human consumption except alcoholic beverages, tobacco, and hot foods and hot food products prepared for immediate consumption;

B. Seeds and plants to grow foods for the personal consumption of eligible households;

C. Meals prepared and delivered by an authorized meal delivery service to households eligible to use EBT benefits to purchase delivered meals; or meals served by an authorized communal dining facility for the elderly, for SSI households or both, to households eligible to use coupons for communal dining;

D. Meals prepared and served by a drug addiction or alcoholic treatment and rehabilitation center to narcotic addicts or alcoholics and their children who live with them;

E. Meals prepared and served by a group living arrangement facility to residents who are blind or disabled as defined under Elderly or Disabled member;

F. Meals prepared by and served by a shelter for battered women and children to its eligible residents; and

G. Meals prepared for and served by an authorized public or private nonprofit establishment (e.g., soup kitchen, temporary shelter) that feeds homeless persons.

Emergency (for Federal Assistance) - An emergency is any occasion when the President determines that

~~Federal assistance is needed to supplant State and local efforts to save lives, protect property, assure public health and safety, or to lessen the threat of a catastrophe.~~

~~**Expedited Service** means food benefits must be available to the household no later than the seventh calendar day following the date an applicant files an application.~~

~~**Expunged Benefits:** Benefits in client accounts not used for 365 days that are removed from the account forever.~~

~~**Filing Date** means the date DSS receives the application form as long as the form contains the applicant's name and address, and the signature of a responsible household member or the household's representative, a signed Request for Assistance, or an application from ASSIST.~~

~~**FNS** means the Food and Nutrition Service of the U.S. Department of Agriculture.~~

~~**FNS Number:** A unique number assigned to retailers by FNS indicating that the retailer is eligible to accept FSP benefits.~~

~~**Group Living Arrangement** means a public or private nonprofit residential setting, certified by the State, which serves no more than sixteen residents. To be eligible for food benefits, a resident of such a group living arrangement must be blind or disabled as defined under Elderly or Disabled member.~~

~~**Head of Household** is the individual who is an adult parent of children of any age selected by the household or the principal wage earner if selected by DSS.~~

~~**Hold Amount:** When an EBT manual voucher transaction is used, the retailer obtains an authorization number from eFunds. eFunds puts a hold on the participant's food benefit account. Once an accept reason is assigned to the voucher, the hold amount is deducted from the participant's benefit balance and this field becomes blank.~~

~~**Homeless** means an individual who lacks a fixed and regular nighttime residence or an individual whose primary nighttime residence is:~~

~~A. A supervised shelter designed to provide temporary accommodations (such as a welfare hotel or congregate shelter);~~

~~B. A halfway house or similar institution that provides temporary residence for individuals intended to be institutionalized;~~

~~C. A temporary accommodation for not more than 90 days in the residence of another individual; or~~

~~D. A place not designed for, or ordinarily used, as a regular sleeping accommodation for human beings (a hallway, a bus station, a lobby or similar places).~~

~~**Homeless Meal Provider** is a public or private nonprofit establishment (e.g., soup kitchens, temporary shelters) that feeds homeless persons.~~

~~**Ineligible Alien** means an undocumented alien or a documented alien who does not meet a qualified and eligible status.~~

~~**Intentional Program Violation (IPV)** occurs when an individual breaks a FSP rule and is found guilty by a court or an administrative disqualification hearing, or signs a waiver to be disqualified to avoid prosecution.~~

~~**Low-income Household** means a household whose annual income does not exceed 125 percent of the Office of Management and Budget poverty guidelines.~~

~~**Manual Entries:** If an EBT card or POS machine is damaged, the card number can be keyed manually to complete the transaction.~~

~~**Manual Voucher:** Retailers use paper vouchers when the eFunds system is not available. Retailers who are not eligible to have POS terminals also use these vouchers. A voucher has a unique number, which identifies the voucher. This field is completed only if the transaction displayed in the Administrative Terminal is an off-line voucher.~~

~~**Mass Changes** are certain changes initiated by the State or Federal government, which may affect the entire caseload or significant portions of the caseload such as annual cost of living adjustments, shelter/dependent care deduction and periodic cost of living adjustments to RSDI and SSI benefits.~~

~~**Meal Delivery Service** (like Meals on Wheels) is a service agencies contract with for the preparation and delivery of meals at low prices to elderly persons and the physically or mentally handicapped who are unable to adequately prepare all of their meals.~~

~~**Minimum Benefit** means the minimum monthly amount of food benefits that eligible one- and two person households receive.~~

~~**Notice of Expiration** is a notice sent to a household at the end of its certification period notifying a household of what they need to do to continue to get benefits.~~

~~**Over-issuance** means the amount of benefits a household received that exceeded the amount the household~~

~~was eligible to receive.~~

~~**PAN:** The Primary Account Number is the 16-digit number on the EBT card, also called the card number.~~

~~**PIN (Personal Identification Number):** A PIN is a four digit secret code that allows the user to access benefits when using the EBT card. No one can use the card but the participant as long as the participant does not give the PIN to anyone.~~

~~**PIN Info:** The Card Maintenance screen in the Administrative Terminal displays whether or not the household selected a PIN and the method of selection. Yes, means a household selected a PIN. Fails is the number of times the PIN entered has failed that day. Chg Count is the number of times the household changed the PIN. Method is how the household selected the PIN.~~

~~**Point-of-Sale (POS) Terminal:** A POS is the device a participant uses to make transactions at the stores. The POS machine reads the card and allows the participant to buy food with the food benefits.~~

~~**Prospective Budgeting** means the computation of a household's food benefit for an issuance month based on an estimate of income and circumstances which will exist in that month.~~

~~**Quality Control Review** means a review of a statistically valid sample of active and negative cases to determine the extent to which households are receiving the food benefit allotments to which they are entitled, and to determine the extent to which decisions to deny, suspend, or terminate cases are correct.~~

~~**Recertification** is a review conducted at the end of a person's certification period that requires an application, interview and verification of current circumstances.~~

~~**Residents of Institution** means an individual who resides in an institution where the institution provides him or her with the majority of his or her meals (over 50% of three meals daily) as part of the institution's normal services.~~

~~**Riverside Rule** is a rule that requires states to keep food benefits at the same level when a household's TANF/RCA benefits have been reduced or terminated due to the household's failure to perform an action required under the TANF/RCA program or fraud.~~

~~**Shelter for Battered Women and Children** means a public or private nonprofit residential facility that serves battered women and their children.~~

~~**Simplified FSP (SFSP)** is a program that permits a state to substitute certain FSP rules with TANF and RCA rules and procedures.~~

~~**Simplified Reporting** means the only reporting requirement for households is when their income exceeds the 130% FPL threshold for the household size established at the time of intake or recertification.~~

~~**Sponsored alien** means an alien for whom a person has executed an affidavit of support [INS Form I-864 or I-864A] on behalf of the alien according to section 213A of the INA.~~

~~**Sponsor** means a person who executed an affidavit(s) of support or similar agreement on behalf of an alien as a condition of the alien's entry or admission into the United States as a permanent resident.~~

~~**Spouse** refers to either of two individuals: (1) Those defined as married to each other under applicable State law; or (2) Those living together and representing themselves as married to relatives, friends, neighbors, or employers.~~

~~**Stale Benefits**: Benefits not used by a household within 60, 90 or 230 days.~~

~~**State Income and Eligibility Verification System (IEVS)** is a system of information acquisition and exchange for purposes of income and eligibility verification that meets the requirements of section 1137 of the Social Security Act, generally referred to as the IEVS.~~

~~**Supplemental Nutrition Assistance Program (SNAP)** is the Federal name for the former Food Stamp Program.~~

~~**Supplemental Security Income (SSI)** is a means tested monthly cash payment made under the authority of the Social Security Act for aged, blind and disabled individuals.~~

~~**Systematic Alien Verification for Entitlements (SAVE)** means the INS program whereby State agencies may verify the validity of documents provided by aliens applying for food benefits by obtaining information from a central data file.~~

~~**Thrifty Food Plan** means the diet required to feed a family of four persons consisting of a man and a woman 20 through 50, a child 6 through 8, and a child 9 through 11 years of age, determined in accordance with the USDA Secretary's calculations. The cost of such diet shall be the basis for uniform allotments for all households regardless of their actual composition. In order to develop maximum food stamp allotments, the Secretary shall make household size and other adjustments in the Thrifty Food Plan taking into account economies of scale and other adjustments as required by law.~~

~~**Trafficking** means the buying or selling of food benefits for cash or consideration other than eligible food or the~~

~~exchange of firearms, ammunition, explosives, or controlled substances.~~

~~**Under-issuance** means an amount of benefit that the household was entitled to receive that was less than the benefit the household actually received.~~

~~**Verification** is the use of third party information or documentation to establish the accuracy of statements on the application.~~

~~**Work for Your Welfare** is a work experience program in which participants work to earn their benefits.~~

7 CFR 271.2

"Able-bodied Adults Without Dependent Children (ABAWD)" - Individuals without children in their FSP household who must work and/or comply with certain work requirements for 20 hours a week in order to get food benefits.

"**Adequate notice" -** A written notice that includes:

A. A statement of the action the agency has taken or intends to take.
B. The reason for the intended action.
C. The household's right to request a fair hearing.
D. The name of the person to contact for additional information.
E. The availability of continued benefits.
F. The liability of the household for any over issuances received while awaiting a fair hearing if the hearing official's decision is adverse to the household.

"**Administrative Terminal"** - The EBT contractor system through which **[~~DSS~~ DHSS]** staff can obtain EBT card and account information.

"**Alien Status Verification Index (ASVI)" -** The automated database used by States to verify immigration statuses from the Immigration and Naturalization Service (INS).

"**Allotment" -** The total dollar value of food benefits a household receives each month.

"**Application" -** The form completed by a household member or authorized representative to apply for food benefits, cash assistance, child care or medical assistance programs.

"ASSIST" - Delaware's electronic application. The acronym stands for Application for Social Services and Internet Screening Tool.

"**Authorized Representative" -** An individual the household authorizes to act on behalf of the household in the application process, in obtaining food benefits, and in using the EBT card. This individual has access to the household's EBT benefit account. This individual can be a non-household member or a household member, like a spouse, who is a secondary cardholder.

"**Benefit Status" -** A code that indicates the status of the benefit in the Administrative Terminal.

"**Boarders" -** Individuals or groups of individuals residing with others and paying reasonable compensation to the others for lodging and meals.

"**Card Number" -** The card number is on the front of the EBT card. The first six digits are the same for all of Delaware's cards. This number is called the Primary Account Number (PAN).

"**Card Status" -** An EBT card may be active or inactive. The card status for a replacement card can indicate stolen, lost, payee changed, name changed, damaged, undelivered, deactivated/cancelled or bad address.

"**Categorically Eligible Household" -** Any household where all members receive or are authorized to receive TANF/GA/RCA and/or SSI benefits, or the household income is at or under 200% of the FPL for their household size. The household is considered categorically eligible for food benefits. These households meet the resource test.

"**Certification period" -** The period of time in which a household is eligible to receive benefits.

"**Claim" -** The amount owed due to an over-issuance of food benefits.

"**Date Available" -** Benefits are available at 6:00 a.m. on the date specified in the Administrative Terminal. Regular monthly food benefits are available according to a seven day staggered schedule based on the case head's last name. Benefits start staggering on the fifth calendar day of each month.

"**Date of Admission" -** The date established by the Immigration and Naturalization Service as the date the sponsored alien was admitted for permanent residence.

"**Date of Entry" -** The date established by the Immigration and Naturalization Service as the date the sponsored alien was admitted for permanent residence.

"**Deeming" -** Using a portion of an ineligible household member's income or resources for the remaining household members.

"**Destitute Households" -** Migrant or seasonal farm worker households that have little or no income at the time of application and are in need of immediate food assistance.

"**Disaster (for Assistance)" -** A major disaster is any natural catastrophe such as a hurricane or drought, fire, flood, or explosion, which the President declares the severity and magnitude warrants disaster assistance.

"**Drug addiction or alcoholic treatment and rehabilitation program"** means any drug addiction or alcoholic treatment and rehabilitation program conducted by a private, nonprofit organization or institution, or a publicly operated community mental health center, licensed by DHSS.

"**EBT Contractor Customer Support"** - The Customer Support Unit receives phone calls from participants to check balances, report lost or stolen cards, report problems with a retailer, and request new PINs. The CSU number is 1-800-526-9099.

"**Elderly [member] or [disabled] member with a disability"** - A member of a household who:

A. Is 60 years of age or older**[.]**

B. Receives Supplemental Security Income (SSI) benefits under title XVI of the Social Security Act or disability or blindness payments under titles I, II, X, XIV, or XVI of the Social Security Act.

C. Receives federally or State-administered supplemental benefits under section 1616(a) of the Social Security Act provided that the eligibility to receive the benefits is based upon the disability or blindness criteria used under title XVI of the Social Security Act.

D. Receives federally or State-administered supplemental benefits under section 212(a) of Pub. L. 93–66.

E. Receives disability retirement benefits from a governmental agency because of a disability considered permanent under section 221(i) of the Social Security Act.

F. Is a veteran with a service-connected or non-service-connected disability rated by the Veteran's Administration (VA) as total or paid as total by the VA under title 38 of the United States Code.

G. Is a veteran considered by the VA to be in need of regular aid and attendance or permanently housebound under title 38 of the United States Code.

H. Is a surviving spouse of a veteran and considered by the VA to be in need of regular aid and attendance or permanently housebound or a surviving child of a veteran and considered by the VA to be permanently incapable of self-support under title 38 of the United States Code.

I. Is a surviving spouse or surviving child of a veteran and considered by the VA to be entitled to compensation for a service-connected death or pension benefits for a non-service-connected death under title 38 of the United States Code *and* has a disability considered permanent under section 221(i) of the Social Security Act. "Entitled" as used in this definition refers to those veterans' surviving spouses and surviving children who are receiving the compensation or pension benefits stated or have been approved for such payments, but are not yet receiving them.

J. Receives an annuity payment under: section 2(a)(1)(iv) of the Railroad Retirement Act of 1974 *and* is determined to be eligible to receive Medicare by the Railroad Retirement Board; or section 2(a)(1)(v) of the Railroad Retirement Act of 1974 and is determined to be disabled based upon the criteria used under title XVI of the Social Security Act.

K. Is a recipient of interim assistance benefits pending the receipt of Supplemental Security Income, a recipient of disability related medical assistance under title XIX of the Social Security Act, or a recipient of disability-based State general assistance benefits *provided* that the eligibility to receive any of these benefits is based upon disability or blindness criteria established by the State agency which are at least as stringent as those used under title XVI of the Social Security Act (as set forth at 20 CFR part 416, subpart I, Determining Disability and Blindness as defined in Title XVI).

"Electronic Benefit Transfer (EBT)" - The method used for issuing and accessing FSP benefits through the use of a card similar to a debit card.

"**Eligible foods"** mean:

A. Any food or food product intended for human consumption except alcoholic beverages, tobacco, and hot foods and hot food products prepared for immediate consumption.

B. Seeds and plants to grow foods for the personal consumption of eligible households.

C. Meals prepared and delivered by an authorized meal delivery service to households eligible to use EBT benefits to purchase delivered meals; or meals served by an authorized communal dining facility for the elderly, for SSI households or both, to households eligible to use **[~~coupons~~ EBT benefits]** for communal dining.

D. Meals prepared and served by a drug addiction or alcoholic treatment and rehabilitation center to narcotic addicts or alcoholics and their children who live with them.

E. Meals prepared and served by a group living arrangement facility to residents who are blind or disabled as defined under Elderly **[member]** or **[~~Disabled~~ member with a disability]**.

F. Meals prepared by and served by a shelter for battered women and children to its eligible residents.

G. Meals prepared for and served by an authorized public or private nonprofit establishment (e.g., soup kitchen, temporary shelter) that feeds homeless persons.

"**Emergency (for Federal Assistance)"** - An emergency is any occasion when the President determines that Federal assistance is needed to supplant State and local efforts to save lives, protect property, assure public health and safety, or to lessen the threat of a catastrophe.

"**Expedited Service"** - Food benefits must be available to the household no later than the seventh calendar day following the date an applicant files an application.

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"**FNS"** - The Food and Nutrition Service of the U.S. Department of Agriculture.

"**FNS Number"** - A unique number assigned to retailers by FNS indicating that the retailer is eligible to accept FSP benefits.

"**Group Living Arrangement"** - A public or private nonprofit residential setting, certified by the State, which serves no more than sixteen residents. To be eligible for food benefits, a resident of such a group living arrangement must be blind or disabled as defined under Elderly **[member]** or **[~~Disabled~~ member with a disability]**.

"**Head of Household"** - The individual who is an adult parent of children of any age selected by the household or the principal wage earner if selected by **[~~DSS~~ DHSS]**.

"**Hold Amount"** - When an EBT manual voucher transaction is used, the retailer obtains an authorization number from the EBT contractor. The EBT contractor puts a hold on the participant's food benefit account. Once an accept reason is assigned to the voucher, the hold amount is deducted from the participant's benefit balance and this field becomes blank.

"**Homeless"** - An individual who lacks a fixed and regular nighttime residence or an individual whose primary nighttime residence is:

A. A supervised shelter designed to provide temporary accommodations (such as a welfare hotel or congregate shelter).

B. A halfway house or similar institution that provides temporary residence for individuals **[~~intended to be institutionalized~~ who would otherwise reside in an institution]**.

C. A temporary accommodation for not more than 90 days in the residence of another individual.

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"**Meal Delivery Service"** - A service agencies contract with for the preparation and delivery of meals at low prices to elderly persons and **[~~the physically or mentally handicapped~~ persons with physical or mental disabilities]** who are unable to adequately prepare all of their meals. An example is Meals on Wheels.

"**Minimum Benefit**" - The minimum monthly amount of food benefits that eligible one- and two-person households receive.

"**Notice of Expiration**" **-** A notice sent to a household at the end of its certification period notifying a household of what **[~~they need~~ it needs]** to do to continue to get benefits.

"Over-issuance" - The amount of benefits a household received that exceeded the amount the household was eligible to receive.

"**PAN**" - The Primary Account Number is the 16-digit number on the EBT card, also called the card number.

"PIN (Personal Identification Number)" - A four digit secret code that allows the user to access benefits when using the EBT card. No one can use the card but the participant as long as the participant does not give the PIN to anyone.

"**PIN Info**" - The Card Maintenance screen in the Administrative Terminal displays whether or not the household selected a PIN and the method of selection. Yes, means a household selected a PIN. Fails is the number of times the PIN entered has failed that day. Chg Count is the number of times the household changed the PIN. Method is how the household selected the PIN.

"**Point-of-Sale (POS) Terminal**" - The device a participant uses to make transactions at the stores. The POS machine reads the card and allows the participant to buy food with the food benefits.

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"**Riverside Rule**" - A rule that requires states to keep food benefits at the same level when a household's TANF/RCA benefits have been reduced or terminated due to the household's failure to perform an action required under the TANF/RCA program or fraud.

"**Shelter for Battered Women and Children**"- A public or private nonprofit residential facility that serves battered women and their children.

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"**Sponsor**" - A person who executed an affidavit(s) of support or similar agreement on behalf of an alien as a condition of the alien's entry or admission into the United States as a permanent resident.

"**Spouse**" - Refers to either of two individuals:

1. Those defined as married to each other under applicable State law.
2. Those living together and representing themselves as married to relatives, friends, neighbors, or employers.

"**Stale Benefits**" - Benefits not used by a household within 60, 90 or 230 days.

"**State Income and Eligibility Verification System (IEVS)**" - A system of information acquisition and exchange for purposes of income and eligibility verification that meets the requirements of section 1137 of the Social Security Act, generally referred to as the IEVS.

"**Supplemental Nutrition Assistance Program (SNAP)**" - The Federal name for the former Food Stamp Program.

"**Supplemental Security Income (SSI)**" - A means-tested monthly cash payment made under the authority of the Social Security Act for **[individuals who are]** aged, blind **[~~and disabled individuals~~ or have a disability]**.

"**Systematic Alien Verification for Entitlements (SAVE)**" - The INS program whereby State agencies may verify the validity of documents provided by aliens applying for food benefits by obtaining information from a central data file.

"**Thrifty Food Plan**" - The diet required to feed a family of four persons consisting of a man and a woman 20 through 50, a child 6 through 8, and a child 9 through 11 years of age, determined in accordance with the USDA Secretary's calculations. The cost of such diet shall be the basis for uniform allotments for all households regardless of their actual composition. In order to develop maximum food stamp allotments, the Secretary shall make household size and other adjustments in the Thrifty Food Plan taking into account economies of scale and other adjustments as required by law.

"**Trafficking"** - The buying or selling of food benefits for cash or consideration other than eligible food or the exchange of firearms, ammunition, explosives, or controlled substances.

"**Under-issuance"** - An amount of benefit that the household was entitled to receive that was less than the benefit the household actually received.

"**Verification**" - The use of third party information or documentation to establish the accuracy of statements on the application.

"**Work for Your Welfare**" - A work experience program in which participants work to earn their benefits.

DIVISION OF SOCIAL SERVICES

Statutory Authority: 16 Delaware Code, Section 512 (16 **Del.C.** §512)
16 **DE Admin. Code** 15110

ORDER

Delaware's Temporary Assistance for Needy Families (TANF) State Plan Renewal

Delaware Health and Social Services ("Department") / Division of Social Services (DSS) initiated proceedings

to renew Delaware's Temporary Assistance for Needy Families (TANF) State Plan as provided for in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), (P.L. 104-193). The Department's proceedings to amend its regulations were initiated pursuant to 29 Delaware Code Section 10114 and its authority as prescribed by 31 **Delaware Code** Section 512.

The Department published its notice of proposed regulation changes pursuant to 29 **Delaware Code** Section 10115 in the October 2011 Delaware *Register of Regulations* requiring written materials and suggestions from the public concerning the proposed regulations to be produced by November 15, 2011 at which time the Department would receive information, factual evidence and public comment to the said proposed changes to the regulations. Additionally, Delaware's TANF State Plan can be viewed on the Department's website at: http://www.dhss.delaware.gov/dhss/dss/

NOTICE OF COMMENT PERIOD FOR DRAFT TANF STATE PLAN

As a reminder, this notice is given to provide information of public interest with respect to Delaware's eligibility status for the Temporary Assistance for Needy Families (TANF) Program.

Statutory Authority

Title IV-A of the Social Security Act, Section 402, *Eligible States; State Plan*

Title of Notice

Delaware's Temporary Assistance for Needy Families (TANF) State Plan

Background

The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 (Public Law 104-193) provides funding to states through the Temporary Assistance for Needy Families (TANF) block grant. Section 402 of the Social Security Act requires that States periodically submit to the Secretary of the Department Health and Human Services a TANF state plan to maintain or renew their status as an "eligible State". In general the State plan describes the eligibility rules, the populations served, the programs offered, and the State maintenance of effort spending. States also provide certifications that they will maintain other services such as child support enforcement and foster care services. Delaware's TANF State plan is due December 31, 2011.

The TANF Program is delivered through a collaborative partnership among Delaware's Department of Health and Social Services (DHSS), Department of Labor (DOL), and the Delaware Economic Development Office (DEDO). The Delaware Transit Corporation (DTC) is also a planning partner.

Summary of Notice of Comment Period for Draft TANF State Plan

In order to continue to receive Federal TANF funding, Delaware must file for renewal of the grant with the Department of Health and Human Services (DHHS), Administration for Children and Families (ACF) by December 31, 2011. The State Plan outlines the provisions under which the State will administer the TANF program.

Prior to submission of the plan, States must offer the public a 45 day period to review and comment on the plan, Publication of the State plan creates the opportunity for the public to comment on the proposed TANF State Plan.

Developed in accordance with the requirements of PRWORA, the updated State Plan incorporates changes identified through a collaborative process that included development of proposed regulation, distribution of the draft regulation to Delaware stakeholders and the public, review and incorporation of appropriate comments in the plan, and the ongoing review of the TANF program.

Future amendments to the State Plan will incorporate suggestions and recommendations received during the comment period. The 45-day comment period begins on the date this notice is published in the *Delaware Register of Regulations*. Comments received within 45 days will be reviewed and considered for any subsequent revision of the TANF State Plan.

SUMMARY OF COMMENTS RECEIVED WITH AGENCY RESPONSE AND EXPLANATION OF CHANGES

The Governor's Advisory Council for Exceptional Citizens (GACEC) and the State Council for Persons with Disabilities (SCPD) offered the following observations and recommendations summarized below. The Division of

Social Services (DSS) has considered each comment and responds as follows.

First, on p. 7, the section titled "Eligibility For Assistance Under the TANF Program", subsection "Conditions of Eligibility, Fugitive Felons, Individuals Convicted of Drug Related Felonies", recites as follows:

> Fugitive felons and parole violators are ineligible for TANF assistance. In addition, as of August 22, 1996, individuals convicted of drug related felonies are permanently barred from the date of conviction.

The Plan does mention "food benefits" and "Food Supplement Program benefits" on the next page. Given enactment of S.B. 12, DSS may wish to add the following sentence: "Effective with enactment of S.B. 12 in June 2011, individuals convicted of drug related felonies are not barred from receiving Food Supplement Program benefits."

Agency Response: While it is correct that the food supplement is mentioned in the section following the discussion of TANF eligibility of drug felons, the reference to the food supplement program is made in regard to the TANF Family cap rules. The family cap rules are independent of the drug felony rules; it could cause confusion to reference in the TANF State Plan the State's treatment of drug felons in the Supplemental Nutrition Assistance Program (SNAP). Therefore a reference to S.B. 12 will not be made in the TANF State Plan.

Second, Attachment "C" refers to the "Department of Public Instruction" and the "Department of Public Safety" and includes a copy of a 1996 MOU signed by these agencies. These agencies obviously no longer exist.

Agency Response: The Division of Social Services continues to meet the conditions established in the MOU, but will explore securing a new MOU.

Moreover, Attachment "D" includes an outdated copy of the Delaware Code which omits amendments adopted subsequent to 73 Delaware Laws, including revisions to Title 10 **Del.C.** §§1041, 1043, and 1045. It also omits Title 10 **Del.C.** §§1049A-1049F. It would be preferable to secure an updated MOU with current State agencies and to provide a current version of the Delaware Code references.

Agency Response: Attachment "D" will be corrected to include a current version of the Delaware Code.

FINDINGS OF FACT:

The Department finds that the proposed changes as set forth in the October 2011 *Register of Regulations* should be adopted.

THEREFORE, IT IS ORDERED, that the proposed regulation to renew Delaware's TANF State Plan beginning Federal Fiscal Year 2012 is adopted and shall be final effective January 10, 2012.

Rita M. Landraf, Secretary, DHSS

A copy of the Delaware TANF State Plan is located here:

Delaware's Temporary Assistance for Needy Families (TANF) State Plan Renewal

DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH AND THEIR FAMILIES

DIVISION OF MANAGEMENT AND SUPPORT SERVICES

Statutory Authority: 29 Delaware Code, Section 9020 (29 **Del.C.** §9020)

REGULATORY IMPLEMENTING ORDER

501 Procedures for Drug Testing Certain Employees

NATURE OF THE PROCEEDINGS:

In compliance with the State's Administrative Procedures Act (APA - Title 29, Chapter 101 of the **Delaware Code**) and as required by HB 190 of the 145th General Assembly the Department initiated proceedings to establish

an employee drug testing program.

The Department published its notice of proposed regulation changes in the April, 2011 Delaware *Register of Regulations*, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by April 30, 2011 at which time the Department would receive information, factual evidence and public comment to the said proposed changes to the regulations.

SUMMARY OF PROPOSAL

The proposed regulation establishes guidelines by which the Department of Services for Children, Youth and their Families (DSCYF) will develop a policy requiring all employees in a safety, security sensitive or childcare position to undergo testing for illegal drugs and commonly abused controlled substances and to establish procedures for the Department's drug testing program in order to detect and deter the use of illegal drugs and illegally held controlled substances by employees.

SUMMARY OF COMMENTS RECEIVED WITH AGENCY RESPONSE

After reviewing comments from employees pursuant to the April, 2011 publication, the Department reviewed its internal policies and has determined that all employees fall under the definition of "safety, secure sensitive or childcare" positions. The regulation has been amended to reflect the change from "certain" employees to all employees of the Department.

In addition, the final order reflects that all employees will be provided with a copy of the Department's drug testing policy, and will be required to sign an acknowledgement form confirming that they received and read the policy.

ADDITIONAL AMENDMENTS TO THE PROPOSED REGULATIONS

In addition to amendments made in response to comments received, the agency has incorporated technical amendments into the final regulations, including clarification of incident triggered testing; testing procedures; procedures on receipt of non-negative test results, and federal testing standards comparison.

FINDINGS OF FACT:

The Department finds that Department Drug Testing Regulations as amended to reflect comments received in the proposed regulation in the April 2011 *Register of Regulations* should be adopted.

THEREFORE, IT IS ORDERED, that the proposed regulation to establish an employee drug testing program shall be final and effective January 1, 2012.

Vivian L. Rapposelli, Secretary, DSCY

501 Procedures for Drug Testing Certain Employees

1.0 Authority

29 **Del.C.**, §9020

2.0 Purpose

The purpose of this policy is to affirm the commitment of the Department of Services for Children, Youth and Their Families (DSCYF) to the protection of children/youth in our care by requiring all employees in a safety, security sensitive or childcare position to undergo testing for commonly abused controlled substances and to establish procedures for the department's drug testing program in order to detect and deter the **[illegal]** use of **[~~illegal~~]** drugs by employees.

3.0 Applicability

This policy applies to all employees in a safety, security sensitive or childcare position including merit, merit exempt and casual/seasonals. **[Since all positions within the Department are considered safety, security sensitive or childcare positions this policy is applicable to all employees.]** If there are any conflicts between this policy and the merit rules, the merit rules shall prevail unless superseded by a collective bargaining agreement (CBA).

[All employees will receive a copy of this policy and will sign and return the attached receipt to Human Resources. This policy will act as an official notice for periodic drug testing. No other announcement will be made.]

4.0 Definitions

"**Chain of custody**": the method of tracing each urine specimen to maintain control from initial collection to final disposition.

"**Collection sites**": the designated locations where employees present themselves to provide urine specimens.

"**Confirmation test**": an analytical procedure to identify the presence of a specific drug or metabolite, which is independent of the initial test, performed on the same specimen and which uses a different chemical principle from that of the initial test to ensure reliability and accuracy.

"**Confirmed positive result**": the presence of a controlled substance in the pure form or its metabolites, at or above the cutoff level, as identified in two consecutive tests on the same sample which employ different test methods, and which is determined not to have been caused by an alternative medical explanation.

"**Contractor**": entity paid on a contractual basis to maintain a list of employees in the random testing pool, select employees for random testing, collect specimens, conduct reasonable suspicion and **[~~post-~~incident triggered]** testing, safeguard specimens, interpret results, notify DSCYF of positive tests and provide training to supervisors regarding bases for reasonable suspicion testing.

"**Employee**": any person occupying a safety, security sensitive or childcare position and receiving compensation as an employee of the DSCYF.

"**Employee Assistance Program (EAP)**": the state of delaware's employee assistance program that provides services to a benefit covered employee who has tested positive for the use of prohibited drugs.

"**Employee testing number**": the employee id (EMPLID) number assigned to each employee by the Payroll Human Resource Statewide Technology (PHRST) system.

["Incident Triggered Testing": Any incident involving death or serious injury to a DSCYF employee, resident or client, loss or significant damage to department property, including any accident involving a motor vehicle transporting DSCYF clients or residents, or the escape or runaway of a resident where the security sensitive employee was involved in the incident.

"Non-negative test result": Test results that indicate a positive, diluted, adulterated, substituted or similar result. All non-negative test results are reviewed by a Medical Review Officer (MRO).

"Random Testing": Tests based upon an appropriate random sampling technique, with significant samples of DSCYF employees in safety, security sensitive or childcare positions being selected on a periodic basis with all such employees having an equal chance of being selected.

"Reasonable Suspicion Testing": Includes, but is not limited to, observing the employee(s) either using or possessing a drug, displaying physical symptoms of being under the influence of a drug, or finding drug paraphernalia in the workplace.

~~"Security sensitive positions": all positions within DSCYF residential facilities including, Ferris School, Stevenson House Detention Center, New Castle County Detention Center, Grace Cottage, Snowden Cottage, Mowlds Cottage, Terry Children's Psychiatric Center, Bronford Residential Treatment Center, Middletown Residential Treatment Center and Silver Lake Consortium.~~

~~In addition to positions assigned to the locations listed above, see addendum a for other positions/classifications covered under this policy.~~**]**

5.0 Policy

[5.1 ~~It is the policy of the DSCYF~~ **The department is committed]** to maintain**[ing]** a drug free environment through the use of a reasonable suspicion, **[**~~post-~~**incident triggered]** and random **[and return to duty]** drug testing program. The DSCYF personnel hold positions of public trust and must not place themselves in a position where client safety may be compromised as a result of an employee's drug **[**~~dependency~~ **use]**. Such misconduct conflicts with their duties, poses a risk to the safety and security of residents, clients, other employees, and the public and jeopardizes the public's confidence.

[5.2 Employees on initial probation and casual/seasonal employees who have not satisfied the merit comparable initial probation requirement will be terminated if they receive a positive test result without recourse to the grievance procedure.

Casual/seasonal employees who have satisfied the merit comparable initial probation requirement may enter into an accredited drug abuse assistance or rehabilitation program at their own expense. Refer to section X. G. for returning to duty.

5.3 Employees who seek assistance, prior to being randomly selected for testing, may enter into an accredited drug abuse assistance or rehabilitation program. The employee may not return to work until they have complied with section X. G. for returning to duty.]

6.0 Procedures

6.1 Notice of testing:

6.1.1 **[**~~This policy will act as an official notice for periodic drug testing. No other announcement will be made. All employees will receive a copy of this policy and will sign and return the attached receipt to Human Resources.~~

Upon arrival at the worksite, selected employees will be given and acknowledge receipt of a Chain of Custody form. The employee must report to a designated collection site and provide a sample within twenty-four (24) hours of notification.

6.1.2 Employees notified to report must report for testing to the designated collection site. No requests to be excused or rescheduled shall be granted. Any failure to report, refusal to be tested or refusal to cooperate with the testing procedure will result in the removal from the workplace without pay and will be considered as a positive result.]

6.2 Random testing:

6.2.1 All employees **[**~~in a safety, security sensitive or childcare position~~**]** are subject to random testing.

6.2.2 Selection is to be based on a computerized random selection of employee testing numbers, not names.

6.2.3 Monthly, the drug testing contractor will randomly select EMPLIDs equivalent to 25% of the random testing population per quarter. Because the selection process is random, some employees may not be tested within a year, while others may be tested more than once.

[~~6.2.4 Employees will be given and acknowledge receipt of a chain of custody form upon selection and must report to a designated collection site within twenty-four (24) hours of notification.~~

~~6.2.5 Employees notified to report must report for testing to the site specified. No requests to be excused or rescheduled shall be granted. Any failure to report, refusal to be tested or refusal to cooperate with the testing procedure will result in the removal from the workplace without pay and will be considered as a positive result. Employees on initial probation will be terminated from employment.~~**]**

6.3 Reasonable suspicion testing

6.3.1 In the event of reasonable suspicion, the facility head will contact human resources, who will make a determination and contact the contractor if a decision is made to test.

[~~6.3.2 Evidence of reasonable suspicion includes, but is not limited to, observing the employee(s) either using or possessing a drug, displaying physical symptoms of being under the influence of a drug, or finding drug paraphernalia in the workplace.~~]

6.4 Incident triggered testing

6.4.1 In the event of an incident triggered event, the facility head will contact human resources, who will make a determination and contact the contractor if a decision is made to test.

[~~6.4.2 Incident triggered testing is based on any incident involving death or serious injury to a DSCYF employee, resident or client, loss or significant damage to department property, including any accident involving a motor vehicle transporting DSCYF clients or residents, or the escape or runaway of a resident where the security sensitive employee was involved in the incident.~~]

6.5 **[~~Specimen collection procedures~~ Return to Duty Testing]**

6.5.1 **[~~Urine specimens will be collected in accordance with current federal department of health and human service standards. Every effort will be made to assure the dignity and privacy of employees being tested.~~ Before any employee is allowed to return to duty, the employee must have a verified negative drug screen performed by the Contractor.**

~~6.5.2 If the contractor determines that the employee is attempting to substitute or adulterate the specimen, the contractor shall document the fact and direct the employee to provide another specimen. Both specimens shall be forwarded to the laboratory.~~

~~6.6 Laboratory procedures~~

~~6.6.1 The laboratory will test for marijuana, cocaine, opiates, phencyclidine and amphetamines. The initial procedure employed will be the enzyme multiplied immunoassay testing (emit). Cutoff levels will be consistent with current federal department of health and human service standards.~~

~~6.6.2 All positive specimens shall be confirmed using the gas chromatography/mass spectrometry (gc/ms), which shall be conducted from the same specimen.~~

~~6.7 Preservation procedures~~

~~6.7.1 Specimens determined to contain drugs will be preserved at the laboratory for a minimum of twelve (12) months. Employees testing positive may, upon written request to human resources, arrange to have their specimen retested. All costs, including lab fees and transportation shall be paid by the employee requesting the retest.~~

~~6.8 Post testing procedures~~

~~6.8.1 If the lab results are negative, the sample shall be destroyed.~~

~~6.8.2 If the lab results are positive, the report will be forwarded to human resources by the laboratory.~~

~~6.8.3 The human resource office will then notify the appropriate division director or designee. They will, in turn, notify the employee and immediately remove him/her from the workplace without pay until the employee contacts an accredited drug rehabilitation program, and provides documentation of same.~~

~~6.8.4 The employee is then directed to participate in an accredited drug abuse assistance or rehabilitation program. Refusal to do so may result in dismissal. All benefit covered employees will be referred to the state's EAP program for assistance in enrollment.~~

~~6.8.4 Before being allowed to return to duty, the employee must provide documentation to human resources showing that the drug abuse assistance or rehabilitation program was successfully completed and the employee has been released to return to work. "Successful completion" means the employee has achieved a drug-free state as determined by the program counselor and received a negative result from an authorized drug test. The employee will then be required to pass a "return to duty" drug test paid for by the DSCYF before being cleared to return to work.~~

~~6.8.5 Any employee who tests positive on a drug test for a second time within five (5) years from the date of program completion will be separated from employment without the option to participate in a treatment program.~~

~~6.8.6 Employees on initial probation and casual/seasonal employees who have not satisfied the merit comparable initial probation requirement will be terminated if they fail a drug test without recourse to the grievance procedure.~~

~~6.8.7 Casual/seasonal employees who have satisfied the merit comparable initial probation requirement may enter into an accredited drug abuse assistance or rehabilitation program at their own expense. Refer to Section X. E. For returning to duty.~~

7.0 Specimen Collection Procedures

7.1 The State will have a federally certified collector who will be responsible for conducting all urine collections.

7.2 Urine specimens will be collected in accordance with current Federal Department of Transportation standards. Every effort will be made to assure the dignity and privacy of employees being tested.

7.3 If the Contractor determines that the employee is attempting to substitute or adulterate the specimen, the Contractor shall document the fact and direct the employee to provide another specimen. Both specimens shall be forwarded to the laboratory. Confirmation of a substituted or adulterated specimen will be considered as a positive test result.

8.0 Laboratory Procedures

8.1 The laboratory will test for marijuana, cocaine, opiates, phencyclidine and amphetamines. The initial procedure employed will be the Enzyme Multiplied Immunoassay Testing (EMIT) or similar federally approved procedure. Cutoff levels will be consistent with current Federal Department of Transportation standards, which are subject to change.

8.2 All positive specimens shall be confirmed using the Gas Chromatography/Mass Spectrometry (GC/MS), which shall be conducted from the same specimen.

8.3 The confirmation test results are reviewed and interpreted by a Medical Review Officer (MRO) before they are reported to the employer. If the laboratory reports a non-negative result to the MRO, the MRO contacts the employee and conducts an interview to determine if there is an alternative explanation for the. If the employee provides appropriate documentation and the MRO determines that it is legitimate explanation and/or medical documentation, the drug test result is reported as negative to the employer.

8.4 The MRO will contact the DSCYF Designated Employer Representative (DER) within the Human Resource Office.

9.0 Preservation Procedures

Specimens determined to contain drugs will be preserved at the laboratory for a minimum of twelve (12) months. Employees testing positive may, upon written request to Human Resources, arrange to have their specimen retested. All costs, including lab fees and transportation shall be paid by the employee requesting the retest.

10.0 Post Testing Procedures

10.1 If the lab results are negative, the sample shall be destroyed.

10.2 If the lab results are positive, the report will be forwarded to Human Resources by the MRO.

10.3 The Human Resource Office will then notify the appropriate Division Director or designee. They will, in turn, notify the employee and immediately remove him/her from the workplace without pay.

10.4 The employee is then directed to participate in an accredited drug abuse assistance or rehabilitation program. Refusal to do so may result in dismissal. All benefit covered employees will be referred to the State's EAP program for assistance in enrollment.

10.5 Once the employee makes contact with an accredited drug abuse assistance or rehabilitation program, and provides documentation of same, the employee will be allowed to use accrued leave, rescheduled holidays or compensatory time previously earned.

10.6 Before being allowed to return to duty, the employee must:

10.6.1 Provide documentation to Human Resources showing that the drug abuse assistance or rehabilitation program was successfully completed and the employee has been released to return to work. "Successful completion" means the employee has achieved a drug-free state as determined by the program counselor, and

10.6.2 The employee will then be required to pass a "return to duty" drug test paid for by the DSCYF before being cleared to return to work.

10.7 Any employee who tests positive on a drug test for a second time within five (5) years from the date of program completion will be terminated without the option to participate in a treatment program.

~~**CONFIRMATION OF RECEIPT ACKNOWLEDGEMENT**~~

~~**I have received a copy of the Department of Services for Children Youth and Their Families Drug Testing Policy.**~~

_____

~~**Employee Signature Date**~~

~~**Please sign and return this page to:**~~

~~**Human Resources**~~
~~**1825 Faulkland Road**~~
~~**Wilmington, DE 19805**~~

[~~ADDENDUM A~~

~~In addition to Section IV, Subsection I, security sensitive positions shall include, but are not limited to, the following positions/classifications within the DSCYF:~~

- **~~Senior Probation and Parole Officer and Probation and Parole Officer Supervisor~~**
- **~~Family Service Specialist, Senior Family Service Specialist, Master Family Service Specialist and Family Service Supervisor~~**
- **~~Adolescent Treatment Services Coordinators~~**
- **~~Psychiatric Social Worker I, II, III~~**
- **~~Psychologists and Psychologist Supervisors~~**
- **~~Teacher's Aides, Teachers, Principals~~**
- **~~Family crisis therapists and family crisis therapist supervisors~~**
- **~~Family Service Assistant I and Family Service Assistant II~~**
- **~~Child Care Licensing Specialist and Child Care Licensing Supervisor~~**
- **~~Social Service Technician~~]**

DEPARTMENT OF STATE

DIVISION OF PROFESSIONAL REGULATION

Statutory Authority: 24 Delaware Code, Section 2612 (24 **Del.C.** §2612)
24 **DE Admin. Code** 2600

ORDER

2600 Examining Board of Physical Therapists

The Examining Board of Physical Therapists and Athletic Trainers ("the Board") was established to protect the general public from unsafe practices and from occupational practices which tend to reduce competition or fix the price of services rendered by the professions under its purview. The Board was further established to maintain minimum standards of practitioner competence in the delivery of services to the public. The Board is authorized, by 24 **Del.C.** §2604(a)(1), to make, adopt, amend and repeal regulations as necessary to effectuate those objectives.

Pursuant to 24 **Del.C.** §2604(a)(1), the Board proposes the re-organization of the rules and regulations for greater clarity for both licensees and members of the public. Rules 1.2.3 and 1.2.8 are modified with respect to the requirements for supervision. Rule 12.4.23 is added to state that a licensee is required to report to the Division of Professional Regulation any licensee who is in violation of the Board's laws or rules. Rule 13.0, pertaining to continuing education, is amended to add requirements for ethics hours and completion of a CPR course. In addition, Rule 13.2.2 specifies that course approval is good for three years, unless the course is modified. Rule 13.4.4 is added to make explicit that the Board has the authority to conduct continuing education audits and sanction licensees not in compliance with continuing education requirements. Finally, the revisions correct typos and grammatical errors.

Pursuant to 29 **Del.C.** §10115, notice of the public hearing and a copy of the proposed regulatory changes were published in the Delaware *Register of Regulations*, on August 1, 2011, Volume 15, Issue 2. Notice of the rescheduled hearing was published in the Delaware *Register of Regulations* on November 1, 2011, Volume 15, Issue 5.

Summary of the Evidence and Information Submitted

A public hearing on the proposed rule revisions was held on December 6, 2011. No written or verbal comments were submitted.

Findings of Fact

The Board carefully reviewed and considered the proposed rule revisions.

In reviewing the proposed rules, the Board noted a formatting error in Rule 13.1, where the first word, "Three," needs to be corrected to remove the space between the "T" and the "h."

In addition, in reviewing the proposed Rule 12.0, the Board finds that non-substantive revision is needed to permit numbering of the items listed under "Unprofessional Conduct," rather than the use of bullet points. Pursuant to 29 **Del.C.** §10113(b)(4), the Board has the authority to make non-substantive revisions to current rules, in order to correct technical errors, without further rule-making. Therefore, the Board adopts the revisions to Rule 12.0, as set forth in Exhibit A attached hereto.

With respect to the remainder of the proposed revisions, the Board finds that the amendments are needed to provide greater guidance to licensees and to afford heightened protection to the public. In particular, the new Rule 12.4.3 imposes a duty on licensees to report to the Division of Professional Regulation any other licensee who is in violation of the Board's laws or rules. The proposed revisions also create increased requirements for continuing education. The Board finds that adoption of the proposed amendments is in the best interests of the public.

The Board, therefore, adopts the proposed revisions to the rules and regulations as published on August 1, 2011 in the *Register of Regulations*, Volume 15, Issue 2, with the non-substantive revisions noted herein and set forth in Exhibit A.

Decision and Effective Date

The Board hereby adopts the proposed amendments to the regulations to be effective 10 days following final publication of this Order in the *Register of Regulations*.

Text and Citation

The text of the revised rules and regulations remains as published in the Delaware *Register of Regulations*, Volume 15, Issue 2 on August 1, 2011, with the non-substantive revisions included in Rule 12.0, attached hereto as Exhibit A.

IT IS SO ORDERED this 6h day of December 2011, by the Examining Board of Physical Therapists and Athletic Trainers.

Laura Schmitt, Chairperson	W. Wayne Woodzell, Vice-Chairperson
Julie Knowles, Secretary	Jeffrey Schneider
Damien McGovern	Christopher Kay
Amy Blansfield	Waheedah Shabazz
Cheryl Fruchtman	Tyler Luff

2600 Examining Board of Physical Therapists

***Please Note: Due to the size of the proposed regulation, it is not being published here. A copy of the regulation is available at:**

2600 Examining Board of Physical Therapists

DIVISION OF PROFESSIONAL REGULATION

Statutory Authority: 24 Delaware Code, Section 3006(a)(1) (24 **Del.C.** §3006(a)(1))
24 **DE Admin. Code** 3000

3000 Board of Professional Counselors of Mental Health and Chemical Dependency Professionals

ORDER

Pursuant to 29 **Del.C.** §10118 and 24 **Del.C.** §3006(A)(1), the Delaware Board of Professional Counselors of Mental Health and Chemical Dependency issues this Order adopting proposed amendments to the Board's Rules. Following notice and a public hearing on September 28, 2011, the Board makes the following findings and conclusions:

SUMMARY OF THE EVIDENCE

1. The Board posted public notice of the proposed amendments in the September 1, 2011 *Register of Regulations* and in the Delaware *News Journal* and *Delaware State News*. The Board proposed to rework its regulations in an attempt to clarify the certifying organizations acceptable to the Board for licensure as a Professional Counselor of Mental Health.
2. The Board received no written comments during the month of September 2011. The Board held a public hearing on September 28, 2011 and received no public comments.
3. The Board proposed to add language to limit the certifying organizations for licensure for Professional Counselors of Mental Health to organizations that set standards in clinical mental health counseling.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

4. The public was given notice and an opportunity to provide the Board with comments in writing and by testimony at the public hearing on the proposed amendments to the Board's Rules. No public comment was received and therefore no further revision of the rules need be considered.

5. There being no public comment to consider, the Board hereby adopts the regulation changes as originally published on September 1, 2011.

The effective date of this Order will be ten (10) days from the publication of this Order in the *Register of Regulations* on December 1, 2011.

IT IS SO ORDERED THIS 26th day of October, 2011, by the Board of Mental Health and Chemical Dependency Professionals of the State of Delaware

Robert Doyle III, President	Tracy Hansen, LMFF
Lisa Ritchie, Vice President	Daniel Cherneski, LMFF
Vera Murrell, Public Member	Daniel Cooper, LPCMH
Julius Mullen, Ph.D., LPCMH	Clayton Yocum, Public Member
Greg Drevno, LPCMH	Ruth Banta, Public Member

3000 Board of Professional Counselors of Mental Health and Chemical Dependency Professionals

***Please note that no changes were made to the regulation as originally proposed and published in the September 2011 issue of the *Register* at page 322 (15 DE Reg. 322). Therefore, the final regulation is not being republished. A copy of the final regulation is available at:**

3000 Board of Professional Counselors of Mental Health and Chemical Dependency Professionals

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OFFICE OF THE STATE BANK COMMISSIONER

Statutory Authority: 5 Delaware Code, Section 121(b); 29 Delaware Code, Sections 10003(d), and 10113(b) (5 **Del.C.** §121(b); 29 **Del.C.** §§10003(d), and 10113(b))
5 **DE Admin.Code** §1201

ORDER

Policies and Procedures Regarding FOIA Requests

AND NOW, this 12th day of December, 2011 in accordance with 5 **Del.C.** §121(b) and 29 **Del.C.** §10003(d), for the reasons stated below, this ORDER is adopted promulgating regulations setting forth the Policies and Procedures regarding FOIA requests.

NATURE OF PROCEEDINGS

On October 20, 2011, the Governor of the State of Delaware signed Executive Order Number 31, directing each Executive Branch agency to implement and promulgate Uniform Freedom of Information Act policies that are substantially compliant with the form attached to the Executive Order. In accordance with 29 **Del.C.** §10113(b)(1), the Office of the State Bank Commissioner, an Executive Branch agency, is adopting final regulations governing the Policies and Procedures regarding FOIA requests.

The purpose of these regulations is to prescribe procedures relating to the inspection and copying of public records retained by the Office of the State Bank Commissioner pursuant to 29 **Del.C.** Ch. 100, the Freedom of Information Act. The regulations establish a reasonable fee structure for copying public records and streamlines procedures used to disseminate this information.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. The Office of the State Bank Commissioner has developed procedures for responding to requests from the public for information as set forth in 29 **Del.C.** Ch. 100, the Freedom of Information Act. These regulations are in substantial compliance with, and necessary to, effectuate the Governor's Executive Order. The regulations reflect these procedures.

2. The State Bank Commissioner has statutory authority to promulgate regulations governing the administration and operation of the Office of the State Bank Commissioner pursuant to 5 **Del.C.** §121(b).

3. Pursuant to 29 **Del.C.** §10113(b)(1), regulations describing an agency's procedures for obtaining information are exempted from the notice and public comment requirements of 29 **Del.C.** Ch. 101.

DECISION AND ORDER CONCERNING THE REGULATIONS

NOW THEREFORE, under the statutory authority and for the reasons set forth above, the State Bank Commissioner does hereby ORDER that the regulations be, and that they hereby are, adopted and promulgated as set forth below. The effective date of this Order is ten days from the date of its publication in the Delaware *Register of Regulations*, in accordance with 29 **Del.C.** §10118(g).

Robert A. Glen, State Bank Commissioner
12 December, 2011

1201 Policies and Procedures Regarding FOIA Requests

~~Effective Date: November 12, 2010~~

1.0 Definitions

~~The following words and terms when used in this Regulation have the following meaning unless the context clearly indicates otherwise:~~

~~"**FOIA**" shall mean the Delaware Freedom of Information Act, 29 **Del.C.** Ch. 100, as amended.~~

~~"**Office**" shall mean the Office of the State Bank Commissioner for the State of Delaware.~~

~~"**Public record**" shall mean the same as that term is defined in 29 **Del.C.** §10002(g) and shall not include records deemed non-public pursuant to that section or records deemed confidential pursuant to the Delaware Banking Code, Title 5 of the Delaware Code.~~

~~"**Standard size**" shall mean 8.5" x 11"; 8.5" x 14"; and 11" x 17".~~

~~**2.0 General**~~

~~2.1 This Regulation establishes the policy, procedures, charges and fees for responding to requests seeking to inspect public records of the Office under FOIA.~~

~~2.2 The Office shall provide reasonable access for reviewing public records during the Office's regular business hours.~~

~~2.3 Notwithstanding the scope or nature of the request, only existing public records in the possession of the Office will be provided under FOIA.~~

~~2.4 The Office has no obligation under FOIA to answer written questions, analyze data, create records not already in its possession or compile information in any way.~~

~~**3.0 Requests**~~

~~3.1 Persons seeking to inspect public records pursuant to FOIA shall send an original and one copy of a written request addressed to:~~

~~Office of the State Bank Commissioner~~

~~555 East Loockerman Street~~

~~Dover, Delaware 19901~~

3.2 A FOIA request shall:

3.2.1 clearly state the name, address and telephone number of the person making the request;

3.2.2 indicate that the request is being made pursuant to FOIA; and

3.2.3 describe the records sought in sufficient detail to enable the Office to determine their identity and location with reasonable effort.

3.3 FOIA requests by electronic mail will not be accepted.

3.4 FOIA requests that do not comply with this Regulation may be denied in whole or in part.

3.5 Records may not be produced to any person who has an outstanding balance to the Office relating to a pending or prior FOIA request.

4.0 Responses

4.1 Upon receipt of a FOIA request, the Office shall review the records in its possession to identify those that are public records.

4.2 No later than fifteen (15) business days after a FOIA request is received, the Office shall send a written response to the person making the request using the address specified in the request. Additional reasonable time shall be allowed for granting or denying access to the requested records when the request is for voluminous records, requires legal advice or a record is in storage or archived.

4.3 The response may require inspection of requested records; may indicate when, where and under what conditions the requested records may be inspected; may include copies of requested records; may deny the request in whole or in part stating the reasons therefor; or may indicate that additional time is required for a further response in accordance with § 4.2 of this Regulation. If the response indicates that additional time is required, an expected date for the further response shall be specified.

4.4 Public records may be inspected only during the Office's regular business hours.

15 DE Reg. 100 (07/01/11)

5.0 Administrative Fees, Photocopying Charges, and Other Costs.

5.1 Administrative Fees. The Office may assess the person making a FOIA request administrative fees incurred pursuant to the request.

5.1.1 Administrative fees include personnel time associated with processing the request, including but not limited to, time spent locating and reviewing records; monitoring record reviews; photocopying paper records; generating paper copies of microfilm, microfiche and electronic records; review by legal counsel; and any other work necessitated by the request.

5.1.2 Administrative fees will be charged per quarter hour at the current, hourly pay rate plus benefits of the personnel performing the work, pro-rated in quarter hour increments.

5.1.3 Administrative fees will be in addition to all photocopy charges and other costs.

5.2 Photocopy Charges. The Office may assess the person making a FOIA request the following photocopy charges:

5.2.1 Standard Size or Smaller Paper Records. The charge for copying public records maintained on standard size or smaller paper will be $0.50 per printed page for black and white copies and $2.00 per printed page for color copies.

5.2.2 Large Size Paper Records. For black and white copies, the charge for copying public records maintained on paper that is larger than standard size will be $2.00 per 24" x 26" printed page, $3.00 per 24" x 36" printed page, $5.00 per 30" x 42" printed page, and $1.00 per square foot of printed page for all other oversized records. For color copies, an additional $1.50 per printed page will be charged.

5.2.3 Microfilm and Microfiche Records. The charge for copying public records maintained on microfilm or microfiche will be $1.00 per printed page. All such records will be copied to standard size paper in black and white.

5.2.4 Electronic Records. The charge for copying public records maintained electronically will be the same as standard size paper records if the requested records are copied to paper. Standard size paper will be used for all such copies. If the requested records are copied to an electronic storage device or media (such as magnetic tape, diskette, compact disc, thumb drive, etc.), the charge will be the cost of the device or media.

~~5.3 Other Costs. The Office may assess the person making a FOIA request any other costs incurred pursuant to the request, including charges assessed by an outside vendor to copy the requested records.~~

~~5.4 Payment for all fees, charges and costs is due at the time records are provided. The Office may also require payment prior to sending copies of records.~~

6.0 Effective Date

~~These regulations shall become effective 11 days after being published as a final regulation. Any and all FOIA requests currently in process at the time of adoption will be subject to these regulations.~~

Effective date: January 11, 2012

1.0 Purpose

The purpose of this regulation is to set forth the rules and procedures for responding to requests from the public for Public Records under Title 29, Chapter 100 of the **Delaware Code**, the Freedom of Information Act.

Agency employees are reminded that all Public Records requested under FOIA shall be considered open and subject to disclosure to the Requesting Party, and any information therein may be withheld only if a specific exception applies. Exceptions shall be construed in a manner that shall further the accountability of the Agency and to comply with the policy that the public shall have reasonable access to Public Records.

2.0 Definitions

The following words and terms, when used in this regulation, shall have the following meaning unless the context clearly indicates otherwise:

"**Agency**" means Office of the State Bank Commissioner.

"**Commissioner**" means the State Bank Commissioner for the State of Delaware.

"**FOIA**" means the Freedom of Information Act as established pursuant to Title 29, Chapter 100 of the **Delaware Code**.

"**FOIA Coordinator**" shall mean the person designated by the Commissioner to receive and process FOIA Requests.

"**FOIA Request**" or "**Request**" means a request to inspect or copy Public Records pursuant to 29 **Del.C.** §10003 and in accordance with this regulation.

"**FOIA Request Form**" means the form promulgated by the Office of the Attorney General upon which requests for Public Records may be made.

"**Non-Custodial Records**" shall have the meaning set forth in Section 3.6.

"**Public Record**" shall have the meaning set forth in 29 **Del.C.** §10002.

"**Requesting Party**" shall mean the party filing a FOIA Request.

3.0 Records Request, Response Procedures and Access

3.1 Form of Request

3.1.1 All FOIA Requests shall be made in writing to the Agency in person, by email, by fax, or online in accordance with this regulation. FOIA Requests may be submitted using the FOIA Request Form promulgated by the Office of the Attorney General; provided, however, that any FOIA Request that otherwise conforms with this regulation shall not be denied solely because the request is not on the promulgated form. Copies of the FOIA Request Form may be obtained from the Agency's website, or from the office or website of any state agency.

3.1.2 All requests shall adequately describe the records sought in sufficient detail to enable the Agency to locate such records with reasonable effort. The Requesting Party shall be as specific as possible when requesting records. To assist the Agency in locating the requested records, the Agency may request that the Requesting Party provide additional information known to the

Requesting Party, such the types of records, dates, parties to correspondence, and subject matter of the requested records.

3.2 Method of Filing Request

3.2.1 FOIA Requests may be made by mail or in person to the FOIA Coordinator at the Office of the State Bank Commissioner; 555 East Loockerman Street, Dover, Delaware 19901; by email to the Agency through the contact link on its website; by fax at 302-739-3609; or via the online request form on the Agency's home page at http://www.banking.delaware.gov/.

3.3 FOIA Coordinator

3.3.1 The Commissioner shall designate a FOIA Coordinator, who shall serve as the point of contact for FOIA Requests and coordinate the Agency's responses thereto. The FOIA Coordinator shall be identified on the Agency's website. The FOIA Coordinator may designate other Agency employees to perform specific duties and functions hereunder.

3.3.2 The FOIA Coordinator and/or his or her designee, working in cooperation with other Agency employees and representatives, shall make every reasonable effort to assist the Requesting Party in identifying the records being sought, and to assist the Agency in locating and providing the requested records. The FOIA Coordinator and/or his or her designee will also work to foster cooperation between the Agency and the Requesting Party. Without limitation, if a Requesting Party initiates a FOIA Request that would more appropriately be directed to another agency, the FOIA Coordinator shall promptly forward such request to the relevant agency and promptly notify the Requesting Party that the request has been forwarded. The Agency may close the initial request upon receipt of a written confirmation from the FOIA Coordinator of the relevant agency that the relevant agency has received such request. The Agency shall provide the Requesting Party with the name and phone number of the FOIA Coordinator of the relevant agency.

3.3.3 In addition to the foregoing responsibilities, beginning on January 1, 2012, the FOIA Coordinator shall maintain a document tracking all FOIA Requests for the then-current calendar year. For each FOIA Request, the document shall include, at a minimum: the Requesting Party's contact information; the date the Agency received the Request; the Agency's response deadline pursuant to §3.4; the date of the Agency's response pursuant to §3.4 (including the reasons for any extension pursuant to §3.4.1); the names, contact information and dates of correspondence with individuals contacted in connection with requests pursuant to §§3.3.2, 3.5 and 3.6; the dates of review by the Agency pursuant to §3.7 and the names of individuals who conducted such reviews; whether documents were made available; the amount of copying and/or administrative fees assessed; and the date of final disposition.

3.4 Agency Response to Requests

3.4.1 The Agency shall respond to a FOIA Request as soon as possible, but in any event within fifteen (15) business days after its receipt, either by providing access to the requested records; denying access to the records or parts of them; or by advising that additional time is needed because the request is for voluminous records, requires legal advice, or a record is in storage or archived. If access cannot be provided within fifteen (15) business days, the Agency shall cite one of the reasons hereunder why more time is needed and provide a good-faith estimate of how much additional time is required to fulfill the request.

3.4.2 If the Agency denies a request in whole or in part, the Agency's response shall indicate the reasons for the denial. The Agency shall not be required to provide an index, or any other compilation, as to each record or part of a record denied.

3.5 Requests for Email

3.5.1 Requests for email records shall be fulfilled by the Agency from its own records, if doing so can be accomplished by the Agency with reasonable effort. If the Agency determines that it cannot fulfill all or any portion of such request, the Agency shall promptly request that the Department of Technology and Information ("DTI") provide the email records to the Agency. Upon receipt from DTI, the Agency may review the email records in accordance with § 3.7 hereunder.

3.5.2 Before requesting DTI to provide email records, the Agency shall provide a written cost estimate from DTI to the Requesting Party, listing all charges expected to be incurred by DTI in retrieving

such records. Upon receipt of the estimate, the Requesting Party may decide whether to proceed with, cancel or modify the request.

3.6 Requests for Other Non-Custodial Records

3.6.1 If all or any portion of a FOIA Request seeks records controlled by the Agency but that are either not within its possession or cannot otherwise be fulfilled by the Agency with reasonable effort from records it possesses (collectively, the "Non-Custodial Records"), then the Agency shall promptly request that the relevant public body provide the Non-Custodial Records to the Agency. Prior to disclosure, records may be reviewed in accordance with §3.7 of this regulation by the Agency, the public body fulfilling the request, or both. Without limitation, Non-Custodial Records shall include budget data relating to the Agency.

3.6.2 Before requesting any Non-Custodial Records, the Agency shall provide a written cost estimate to the Requesting Party, listing all charges expected to be incurred in retrieving such records. Upon receipt of the estimate, the Requesting Party may decide whether to proceed with, cancel or modify the request.

3.7 Review by Agency

3.7.1 Prior to disclosure, records may be reviewed by the Agency to ensure that those records or portions of records deemed non-public may be removed pursuant to 29 **Del.C.** §10002(g) or any other applicable provision of law. In reviewing the records, all documents shall be considered Public Records unless subject to one of the exceptions set forth in 29 **Del.C.** §10002(g) or any other applicable provision of law. Nothing in this regulation shall prohibit the Agency from disclosing or permitting access to Public Records if the Agency determines to disclose such records, except where such disclosure or access is otherwise prohibited by law or regulation.

3.8 Hours of Review

3.8.1 The Agency shall provide reasonable access for reviewing Public Records during regular business hours.

4.0 Fees

4.1 Photocopying Fees

4.1.1 In instances in which paper records are provided to the Requesting Party, photocopying fees shall be as follows:

4.1.1.1 Standard Sized, Black and White Copies: The first 20 pages of standard sized, black and white copied material shall be provided free of charge. The charge for copying standard sized, black and white Public Records for copies over and above 20 shall be $0.10 per sheet (*i.e.*, $0.10 for a single-sided sheet, $0.20 for a double-sided sheet). This charge applies to copies on the following standard paper sizes: 8.5" x 11"; 8.5" x 14"; and 11" x 17".

4.1.1.2 Oversized Copies/Printouts: The charge for copying oversized Public Records shall be as follows:

18" x 22":	$2.00 per sheet
24" x 36":	$3.00 per sheet
Documents larger than 24" x 36":	$1.00 per square foot

4.1.1.3 Color Copies/Printouts: An additional charge of $1.00 per sheet will be assessed for all color copies or printouts for standard sized copies (8.5" x 11"; 8.5" x 14"; and 11" x 17"), and $1.50 per sheet for larger copies.

4.2 Administrative Fees

4.2.1 Administrative fees shall be levied for requests requiring more than one hour of staff time to process. Charges for administrative fees may include staff time associated with processing FOIA Requests, including, without limitation, (a) identifying records; (b) monitoring file reviews; and (c) generating computer records (electronic or print-outs). Administrative fees shall not include any cost associated with the Agency's legal review of whether any portion of the requested records is

exempt from FOIA. The Agency shall make every effort to ensure that administrative fees are minimized, and may only assess such charges as shall be reasonably required to process FOIA Requests. In connection therewith, the Agency shall minimize the use of non-administrative personnel in processing FOIA Requests, to the extent possible.

4.2.2 Prior to fulfilling any request that would require a Requesting Party to incur administrative fees, the Agency shall provide a written cost estimate of such fees to the Requesting Party, listing all charges expected to be incurred in retrieving such records. Upon receipt of the estimate, the Requesting Party may decide whether to proceed with, cancel or modify the request.

4.2.3 Administrative fees will be billed to the Requesting Party per quarter hour. These charges will be billed at the current hourly pay grade (pro-rated for quarter hour increments) of the lowest-paid employee capable of performing the service. Administrative fees will be in addition to any other charges incurred under this Section 4, including copying fees.

4.2.4 When multiple FOIA Requests are submitted by or on behalf of a Requesting Party in an effort to avoid incurring administrative charges, the Agency may in its discretion aggregate staff time for all such requests when computing fees hereunder.

4.3 Microfilm and/or Microfiche Printouts: The first 20 pages of standard sized, black and white material copied from microfilm and/or microfiche shall be provided free of charge. The charge for microfilm and/or microfiche printouts over and above 20 shall be $0.15 per sheet.

4.4 Electronically Generated Records: Charges for copying records maintained in an electronic format will be calculated by the material costs involved in generating the copies (including but not limited to DVD, CD, or other electronic storage costs) and administrative costs.

4.5 Payment

4.5.1 The Agency may require all fees to be paid prior to any service being performed under this regulation.

4.5.2 The Agency may require pre-payment of all fees prior to fulfillment of any request for records under this regulation.

4.6 Waiver of Fees Pursuant to Prior Policy

Omitted

4.7 Appointment Rescheduling or Cancellation: Requesting Parties who do not reschedule or cancel appointments to view files at least one full business day in advance of the appointment may be subject to the charges incurred by the Agency in preparing the requested records. The Agency shall prepare an itemized invoice of these charges and provide the same to the Requesting Party for payment.

5.0 Applicability

To the extent any provision in this regulation conflicts with any other law or regulation, such law or regulation shall control, and the conflicting provision herein is expressly superseded.

6.0 Agency-Specific Provisions

6.1 Documents which the Commissioner and any of the employees who work for the Commissioner are bound to keep confidential and are prohibited from disclosing pursuant to 5 **Del.C.** §125 are not public records for FOIA purposes and are not subject to inspection or disclosure under FOIA.

6.2 Documents constituting “confidential supervisory information” as defined by 5 **Del.C.** §145 are not public records for FOIA purposes and are not subject to inspection or disclosure under FOIA.

7.0 Effective Date

This regulation shall become effective on January 11, 2012.

4 DE Reg. 487 (11/01/10)

PUBLIC SERVICE COMMISSION

Statutory Authority: 29 Delaware Code, Section 103(3) (3 **Del.C.** §103(b))

ORDER

IN THE MATTER OF THE ADOPTION OF RULES AND REGULATIONS GOVERNING THE PROCEDURE FOR INSPECTION AND COPYING OF PUBLIC RECORDS UNDER THE FREEDOM OF INFORMATION ACT, 29 Del.C., §§10001-10006 (OPENED AUGUST 17, 2010; REOPENED MAY 10, 2011; REOPENED NOVEMBER 8, 2011	PSC REGULATION DOCKET NO. 62

Policies and Procedures Regarding FOIA Requests

AND NOW, this 20th day of December, 2011, in accordance with 26 **Del.C.** §209(a)(1) and 29 **Del.C.** §§10113(b) and 10003(b), for the reasons stated below, this ORDER is adopted to repeal the prior regulations and to promulgate new regulations setting forth the Policies and Procedures regarding requests under the Delaware Freedom of Information Act ("FOIA").

NATURE OF PROCEEDINGS

1. On October 20, 2011, the Governor of the State of Delaware signed Executive Order Number 31 which directs each executive branch agency to implement and promulgate uniform FOIA policies in substantial compliance with the form attached to the Executive Order. In accordance with 29 **Del.C.** §10113(b)(1), the Public Service Commission ("Commission") is repealing its prior regulations adopting new final regulations governing the policies and procedures regarding FOIA requests (*See* the attached Exhibit "A").

2. The purpose of the new regulations is to prescribe procedures relating to the inspection and copying of public records retained by the Commission pursuant to 29 **Del.C.** Ch. 100 ("FOIA"). The regulations establish a reasonable fee structure for copying public records and streamlines procedures used to disseminate this information.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

3. The Commission has developed new procedures for responding to requests from the public for information as set forth in 29 **Del.C.** Ch. 100 (FOIA). These regulations are in substantial compliance with, and necessary to, effectuate the Governor's Executive Order. The regulations reflect these procedures.

4. The Commission has statutory authority to promulgate regulations pursuant to 26 **Del.C.** §209(a)(1).

5. Pursuant to 29 **Del.C.** §10113(b)(1), regulations describing an agency's procedures for obtaining information are exempted from the notice and public comment requirements of 29 **Del.C.** Ch. 101.

NOW, THEREFORE, IT IS HEREBY ORDERED BY THE AFFIRMATIVE VOTE OF NOT FEWER THAN THREE COMMISSIONERS:

6. Under the statutory authority and for the reasons set forth in the body of this Order, the Commission does hereby ORDER that the regulations attached as Exhibit "A" be, and that they hereby are, adopted and promulgated

as set forth below. The effective date of this Order is ten days from the date of its publication in the Delaware *Register of Regulations,* in accordance with 29 **Del.C.** §10118(g).

BY ORDER OF THE COMMISSION:

1202 Policies and Procedures Regarding FOIA Requests

1.0 Definitions

~~Capitalized terms not otherwise defined in these regulations shall have the meanings given those terms in FOIA and the Commission's Rules of Practice and Procedure (see 26 **DE Admin. Code** §1001), as applicable.~~

~~"**Affected Party**" means any party who has submitted Third Party Confidential Records.~~

~~"**FOIA**" shall mean the Freedom of Information Act, 29 **Del.C.**, Ch. 100, as may be amended from time to time.~~

~~"**Third Party Confidential Records**" are records submitted to the Commission by a third party under a claim of confidentiality pursuant to the Commission's Rules of Practice and Procedure. Records will not be considered Third Party Confidential Records for purpose of these regulations if the records were not identified and submitted as confidential in accordance with the Commission's Rules of Practice and Procedure.~~

2.0 General

~~2.1 The Commission promulgates these regulations, pursuant to 29 **Del.C.** §10003(b), to establish procedures regarding requests made to the Commission pursuant to FOIA for public records in the possession of the Commission. The Commission is under no obligation under FOIA to answer written questions, analyze data, create documents not already in its possession or compile information in a record. FOIA requests shall be made for the purposes of obtaining existing documents in the Commission's possession.~~

~~2.2 Consistent with FOIA, it is the Commission's desire that the public have access to the Commission's public records under reasonable terms and conditions. These regulations establish reasonable fees for compiling and photo copying public records and provide instructions regarding how to make FOIA requests with the Commission and how such requests will be processed.~~

~~2.3 Commission staff may perform the duties of the Commission under these regulations.~~

3.0 Requests

~~3.1 Persons requesting requests for records pursuant to FOIA shall submit an original and one copy of a written letter request indicating that the request is being made pursuant to FOIA. The written request shall be addressed to:~~

~~Delaware Public Service Commission~~
~~Attn.: Commission Secretary~~
~~861 Silver Lake Boulevard~~
~~Cannon Building, Suite 100~~
~~Dover, Delaware 19904~~

~~Requests by electronic mail will not be entertained.~~

~~3.2 Requests shall indicate clearly where records are to be sent.~~

~~3.3 Requests for records shall describe the records sought in sufficient detail to enable their location with reasonable effort.~~

~~3.4 Records may not be produced to any person who has an outstanding balance with the Commission relating to a prior FOIA request.~~

~~3.5 Requests that do not comply with these regulations may be denied in whole or in part.~~

4.0 Responses

~~4.1 The Commission shall respond to a request made under these regulations within fifteen (15) business days of receipt of the request. Such response may include the requested records, deny the request in whole or in part, or indicate when the requested records will be produced and under what, if any, conditions. A response to a request for Third Party Confidential Records shall be made pursuant to the procedures and the timeframe set forth in Rule 6 below.~~

~~4.2 Additional time shall be allowed beyond the fifteen business days provided for in Section 4.1 when a request is for voluminous records, requires legal advice or a record is in storage or archived. In any of these cases, the requestor shall be advised by the custodian of a record, within fifteen business days after the custodian of a record receives the request, stating the need for additional time. Such additional time provided for in this section 4.2 shall be reasonable.~~

~~4.3 To the extent a FOIA request seeks documents that the Commission, in its sole discretion, may consider voluminous, the Commission may require that the party requesting the records inspect and copy the records at the Commission's office during its regular business hours. Alternatively, the Commission may, in its sole discretion, employ the assistance of an outside vendor to copy the requested records, in which case the requester will be required to pay the copy charges assessed by such vendor.~~

~~14 DE Reg. 1397 (06/01/11)~~

5.0 Fees for Photocopying Performed by Commission and Administrative Fees.

~~5.1 Administrative Fees. The Commission may assess administrative fees incurred in responding to a FOIA request as set forth herein. Such fees include:~~

~~5.1.1 Staff time associated with processing FOIA requests, including, but not limited to, time spent locating and reviewing files, monitoring file reviews, and generating computer records.~~

~~5.1.2 Administrative fees will be billed per quarter hour and will be billed at the current, hourly pay grade rate of the personnel performing the service. Administrative charges will be in addition to any copying charges.~~

~~5.2 Photocopy Charges~~

~~5.2.1 Standard Size Copies. The charge for copying standard size black and white public records shall be $0.50 per printed page (i.e., single sided copies are $0.50 and double sided copies are $1.00). The charge for color copies or printouts shall be $2.00 per page. This charge applies to copies on the following standard paper sizes: 8.5 x 11; 8.5 x 14; and 11 x 17.~~

~~5.2.2 Oversized Copies/Printouts. The charge for copying oversized public records (including but not limited to blueprints, engineering drawings, GIS printouts and maps) shall be as follows: 24 x 26: $2.00 each; 24 x 36: $3.00 each; 30 x 42: $5.00 each; and all larger documents: $1.00 per square foot. An additional charge of $1.50 per page will be assessed to color copies.~~

~~5.2.3 Microfilm/Microfiche Printouts. Microfilm and/or microfiche printouts made by Commission personnel and printed on standard sized paper will be $1.00 per page.~~

~~5.2.4 Electronically Generated Records. Charges for copying records maintained in an electronic format will be calculated by the material costs involved in generating the copies, including but not limited to magnetic tape, diskette or compact disc costs and third party costs.~~

~~5.3 Payment for copies and/or administrative charges are due at the time the records are released.~~

6.0 Requests Seeking Non-Public and Third Party Confidential Records.

~~6.1 Records identified as non-public pursuant to 29 **Del.C.** §10002(g) shall not be produced in response to a FOIA request. In addition, the following procedures shall apply to requests seeking records that the Commission believes are non-public because they are Third Party Confidential Records:~~

~~6.1.1 Upon receipt of a request seeking Third Party Confidential Records, the Commission will notify the Affected Party in writing of the request, identifying the party making the request and the Third Party Confidential Records sought.~~

~~6.1.2 Within ten (10) days of receipt of the notice required by Rule 6.1, the Affected Party shall advise the Commission in writing whether it opposes the disclosure of the Third Party Confidential Records. If the Commission is not so notified, it will produce the Third Party Confidential Records.~~

~~6.1.3 If the Affected Party timely objects to the production of the Third Party Confidential Records, the Affected Party shall, at the time of notifying the Commission of its objection, provide in writing information sufficient to justify a claim of confidentiality under FOIA. Such information shall include, but not be limited to, the following:~~

~~6.1.3.1 Any measures taken by the Affected Party to guard against disclosure of the Third Party Confidential Records;~~

~~6.1.3.2 Whether the Third Party Confidential Records have been intentionally or inadvertently disclosed since their submission to the Commission and any actions or precautions taken in connection with such disclosure; and~~

~~6.1.3.3 Whether the disclosure of the Third Party Confidential Records would result in substantial or harmful effects on the Affected Party's commercial or financial interests, and if so: (a) what those harmful effects would be; (b) why the effects should be viewed as substantial; and (c) how the disclosure would cause such harmful effects.~~

~~6.1.4 The Affected Party bears the burden of establishing confidentiality under FOIA. A unilateral assertion that records are confidential or otherwise not subject to a FOIA request is insufficient to support a finding that requested information is in fact non public.~~

~~6.1.5 Within a reasonable time after receiving the Affected Party's response filed pursuant to Rule 5.1.2, the Commission shall determine whether the Third Party Confidential Documents should be produced pursuant to FOIA despite the Affected Party's claim of confidentiality. Written notice of the Commission's decision shall be provided to the party making the FOIA request and the Affected Party.~~

7.0 Appeals of Commission's Decision.

~~As authorized by 29 **Del.C.** §10005, any person denied access to requested records may (i) bring suit in a court of competent jurisdiction within sixty (60) days of such denial or (ii) petition the Attorney General to determine whether a violation of FOIA has occurred. The procedures applicable to such petition are provided in 29 **Del.C.** §10005.~~

1.0 Purpose

The purpose of this policy is to set forth the rules and procedures for responding to requests from the public for Public Records under Title 29, Chapter 100 of the **Delaware Code**, the Freedom of Information Act.

Commission employees are reminded that all Public Records requested under FOIA shall be considered open and subject to disclosure to the Requesting Party, and any information therein may be withheld only if a specific exception applies. Exceptions shall be construed in a manner that shall further the accountability of the Commission and comply with the policy that the public shall have reasonable access to Public Records.

2.0 Definitions

The following words and terms, when used in this policy, shall have the following meaning unless the context clearly indicates otherwise:

"**Affected Party**" means any party who has submitted Third Party Confidential Records.

"**Commission**" means the Public Service Commission of Delaware.

"**FOIA**" means the Freedom of Information Act as established pursuant to Title 29, Chapter 100 of the **Delaware Code**.

"**FOIA Coordinator**" shall mean the person designated by the Secretary to receive and process FOIA Requests.

"**FOIA Request**" or "**Request"** means a request to inspect or copy Public Records pursuant to Chapter 29, Section 10003 of the **Delaware Code**, and in accordance with this policy.

"**FOIA Request Form**" means the form promulgated by the Office of the Attorney General upon which requests for Public Records may be made.

"**Non-Custodial Records**" shall have the meaning set forth in Section 3.6.

"**Public Record**" shall have the meaning set forth in 29 **Del.C.** §10002.

"**Requesting Party**" shall mean the party filing a FOIA Request.

"**Secretary**" means the Secretary of State.

"**Third Party Confidential Records**" are records submitted to the Commission by a third party under a claim of confidentiality pursuant to the Commission's Rules of Practice and Procedure, 26 **DE Admin. Code** §1001. Records will not be considered Third Party Confidential Records for purpose of this policy if the records were not identified and submitted as confidential in accordance with the Commission's Rules of Practice and Procedure, 26 **DE Admin. Code** §1001.

3.0 Records Request, Response Procedures and Access

3.1 Form of Request

3.1.1 All FOIA Requests shall be made in writing to the Commission in person, by email, by fax, or online in accordance with the provisions of this policy. FOIA Requests may be submitted using the FOIA Request Form promulgated by the Office of the Attorney General; provided, however, that any FOIA Request that otherwise conforms with this policy shall not be denied solely because the request is not on the promulgated form. Copies of the FOIA Request Form may be obtained from the Commission's website or from the office or website of any state agency.

3.1.2 All requests shall adequately describe the records sought in sufficient detail to enable the Commission to locate such records with reasonable effort. The Requesting Party shall be as specific as possible when requesting records. To assist the Commission in locating the requested records, the Commission may request the Requesting Party to provide additional information known to the Requesting Party, such as the types of records, dates, parties to correspondence, and subject matter of the requested records.

3.2 Method of Filing Request

3.2.1 FOIA Requests may be made by mail or in person to the FOIA Coordinator, Delaware Department of State, Office of the Secretary, 401 Federal Street, Suite 3, Townsend Building, Dover, Delaware 19901; by fax at (302) 739-3811; by online request form, which may be found on the Commission's home page at http://depsc.delaware.gov/default.shtml; or by email to the FOIA Coordinator email address listed at www.sos.delaware.gov.

3.3 FOIA Coordinator

3.3.1 The Secretary shall designate a FOIA Coordinator, who shall serve as the point of contact for FOIA Requests and coordinate the Commission's responses. The FOIA Coordinator shall be identified on the Commission's website. The FOIA Coordinator may designate other Commission employees to perform specific duties and functions hereunder.

3.3.2 The FOIA Coordinator or his or her designee, working in cooperation with other Commission employees and representatives, shall make every reasonable effort to assist the Requesting Party in identifying the records being sought and to assist the Commission in locating and providing the requested records. The FOIA Coordinator or his or her designee will also work to foster cooperation between the Commission and the Requesting Party. Without limitation, if a Requesting Party initiates a FOIA Request that would more appropriately be directed to another agency, the FOIA Coordinator shall promptly forward such request to the relevant agency and promptly notify the Requesting Party that the request has been forwarded. The Commission may

close the initial request upon receipt of a written confirmation from the FOIA Coordinator of the relevant agency that the relevant agency has received such request. The Commission shall provide the Requesting Party with the name and phone number of the FOIA Coordinator of the relevant agency.

3.3. In addition to the foregoing responsibilities, the FOIA Coordinator shall maintain a document tracking all FOIA Requests for the then-current calendar year. For each FOIA Request, the document shall include, at a minimum: The Requesting Party's contact information; the date the Commission received the Request; the Commission's response deadline pursuant to §3.4; the date of the Commission's response pursuant to §3.4 (including the reasons for any extension pursuant to §3.4.1); the names, contact information, and dates of correspondence with individuals contacted in connection with requests pursuant to §§3.3.2, 3.5 and 3.6; the dates of review by the Commission pursuant to §3.7 and the names of individuals who conducted such reviews; whether documents were made available; the amount of copying and administrative fees assessed; and the date of final disposition.

3.4 Agency Response to Requests

3.4.1 The Commission shall respond to a FOIA Request as soon as possible, but in any event within fifteen (15) business days after receiving such request, either by providing access to the requested records; denying access to the records or parts of them; or by advising that additional time is needed because the request is for voluminous records, requires legal advice, or a record is in storage or archived. If access cannot be provided within fifteen (15) business days, the Commission shall cite one of the reasons why more time is needed and provide a good-faith estimate of how much additional time is required to fulfill the request.

3.4.2 If the Commission denies a request in whole or in part, the Commission's response shall indicate the reasons for the denial. The Commission shall not be required to provide an index, or any other compilation, as to each record or part of a record denied.

3.5 Requests for Email

3.5.1 Requests for email records shall be fulfilled by the Commission from its own records, if doing so can be accomplished by the Commission with reasonable effort. If the Commission determines that it cannot fulfill all or any portion of such request, the Commission shall promptly request that the Department of Technology and Information ("DTI") provide the email records to the Commission. Upon receipt from DTI, the Commission may review the email records in accordance with §3.7.

3.5.2 Before requesting DTI to provide email records, the Commission shall provide a written cost estimate from DTI to the Requesting Party, listing all charges expected to be incurred by DTI in retrieving such records. Upon receipt of the estimate, the Requesting Party may decide whether to proceed with, cancel, or modify the request.

3.6 Requests for Other Non-Custodial Records

3.6.1 If all or any portion of a FOIA Request seeks records controlled by the Commission but that are either not within its possession or cannot otherwise be fulfilled by the Commission with reasonable effort from records it possesses (collectively, the "Non-Custodial Records"), then the Commission shall promptly request that the relevant public body provide the Non-Custodial Records to the Commission. Prior to disclosure, records may be reviewed in accordance with §3.7 by the Commission, the public body fulfilling the request, or both. Without limitation, Non-Custodial Records shall include budget data relating to the Commission.

3.6.2 Before requesting any Non-Custodial Records, the Commission shall provide a written cost estimate to the Requesting Party, listing all charges expected to be incurred in retrieving such records. Upon receipt of the estimate, the Requesting Party may decide whether to proceed with, cancel, or modify the request.

3.7 Review by Commission

3.7.1 Prior to disclosure, records may be reviewed by the Commission to ensure that those records or portions of records deemed non-public may be removed pursuant to 29 **Del.C.** §10002(g) or any other applicable provision of law. In reviewing the records, all documents shall be considered

Public Records unless subject to one of the exceptions set forth in 29 **Del.C.** §10002(g) or any other applicable provision of law. Nothing herein shall prohibit the Commission from disclosing or permitting access to Public Records if the Commission determines to disclose such records, except where such disclosure or access is otherwise prohibited by law or regulation.

3.8 Hours of Review

3.8.1 The Commission shall provide reasonable access for reviewing Public Records during its regular business hours.

4.0 Fees

4.1 Photocopying Fees

4.1.1 In instances in which paper records are provided to the Requesting Party, photocopying fees shall be as follows:

4.1.1.1 Standard Sized, Black and White Copies: The first 20 pages of standard sized, black and white copied material shall be provided free of charge. The charge for copying standard sized, black and white Public Records for copies over and above 20 shall be $0.10 per sheet (*i.e.*, $0.10 for a single-sided sheet, $0.20 for a double-sided sheet). This charge applies to copies on the following standard paper sizes: 8.5” x 11”; 8.5” x 14”; and 11” x 17”.

4.1.1.2 Oversized Copies/Printouts: The charge for copying oversized Public Records shall be as follows:

18" x 22":	$2.00 per sheet
24" x 36":	$3.00 per sheet
Documents larger than 24" x 36":	$1.00 per square foot

4.1.1.3 Color Copies/Printouts: An additional charge of $1.00 per sheet will be assessed for all color copies or printouts for standard sized copies (8.5” x 11”; 8.5” x 14”; and 11” x 17”), and $1.50 per sheet for larger copies.

4.2 Administrative Fees

4.2.1 Administrative fees shall be levied for requests requiring more than one hour of staff time to process. Charges for administrative fees may include staff time associated with processing FOIA Requests, including, without limitation:

4.2.1.1 identifying records;

4.2.1.2 monitoring file reviews; and

4.2.1.3 generating computer records (electronic or print-outs).

Administrative fees shall not include any cost associated with the Commission’s legal review of whether any portion of the requested records is exempt from FOIA. The Commission shall make every effort to ensure that administrative fees are minimized and may only assess such charges as shall be reasonably required to process FOIA Requests. In connection therewith, the Commission shall minimize the use of non-administrative personnel in processing FOIA Requests, to the extent possible.

4.2.2 Prior to fulfilling any request that would require a Requesting Party to incur administrative fees, the Commission shall provide a written cost estimate of such fees to the Requesting Party, listing all charges expected to be incurred in retrieving such records. Upon receipt of the estimate, the Requesting Party may decide whether to proceed with, cancel, or modify the request.

4.2.3 Administrative fees will be billed to the Requesting Party per quarter hour. These charges will be billed at the current hourly pay grade (pro-rated for quarter hour increments) of the lowest-paid employee capable of performing the service. Administrative fees will be in addition to any other charges incurred under this Section 4, including copying fees.

4.2.4 When multiple FOIA Requests are submitted by or on behalf of a Requesting Party in an effort to avoid incurring administrative charges, the Commission in its discretion may aggregate staff time for all such requests when computing fees hereunder.

4.3 Microfilm and/or Microfiche Printouts: The first 20 pages of standard sized, black and white material copied from microfilm or microfiche shall be provided free of charge. The charge for microfilm or microfiche printouts over and above 20 shall be $0.15 per sheet.

4.4 Electronically Generated Records: Charges for copying records maintained in an electronic format will be calculated by the material costs involved in generating the copies (including, but not limited to, DVD, CD, or other electronic storage costs) and administrative costs.

4.5 Payment

4.5.1 The Commission may require all fees to be paid prior to performing any service under this policy.

4.5.2 The Commission may require pre-payment of all fees prior to fulfilling any request for records under this policy.

4.6 Appointment Rescheduling or Cancellation: Requesting Parties who do not reschedule or cancel appointments to view files at least one full business day in advance of the appointment may be subject to the charges incurred by the Commission in preparing the requested records. The Commission shall prepare an itemized invoice of these charges and provide the same to the Requesting Party for payment.

5.0 Applicability

5.1 To the extent any provision in this policy conflicts with any other law or regulation, such law or regulation shall control, and the conflicting provision herein is expressly superseded.

6.0 Agency-Specific Provisions.

6.1 Fees for archival and historical materials: Special handling of archival and/or historical materials may require the assessment of fees in excess of those listed in Section 4.0 of this policy. Such fees shall be posted online and may include, but are not limited to: fees associated with outsourcing; fees associated with copying of certain bound materials; and fees for the copying or duplication of photographic, video, audio or other special holdings of the Delaware Public Archives and Division of Historical and Cultural Affairs. Unless otherwise noted at www.archives.delaware.gov or www.history.delaware.gov, all requests for copies under this policy shall adhere to the fees set forth in Section 4.0 of this policy.

6.2 Records identified as non-public pursuant to 29 **Del.C.** §10002(g) shall not be produced in response to a FOIA Request. In addition, the following procedures shall apply to requests seeking records that the Commission believes are non-public because they are Third Party Confidential Records:

6.2.1 Upon receipt of a request seeking Third Party Confidential Records, the Commission will notify the Affected Party in writing of the request and identify the party making the request and the Third Party Confidential Records sought.

6.2.2 Within ten (10) days of receipt of the notice required by Rule 6.1.1, the Affected Party shall advise the Commission in writing whether it opposes the disclosure of the Third Party Confidential Records. If the Commission is not so notified, it will produce the Third Party Confidential Records.

6.2.3 If the Affected Party timely objects to the production of the Third Party Confidential Records, the Affected Party shall provide in writing, at the time of notifying the Commission of its objection, information sufficient to justify a claim of confidentiality under FOIA. Such information shall include, but not be limited to, the following:

6.2.3.1 Any measures taken by the Affected Party to guard against disclosure of the Third Party Confidential Records;

6.2.3.2 Whether the Third Party Confidential Records have been intentionally or inadvertently disclosed since their submission to the Commission and any actions or precautions taken in connection with such disclosure; and

6.2.3.3 Whether the disclosure of the Third Party Confidential Records would result in substantial or harmful effects on the Affected Party's commercial or financial interests, and if so:

6.2.3.3.1 what those harmful effects would be;

6.2.3.3.2 why the effects should be viewed as substantial; and

6.2.3.3.3 how the disclosure would cause such harmful effects.

6.2.4 The Affected Party bears the burden of establishing confidentiality under FOIA. A unilateral assertion that records are confidential or otherwise not subject to a FOIA request is insufficient to support a finding that requested information is in fact non-public.

6.2.5 Within a reasonable time after receiving the Affected Party's response filed pursuant to 6.1.3, the Commission shall determine whether the Third Party Confidential Documents should be produced pursuant to FOIA despite the Affected Party's claim of confidentiality. Written notice of the Commission's decision shall be provided to the party making the FOIA request and the Affected Party.

7.0 Effective Date

This policy shall become effective immediately.

14 DE Reg. 584 (12/01/10)

STATE EMPLOYEE BENEFITS COMMITTEE

Statutory Authority: 29 Delaware Code, Sections 5210(4) and 9602(b)(4)
(29 **Del.C.** §§5210(4) and 9602(b)(4))
19 **DE Admin. Code** 2001

ORDER

Employees Eligible to Participate in the State Group Health Insurance Program

Eligibility and Enrollment Rules

Effective on January 1, 2012, under the authority of Title 29 of the **Delaware Code**, Section 9602(b)(4), the State Employee Benefits Committee is amending the Eligibility and Enrollment Rules regarding the Employees Eligible to Participate in the State Group Health Insurance Program to read as provided below. These amended rules were prepared by the Statewide Benefits Office and have been approved by the State Employee Benefits Committee with the consent of the State Employee Benefits Advisory Council. The amended rules are effective upon publication in the Register of Regulations in accordance with House Bill 190, Section 31.

2001 Group Health Care Insurance Eligibility and Coverage Rules

(Used to determine who may enroll. See "Cost of Coverage" to determine the amount of State contributions, toward an employee's coverage.)

1.0 Authority

Pursuant to the authority vested in the State Employee Benefits Committee (SEBC) by 29 **Del.C.** §§5210(4), 9602(b)(4), the SEBC adopts these eligibility and coverage rules for the State of Delaware Group Health Insurance Program ("State Plan"). In the event of a conflict between these rules and the Delaware Code, the Delaware Code takes precedence over these rules.

1.1 An Employee or pensioner must meet one of the following definitions to be eligible for coverage under the State's plan:

1.1.1 a permanent full-time employee (regularly scheduled 30 or more hours per week or 130 or more hours per month);

1.1.2 an elected or appointed official as defined by 29 **Del.C.** §5201**;**

1.1.3 a permanent part-time employee (regularly scheduled to work less than 130 hours per month);

1.1.4 a limited term employee (as defined by Merit Rule 10.1);

1.1.5 a pensioner receiving or eligible to receive a pension from the State;

1.1.6 a per diem or contractual employee of the Delaware General Assembly who has been continuously employed for 5 years.

1.1.7 a temporary employee (regularly scheduled 30 or more hours per week or 130 or more hours per month) as defined by 29 **Del.C.** §5207.

1.2 Those employees who meet the definition outlined in rule 1.1.1, 1.1.2, 1.1.4 and 1.1.5 are considered "regular officers and employees", or "eligible pensioners" as provided by 29 **Del.C.** §5202 and are to receive State Share contributions.

1.3 Short term disability beneficiaries receiving benefits under 29 **Del.C.** §5253(b) will be treated as "regular officers and employees" under these regulations. Long term disability beneficiaries receiving benefits under 29 **Del.C.** §5253(c) will be treated as "eligible pensioners" under these regulations.

1.4 Casual and seasonal and substitutes are not eligible for the State Plan.

1.5 Newly employed school teachers become eligible employees when they start employment not when they sign their contract. (Review the Eligibility Table, see Appendix "A", for coverage start date dependent upon the September hire date). Temporary teachers who are re hired in September are eligible to elect coverage when re hired. Temporary teachers who are re hired in the next contract year are eligible to elect coverage when re hired without fulfilling another 3 month waiting period.

1.6 Employees or pensioners who are enrolled in Medicare Part D may not have prescription coverage in the State Plan.

1.7 Enrollment in State plan is not indicative of eligibility to receive State Share contributions.

6 DE Reg. 690 (11/1/02)

12 DE Reg. 986 (01/01/09)

15 DE Reg. 225 (08/01/11)

2.0 Dependents Eligible to Participate

In compliance with the Civil Union and Equality Act of 2011, 13 **Del.C.**, Chapter 2, effective January 1, 2012 at 10 A.M., regular officers, employees, and pensioners who are party to a civil union in the State of Delaware shall be included in any definition or use of the terms "dependent", "family", "husband and wife", "immediate family", "next of kin", "spouse", "stepparent", "tenants by the entirety", and other terms whether or not gender-specific, that denote a spousal relationship or a person in a spousal relationship as they appear in the Groups Health Eligibility and Enrollment Rules. The same proof of relation required of "dependent", "family", "husband and wife", "immediate family", "next of kin", "spouse", "stepparent", "tenants by the entirety", will be required of employees and pensioners who are party to a civil union.

The Spousal Coordination of Benefits Policy will apply to parties to a civil union or same-sex marriage performed in other jurisdictions as recognized by Delaware law.

2.1 Dependents must meet one of the following definitions to be eligible for enrollment in the State plan:

2.1.1 A regular officer's or employee's or eligible pensioner's:

2.1.1.1 legal spouse or civil union partner (Delaware law does not recognize common law ~~or same sex~~ marriage.) Ex-spouses and ex-civil union partners may not be enrolled in the State's ~~group health insurance program~~ Plan - even if a divorce decree, dissolution decree, settlement agreement or other document requires an employee or pensioner to provide coverage for an ex-spouse or ex-civil union partner;

IMPORTANT NOTE: Spousal Coordination of Benefits Policy has been in effect since 1/1/93 and revised 7-1-11. The policy applies to a spouse who is eligible for health coverage through his/ her own employer or former employer (when spouse is retired). Spouses who work full-time or who are retired and are eligible for health coverage through their current

or former employer, but do not enroll under ~~their~~ that employer's health plan, will have a reduction in benefits under the State Plan. A new Spousal Coordination of Benefits form must be completed each year during Open Enrollment or anytime throughout the year ~~if~~ the spouse's employment or insurance status changes. ~~Employees should refer to the Statewide Benefits Office's website at http://ben.omb.delaware.gov/documents/cob/index.shtm or individual benefit booklets for each plan for more detailed information.~~ Information on the Spousal Coordination of Benefits Policy, form and a Summary Plan Description (SPD) for each health care plan is available on the Statewide Benefit Office's website at http://ben.omb.delaware.gov/

2.1.1.2 child/ren under age 26 born to or legally adopted or lawfully placed for adoption by a regular officer's, or employee or eligible pensioner or a regular officer or employee's or pensioner's legal spouse;

2.1.1.3 child/ren who do not meet the requirements of section 2.1.1.2 above, who is unmarried, under age 19 (age 24 if a full time student), residing with a regular officer or employee or eligible pensioner in a regular parent child relationship, and who is dependent upon the regular officer or employee or eligible pensioner for at least fifty (50) percent support, and who would be considered the regular officer's or employee's or pensioner's "dependent" under Section 105(b) of the Internal Revenue Code. A statement of support form must be completed by the regular officer or employee or eligible pensioner and forwarded to the employee's Benefit Representative or Human Resources Office with the request for coverage together with a copy of the legal guardianship, permanent guardianship or custody order for the dependent child. If a natural parent resides in the same household as the insured regular officer or employee or eligible pensioner, it will be deemed that a regular parent-child relationship does not exist unless the regular officer or employee or eligible pensioner has legal guardianship documents or has legally adopted the dependent child.

2.1.1.4 unmarried dependent child/ren who meet the criteria of section~~s~~ 2.1.1.2 above, but who is age 26 or older and incapable of self-support because of a mental or physical disability which existed before the child reached age 26. The child/ren must have been covered under employee's contract immediately preceding age 26.

2.1.1.5 unmarried dependent child/ren who meet the criteria of section (c) above, but who is age 19 (age 24 if full-time student) or older and incapable of self-support because of a mental or physical disability which existed before the child reached age 19 (age 24 if full-time student). The child/ren must have been covered under employee's contract immediately preceding age 19 (age 24 if full-time student).

IMPORTANT NOTES: The Administration of Dependent Coverage to Age 26 policy became effective July 1, 2011 and provides for coverage of adult dependents until age 26 under the State Plan. As a "grandfathered" health care plan, the State Plan shall exclude adult dependents who are eligible to enroll in an employer-sponsored plan available through the adult dependent's employer until the plan year beginning July 1, 2014. The Adult Dependent Coordination of Benefits form must be completed by the regular officer, employee, or eligible pensioner on an annual basis at Open Enrollment or anytime throughout the year that the adult dependent's employment or health care status changes, except if enrolled in one of the non-grandfathered Consumer-Directed Health Plans.

A separate Dependent Coordination of Benefits (child/ren) form must be completed for each enrolled dependent regardless of age upon enrollment, any time coverage changes, or upon request by the Statewide Benefits Office to determine if the dependent is covered by any other health plan.

2.2 Eligible dependent child/ren covered under the health insurance plans of both parents will be primary to the parent's plan whose birthday is the first to occur during the calendar year. In the event the parents' birth dates are the same, the dependent child will be primary to the parent with the longest employment service. In the event birth dates and length of service are the same, the dependent child will be primary to the ~~male parent's plan~~ mutual choice of the parents.

2.3 Employing agencies shall maintain files that include such documents as SEBC determines appropriate to administer the State Plan; files shall be subject to audit by the SEBC.

6 DE Reg. 690 (11/1/02)

12 DE Reg. 986 (01/01/09)

15 DE Reg. 225 (08/01/11)

3.0 Coverage

3.1 Coverage of an eligible regular officer or employee and his/her eligible dependents will become effective on the first of the month following date of hire provided the employee submits a signed application within 30 days of the employee's date of hire or within 30 days of the employee becoming eligible for the State Share. Refer to Eligibility Table for specific coverage date options for employees who elect coverage when eligible for State Share.

3.1.1 Coverage may become effective on date of hire provided the employee submits a signed application within 30 days of the employee's date of hire. Premiums are not pro-rated.

IMPORTANT NOTES: Spousal Coordination of Benefits Policy became effective 1/1/93 and revised 7/1/11 for a spouse who is eligible for health coverage through his or her own employer or former employer when spouse is retired. Spouses who work full time and are eligible for health coverage through their employer or spouses who are retired and eligible for health coverage through their former employer, but do not enroll under their former employer's health plan, will have a reduction in benefits under the State Plan. ~~Employees should refer to the individual benefit booklets for each plan for more detailed information or see http://ben.omb.delaware.gov/documents/cob/index.shtml.~~ Information on the Spousal Coordination of Benefits Policy, form and a Summary Plan Description (SPD) for each health care plan is available on the Statewide Benefit Office's website at http://ben.omb.delaware.gov/

Adult Dependent Coordination of Benefits form must be completed for each enrolled adult dependent between ages of 21 to 26 upon enrollment, any time coverage changes, or upon request by the Statewide Benefits Office, except if enrolled in a Consumer-Directed Health Plan.

A separate Dependent Coordination of Benefits (child/ren) form must be completed for each enrolled dependent regardless of age upon enrollment, any time coverage changes, or upon request by the Statewide Benefits Office to determine if the dependent is covered by any other health plan.

3.2 Employees of the State of Delaware who are enrolled in a health insurance benefit plan must re-enroll in a plan of their choice during the Open Enrollment period as determined by the SEBC. Should such employee(s) neglect to re-enroll in the allotted time, said employee/s and any spouse or dependents shall be automatically re-enrolled in their previous plan as long as verification of employment is provided by the employee and the Statewide Benefits Office.

3.3 Employees or pensioners who cover their spouse on the State Plan must complete a Spousal Coordination of Benefits Policy Form during each annual Open Enrollment period as well as anytime there is a change in the spouse's employment or an insurance status change. Failure to supply the Spousal Coordination of Benefits form shall result in the spouse's medical claims being ~~reduced to 20 percent and inability to have prescriptions filled~~ sanctioned, which reduces health care claims to be processed at 20 percent with the remainder becoming the responsibiity of the employee or pensioner; prescriptions must be paid in full at the pharmacy and a claim submitted to the State's pharmacy benefit manager to be reimbursed at the allowable charge (20 percent minus the applicable copay).

3.4 If an employee elects not to enroll in the State Plan, the employee must complete and sign an application/enrollment form acknowledging the desire not to enroll by noting "waive" on the appropriate form.

3.5 Eligible employees who fail to submit a completed and signed application/enrollment form within 30 days of their date of hire or their date of eligibility for State Share may not join the State Plan until the next open enrollment period (usually May), unless the employee meets the requirements of Eligibility and Enrollment Rule 3.6.

3.6 Pursuant to a federal law, Health Insurance Portability and Accountability Act (HIPAA), if an employee declines enrollment for him or herself or their dependent/s (including the spouse) because of other

health insurance coverage and later involuntarily loses the coverage, the State employee and/or spouse may be eligible to join the State Plan, without waiting for the next Open Enrollment period, as long as the request to enroll is made within 30 days of the loss of coverage. Necessary forms must be completed within 30 days of the request to enroll. If such a change is not made in the time period specified, the eligible employee/and or spouse must wait until the next Open Enrollment period.

3.6.1 The following list includes examples of loss of coverage or loss of eligibility for coverage rules under which an employee may request enrollment for him/her-self and for dependent/s:

- Loss of eligibility for coverage as a result of legal separation, divorce, death, termination of employment or reduction in the hours of employment;
- Loss of eligibility for coverage provided through a Health Maintenance Organization (HMO) because the individual no longer resides, lives, or works in an HMO service area (regardless of whether the choice of the individual) and no other benefit package is available to the individual;
- Loss of eligibility for coverage due to the cessation of dependent status;
- Loss of coverage because an individual incurs a claim that meets or exceeds a lifetime limit on all benefits under the plan;
- A plan discontinues a benefit package option and no other option is offered;
- If the employer ceases making contributions toward the employee's or dependent's coverage, the employee or dependent will be deemed to have lost coverage and does not need to drop coverage to have special enrollment rights;
- Exhaustion of Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage, except that an employee/dependent losing coverage under another plan is not required to elect COBRA under that plan before using their special enrollment rights to enroll with the State.

3.6.2 An increase in employee contribution, change of benefits or change of carrier of the spouse's plan shall not constitute loss of coverage, except where the other plan terminates employer contributions. Employees should contact their Benefit Representative or Human Resources Office and pensioners should contact Pension Office to ask specific questions about eligibility.

3.7 If an employee declines enrollment for him/her-self or his/her dependents (including the spouse) and later has a new dependent as a result of marriage, birth, adoption, or placement for adoption, the employee may be able to enroll him/her-self and his/her dependents provided that he/she request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Necessary forms must be completed within 30 days of the request to enroll.

3.8 The eligible employee who is currently enrolled in a group health plan, may change his/her benefit plan upon the dependent's involuntary loss of coverage, pursuant to Eligibility and Enrollment Rule 3.06, and addition to the State's Plan, provided the request for enrollment is made within 30 days of the loss of dependent's coverage and necessary form must be completed within 30 days of the request. In addition, if the employee has a new dependent as a result of marriage, birth, adoption, or placement for adoption, the employee may change his/her benefit plan upon the addition of the dependent to the State Plan provided the request for enrollment is made within 30 days after the marriage, birth, adoption, or placement for adoption and the necessary paperwork is completed within 30 days of the request.

3.9 ~~When husband and wife are eligible State employees, the two employees, or each eligible pensioner, and all eligible dependents may elect to enroll under one family contract. When the employees are both active, and an employee and spouse or family contract is chosen, the spouse whose birthday occurs earlier in the calendar year shall sign an application for coverage form requesting coverage. A change of agency is considered re-enrollment. (In the event the birth dates are the same, length of service and/or gender will be applied as described in Eligibility and Enrollment Rule 2.2.) Beginning with the effective date of these rules, State Share contributions for all new enrollments will be charged to the agency or organization whose employee enrolls for employee, employee and spouse, employee and child/ren or family coverage. Enrollments prior to February 1990 shall continue to be charged to the agency or organization as was previously determined.~~

When two active eligible regular officers, employees, or pensioners and all eligible dependents elect to be covered under “employee and spouse” or one “family” contract then the spouse whose birthday occurs earlier in the calendar year shall sign an application for coverage form requesting coverage. A

change of agency is considered re-enrollment. (In the event the birth dates are the same, length of service, and mutual choice of parents will be applied as described in Eligibility and Enrollment Rule 2.02). Beginning with the effective date, May 2003, of these rules, State Share contributions for all new enrollment will be charged to the agency or organization whose employee enrolls for employee, employee and spouse, employee and children or family coverage. Enrollment prior to February 1990 shall continue to be charged to the agency or organization as was previously determined.

Each eligible regular officer, employee, or pensioner may elect to enroll under a separate contract, but no regular officer or employee or eligible pensioner may be enrolled more than once under the State Plan. Eligible dependents may be enrolled under either contract, but no dependent shall be enrolled more than once under the State Plan.

The increment of cost of the contracts selected by the two regular officers or employees, or eligible pensioners who were hired and married on or before December 31, 2011, which exceeds the cost of two First State Basic family plans, shall be deducted by the Director of the Office of Management and Budget (OMB) from salary, pension, or disability payment or checks through June 30, 2012. Effective July 1, 2012, a charge of $25 per contract per month, or the employee premium associated with the contract (whichever is less in the event one of the plans is an employee only plan) will be assessed to each contract chosen by the husband and wife who were married and active eligible regular officers, employees, or pensioners prior to December 31, 2011.

Any regular officer, employee, and pensioner who marries or whose civil union is legal with another regular officer, employee, or pensioner on or after January 1, 2012, shall pay the applicable employee premium associated with the chosen contract/s.

~~3.9.1 Each regular officer or employee or each eligible pensioner may elect to enroll under a separate contract, but no regular officer or employee or eligible pensioner may be enrolled more than once under the State plan. Eligible dependent/s may be enrolled under either contract, but no dependent shall be enrolled more than once under the State Plan.~~

~~3.9.2 The increment of cost of the options selected by the two regular officers or employees or eligible pensioners, which exceeds the cost of two First State Basic family plans, shall be deducted by the Director of the Office of Management and Budget (OMB) from salary, pension or disability payments or checks.~~

3.10 When the spouse of an eligible regular officer or employee is a retired State of Delaware employee receiving a pension, and enrolled under separate individual contracts, the employing agency and the Pension Office will carry the coverage for their respective employee/pensioner. If an Employee & Spouse, or a Family contract is chosen, the coverage will continue to be carried through the active employee's agency until such time that the Pensioner turns 65. The over age 65 spouse may continue to have the State Plan as primary payor of benefits with the contract to continue under the active employee's agency, or the spouse may choose Medicare as the primary payor through the Pension Office. Also see Eligibility and Enrollment Rules 4.8 and 4/12.

6 DE Reg. 690 (11/1/02)

12 DE Reg. 986 (01/01/09)

13 DE Reg. 126 (07/01/09)

15 DE Reg. 225 (08/01/11)

4.0 Changes In Coverage

4.1 An eligible employee who elects to be covered on his/her EMPLOYMENT COVERAGE DATE may change coverage when the employee first becomes eligible for the State Share payment. (Examples: (1) An employee who at hire enrolls in the "First State Basic" plan may change to "Comprehensive PPO" (or another optional coverage) when beginning State Share contribution, without waiting for the next open enrollment period. (2) An employee who at hire enrolls for "Employee" coverage may change to "Employee and Child/ren", "Employee and Spouse", or "Family" coverage when he/she begins to receive State Share, without waiting for the next open enrollment period.

4.2 When a covered regular officer or employee or eligible pensioner marries, ~~coverage for the spouse will become effective on the date of marriage, or first of the month following the date of marriage provided the regular officer or employee or eligible pensioner requests enrollment of the new spouse within 30 days of the date of the marriage and provides the necessary paperwork within 30 days of the request to enroll. A copy of valid marriage license must be provided. (Delaware law does not recognize common law or same sex marriage). Premiums are paid on a monthly basis and not pro rated; therefore, if a regular officer or employee or eligible pensioner adds the new spouse effective the date of the marriage, the regular officer or employee or eligible pensioner must remit the difference in employee contribution for the entire month. The regular officer or employee or eligible pensioner may submit a signed application within thirty (30) days prior to the date of marriage. If a request to enroll is not made within 30 days after the marriage, a covered regular officer or employee or eligible pensioner must wait until the next open enrollment period to add the spouse. A Spousal Coordination of Benefits Policy form must be completed when adding spouse to coverage~~ or enters into a civil union, coverage for the spouse or civil union partner will become effective on the date of marriage or civil union, or first of the month following the date of marriage or civil union provided the regular officer, employee, or eligible pensioner requests enrollment of the new spouse or civil union partner within 30 days of the date of the marriage or civil union and provides the necessary paperwork within 30 days of the request to enroll. A copy of valid marriage license or civil union certificate must be provided. (Delaware law does not recognize common law marriage.) A Spousal Coordination of Benefits Policy form must be completed when adding a spouse or civil union partner to coverage. The Spousal Coordination of Benefits Policy form must be completed on-line (a copy of certification should be printed and provided to your Benefits Representative/HR Office.

4.3 Coverage for a child/ren born to a regular officer or employee or eligible pensioner or legal spouse who is covered under the State Plan will begin on the date of birth provided a request to enroll the child is made within 30 days of the date of birth and provided the necessary paperwork is received within 30 days of the request to enroll. A copy of a valid birth certificate must be provided. Premiums are paid on a monthly basis and not pro rated. If such a change is not made in the time period specified, a covered employee must wait until the next Open Enrollment period to add the child/ren. For an employee who has an existing Employee and Child, or Family type contract, the 30 day time period does not apply. However, the application to add the newborn child/ren must be made within a reasonable time period and copy of valid birth certificate provided.

IMPORTANT NOTES: Adult Dependent Coordination of Benefits form must be completed for each enrolled adult dependent between ages of 21 to 26 upon enrollment, any time coverage changes, or upon request by the Statewide Benefits Office, except if enrolled in a Consumer-Directed Health Plan.

A separate Dependent Coordination of Benefits (child/ren) form must be completed for each enrolled dependent regardless of age upon enrollment, any time coverage changes, or upon request by the Statewide Benefits Office to determine if the dependent is covered by any other health plan.

4.4 Coverage for a child/ren legally adopted or placed for adoption with a regular officer or employee or eligible pensioner or legal spouse who is covered under the State Plan will begin on the date of adoption or placement for adoption provided a request to enroll for the child/ren is made within 30 days of the date of adoption or placement for adoption and provides the necessary paperwork within 30 days of the request to enroll.

4.4.1 A copy of a valid legal document attesting to the adoption or placement for adoption must be provided. Premiums are paid on a monthly basis and not pro rated. If such a change is not made in the time period specified, a covered employee must wait until the next Open Enrollment period to add the child. For an employee who has an existing Employee and Child/ren, or Family type contract, the 30 day time period does not apply. However, the application to add the newly adopted child must be made within a reasonable time period.

4.5 Coverage for an eligible dependent, other than a newborn child/ren, who becomes an eligible dependent after the employee has been enrolled, becomes covered on the first day of the month following eligibility provided the regular officer or employee or eligible pensioner requests enrollment within 30 days of eligible status. The necessary paperwork must be completed within 30 days of the

request for enrollment. A copy of valid documentation of dependent status must be provided, i.e. legal guardianship, permanent guardianship, custody order. Applicable premiums must be paid.

4.6 An employee who transfers to another agency or school district may change his/her plan and coverage without waiting until the next Open Enrollment period if the transfer impacts the employee contribution to health benefits provided the employee makes the required change within 30 days of the transfer.

4.7 Changes in coverage can only be made at the annual Open Enrollment period, except:

4.7.1 A regular officer or employee or eligible pensioner is making a change due a qualifying event or Special Enrollment Right as previously outlined in Eligibility and Enrollment Rules 3.6 through 3.8;

4.7.2 In the case of divorce, if there is a "qualifying event" under Eligibility and Enrollment Rules 3.6 through 3.8, the regular officer or employee or eligible pensioner's coverage status may change, but the plan cannot unless Double State Share (DSS) is applicable;

4.7.3 The spouse of a regular officer or employee or eligible pensioner has become a State of Delaware employee entitled to State Share in which case the plan may be changed if an Employee and Spouse or Family contract is chosen;

4.7.4 A regular officer or employee or eligible pensioner may change coverage and/or plan if no longer entitled to DSS, provided application is made within 30 calendar days of the qualifying event; or

4.7.5 A regular officer or employee or eligible pensioner electing to drop health coverage or drop one or more dependents (including the spouse of such regular officer, employee, or eligible pensioner) from health coverage may drop coverage of dependents, under the following limited circumstances as per Section 125 of the Internal Revenue Service Code:

"1. Change in status.

(i) Due to death of spouse.

(ii) Due to changes in employment status of the employee, the employee's spouse or dependent (e.g., commencement of employment, change of worksite or return from an unpaid leave of absence).

(iii) Change in the eligibility conditions for coverage under the spouse's or dependent's employer's plan.

(iv) Events that cause the employee's dependent to cease to satisfy the plan's eligibility requirements. (e.g. age, student status or similar circumstance).

(v) Change in the place of residence of the employee, spouse or dependent provided that in each of the circumstances described in subparagraphs (i) through (v), inclusive, the cessation of coverage for the dependent is on account of and corresponds with a change in status that affects eligibility for coverage under the plan.

2. Judicial Order, Decree, or Judgment. Health coverage for one or more of dependent children may be dropped if a judicial order, decree, or judgment permits the cancellation of dependent child coverage, provided that the spouse, former spouse or another individual is required to cover such child and such coverage is in fact provided.

3. Medicare or Medicaid Eligibility. If an employee, spouse, or dependent who is enrolled in an accident or health plan of the employer becomes entitled to coverage (i.e., becomes enrolled) under Part A or Part B of Title XVII of the Social Security Act (Medicare) (Public Law 89-97 (79 Stat. 291) or Title XIX of the Social Security Act (Medicaid) (Public Law 89-97 (79 Stat. 343), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines), the regular officer, employee or eligible pensioner may for themselves or for their dependents make a prospective election change to cancel or reduce coverage of that employee or dependent under the health plan.

4. Change in Costs or Coverage. If the cost charged to an employee for health coverage significantly increases during a period of coverage, the regular officer, employee or eligible pensioner may make a corresponding change in election under the plan, including commencing participation in an option with a decrease in cost, or, in the case of an increase in cost, revoking an election for that coverage and, in lieu thereof, either receiving on a prospective basis coverage under another benefit package

option providing similar coverage or dropping coverage if no other health plan option providing similar coverage is available. (For purposes of this paragraph, a cost increase or decrease refers to an increase or decrease in the amount of the elective contributions under the cafeteria plan, whether that increase or decrease results from an action taken by the employee (such as switching between full-time and part-time status) or from an action taken by an employer (such as reducing the amount of employer contributions for a class of employees)."

4.8 An eligible regular officer or employee or a legal spouse (eligible to receive State Share) who reaches age 65 and becomes eligible for Medicare shall continue to be covered under the State Plan as the primary payor of benefits.

4.8.1 Regular officers or employees and dependents eligible for Medicare, by reason of age or disability, must apply for Medicare Part A when first eligible regardless of their coverage under the State Plan. Also see Eligibility and Enrollment Rule 3.10.

4.8.2 If an employee or dependent covered under the State Plan becomes eligible for Medicare Parts A and B due to End Stage Renal Disease (ESRD), the covered individual must enroll in Medicare Parts A and B and these plans will be primary to the State Plan for the period of time as outlined in the Medicare guidelines. Employees with ESRD should contact their State Plan insurance carrier to discuss coverage options.

4.9 An employee who becomes eligible for pension or Long-Term Disability (LTD) may change their plan at the onset of receiving pension or LTD.

4.10 A regular officer or employee or eligible pensioner who is required by Court or Administrative Order to provide health insurance coverage for a child/ren shall be permitted to enroll under family or employee and child/ren coverage, any child/ren who is eligible for such coverage (without regard to any Open Enrollment restriction). If the employee is enrolled, but fails to make application to obtain coverage of the child/ren, the child/ren shall be enrolled under such family or employee and child/ren coverage upon application by the child/ren's other parent, the Division of Child Support Enforcement or Division of Social Services. The employee shall not disenroll (or eliminate coverage of) any child/ren unless the employer is provided satisfactory written evidence that:

4.10.1 The Court or Administrative Order is no longer in effect, or

4.10.2 The child/ren is or will be enrolled in comparable health coverage, which will take effect no later than the effective date of such disenrollment.

4.11 When a covered regular officer or employee or eligible pensioner divorces, coverage for the ex spouse will terminate on the day following the date of divorce. Premiums are paid on a monthly basis and not prorated. The regular officer or employee or eligible pensioner must remit the employee contribution for the plan, which included the spouse for the entire month. The regular officer or employee or eligible pensioner must submit a signed application within 30 days prior to or 30 days following the date of divorce. If DSS terminates as a result of the divorce, the regular officer or employee or eligible pensioner must pay the employee contribution for the entire month that the divorce occurred.

4.12 Pensioners and dependents eligible for Medicare, by reason of age or disability, must also enroll in Medicare Part A and B when first eligible for these plans and may enroll in the Medicare Supplement plan provided by the State Group Health Plan through the Pension Office. No pensioner or their dependent eligible for Medicare, by reason of age or disability, may be enrolled in a non-Medicare plan through the State. Also see Eligibility and Enrollment Rule 3.10.

6 DE Reg. 690 (11/1/02)

12 DE Reg. 986 (01/01/09)

13 DE Reg. 126 (07/01/09)

15 DE Reg. 225 (08/01/11)

5.0 Cost Of Coverage

(Used to determine the amount of State Share contributed toward an employee's coverage and the amount of employee contributions required, if any.)

5.1 "Regular officers and employees" begin earning State Share contributions on the first of the month following three full months of employment. See Eligibility Table for specific information regarding State Share payments and employee payroll deductions for employees who elect coverage when eligible for State Share.

5.2 Permanent part-time, temporary per diem and contractual employees of the General Assembly as described in Eligibility and Enrollment Rule 1.01 are eligible to participate in the State Plan, but are not eligible for State Share. Therefore, any such employee joining the State Plan must pay the full cost of the health plan selected. Payment must be collected by the organization and forwarded to the Statewide Benefits Office by the first day of the month for which the employee's coverage becomes effective.

5.2.1 If an existing full time state employee takes a limited term position, State Share shall continue.

5.2.2 Casual and seasonal employees and substitutes are not eligible to participate in the State Plan, nor are they eligible for State Share.

5.3 When a husband and wife are both permanent full time active employees or pensioners employed and married on or before December 31, 2011, they shall earn State Share contributions in accordance with the following as of July 1, 2012:

5.3.1 If they elect to enroll in two ~~individual~~ separate contracts, ~~the increment of cost of the options selected by the two employees which exceeds the cost of two First State Basic family plans, shall be deducted by OMB from salary, pension or disability payments~~ a charge of $25 per each contract per month, or the employee premium associated with the contract (whichever is less), will be assessed to each contract chosen by the individuals and deducted by OMB from salary, pension, or disability check.

5.3.2 If they elect to enroll in one employee and spouse or family contract, ~~the increment of cost of the option selected by the employee that exceeds the cost of two First State Basic family plans, shall be deducted by OMB from salary, pension or disability payments~~ one charge of $25 per contract per month shall be deducted by OMB from salary, pension, or disability payments. If a husband and wife who are both permanent full-time active employees or pensioners and married to each other on or before December 31, 2011 leave State Service, on authorized unpaid leave of absence (no longer eligible for State Share), or stop collecting a pension, on or after January 1, 2012, they will be eligible to earn State Share as indicated above if they return or are permanent full-time active employees or pensioners at a future date as long as they are married to the same spouse who is also a regular officer or employee or pensioner.

5.4 When the spouse of an eligible employee is a retired State of Delaware employee receiving a monthly pension or a Disability Insurance Program (DIP) LTD beneficiary receiving an LTD check~~, each may enroll as two individual contracts, employee and spouse contract or a family contract. The increment of cost of the option selected by the employee that exceeds the cost of two First State Basic family plans, shall be deducted by OMB from salary, pension or disability payments. (A notation should be made in the employee's file that the spouse is a State of Delaware Pensioner or DIP LTD beneficiary). The Pension Office should be notified when the active employee terminates State Service~~ on or before December 31, 2011 each may enroll as two separate contracts, employee, and spouse contract or a family contract. The increment of cost of the option selected by the employee that exceeds the cost of two First State Basic family plans, shall be deducted by OMB from salary, pension or disability payments until June 30, 2012. (A notation should be made in the employee's file that the spouse is a State of Delaware pensioner or DIP LTD beneficiary). The Pension Office should be notified when the active employee terminates State Service. Effective July 1, 2012 a charge of $25 per contract per month, or the employee premium associated with the contract (whichever is less in the event one of the plans is an employee only plan) will be assessed to each contract chosen by the husband and wife who were married and active eligible regular officers, employees, or pensioners prior to December 30, 2011.

5.5 An eligible employee who elects to be covered prior to becoming eligible for State Share must pay the full cost of coverage, State Share and employee share, until State Share begins.

5.6 If a regular officer, employee, eligible pensioner, or beneficiary selects coverage under any plan other than the First State Basic Plan, the employee is responsible for paying the additional cost, if any, over and above the cost of the same coverage class (individual, employee & child, employee & spouse, or family) under the First State Basic plan.

5.7 A regular officer or employee or eligible pensioner who is eligible for the State Share contribution may not receive the cash equivalent in lieu of the coverage itself.

5.8 Health coverage premiums are collected on a lag basis. (Example: January coverage is paid by deduction in the second pay of January plus deduction in the first pay of February). Each agency/ school district/sub group is responsible for reconciling premiums to ensure that proper payment has been remitted. Payments, other than those made through OMB's automated payroll system, and all adjustments must be submitted in a timely manner to the Statewide Benefits Office. The State Plan will not be responsible for payment of premiums and/or claims if a signed enrollment form/confirmation statement/waiver is not in the employee file.

5.9 An eligible employee who returns from an authorized unpaid leave of absence is entitled to State Share payments upon return without fulfilling another three month waiting period. The employee must request enrollment by contacting their Human Resources Office within 30 days of return from leave of absence. State Share and coverage (if it has lapsed) begin on the date of return from leave of absence.

5.10 Any regular officer or employee or eligible pensioner who fails to make payment for his/her share of the cost of health coverage when he/she is eligible to continue coverage and does not have sufficient salary from which payment can be deducted will have coverage canceled on the first day of the month that a regular officer or employee or eligible pensioner fails to pay the required share for the coverage selected.

5.10.1 Family and Medical Leave Act (FMLA) regulations provide that employees have a 30 day grace period for late premium payments. The employer's obligation to maintain health coverage ceases if an employee's premium payment is more than 30 days late. Benefit Representative or Human Resources Offices should continue the employee's health coverage for the 30 day period provided under FMLA. The Benefit Representative or Human Resources Offices can then do a retroactive cancellation if the required employee contribution was not paid by the end of the 30 day grace period.

5.11 An employee who has a break in active employment due to authorized leave of absence, suspension, termination or unauthorized leave of absence without pay for a full calendar month, shall not be eligible for State Share for that calendar month and any subsequent calendar month that the employee is in a non pay status for the entire calendar month. In the case of an authorized leave of absence, an intermittent return to work or use of paid leave of less than five full days in one month, the employee shall not be entitled to State Share contributions. Full payment must be made for the month in order to retain coverage. Upon return, the employee is eligible for State Share without fulfilling another three month waiting period, provided the break was the result of any of the following:

5.11.1 an authorized leave of absence;

5.11.2 a suspension without pay;

5.11.3 termination or unauthorized leave of absence for a period less than 30 calendar days.

Coverage begins on the date of employee's return to work.

A LTD recipient whose LTD benefits have terminated and who returns to active employment with the State as a regular officer or employee is entitled to State Share without fulfilling a three month waiting period provided the return to work was less than 30 days after the last day of their LTD benefits. If the time period between the termination of LTD benefits and return to work is 30 days or more, a three month waiting period will apply.

5.12 State Share will be paid for employees drawing Workers' Compensation, provided the employee is not eligible for coverage from a subsequent employer. Such an employee must submit payment for the share of the coverage that would normally be deducted from his/her salary.

5.13 State Share will be paid for employees who are approved for Short Term and/or Long Term Disability through the State's DIP.

5.13.1 Employee's share of premium shall be deducted by OMB from employee's salary or DIP LTD check.

5.13.2 Employees whose STD claims are in a pending status are entitled to receive State Share. If STD claim is denied, the employee is responsible for the State Share paid on his/her behalf while the claim was in a pending status.

5.13.3. Employees who are appealing a STD termination and/or benefit denial are eligible to receive State Share. If the appeal results in a denial, the employee is responsible for the State Share paid on his/her behalf while the claim was in a pending appeal status.

5.14 Any refund of State Share or employee share is subject to the following requirements:

5.14.1 An employee who has paid the State Share in order to insure continuation of health coverage and then later is found to have been eligible for receipt of State Share, is to be refunded the amount that was not paid by the State. The employee must make application for the refund within one calendar year of the date the employee paid the State Share to be refunded;

5.14.2 An employee who has paid the employee share then later is found to have been eligible for receipt of DSS is to be refunded the amount paid for employee share for a period not to exceed one calendar year. The employee seeking a refund must make application for the refund within one year of the date the employee paid the employee share to be refunded;

5.14.3 An employee who has paid the employee share for an ineligible dependent (for example following a divorce, death or exceeding the dependent age limits) is to be refunded the amount paid for employee share for a period not to exceed 60 days, provided that the employee seeking a refund must make application for the refund within 60 days of the date the employee paid the employee share to be refunded and further that the employee shall be liable for any amounts paid by the State Plan on behalf of the ineligible dependent until the employee provides notice to the Statewide Benefits Office of the dependent's ineligibility;

5.14.4 If an employee is terminated from employment and does not pay the employee share for the second half of the month in which terminated, coverage under the Plan is terminated as of the first of the month, any claims paid for that month will be reversed and a refund will be given, if employee makes request for refund within 60 days.

5.14.5 In any event, refunds of less than $1.00 will not be made.

5.15 Teachers who are granted a sabbatical leave of absence are eligible for State Share while they are on such leave. Also see Eligibility and Enrollment Rule 6.3.

5.16 All employees whose positions are involuntarily terminated after they have been employed for a full calendar year who return to full time State employment within 24 months of their termination will be eligible for State Share without fulfilling another three month qualification period.

5.17 A temporary, casual, seasonal employee, or substitute who becomes a "Regular Officer or Employee" shall have his/her unbroken temporary, casual, seasonal, or limited term, provisional or permanent part time "Aggregate State Service" applied toward the three month qualification period for State Share contributions. The "Aggregate State Service" must immediately precede becoming a "Regular Officer or Employee". The temporary, casual, seasonal employee, or substitute must have worked each pay cycle for the three months prior to hire to be eligible for State Share or last three full months of the school year prior to September hire.

5.18 State Share shall continue for a "Regular Officer or Employee" who is temporarily appointed to a position that results in a dual incumbency.

5.19 ~~Any active employee who is also receiving a survivor's pension through the State of Delaware shall receive DSS. The increment of cost, which exceeds the cost of two First State Basic family plans, shall be deducted from employee's salary.~~ Any regular officer, employee or pensioner who is also receiving a survivor's pension through the State of Delaware is also entitled to State Share for the survivor's pension. The increment of cost of the contract selected by the regular officer or employee or eligible pensioner who is also receiving a survivor's pension, which exceeds the cost of two First State Basic family plans, shall be deducted by the Director of the Office of Management and Budget (OMB) from salary, pension, or disability payment or checks through June 30, 2012. Effective July 1, 2012 a charge of $25 per contract per month, or the employee premium associated with the contract (whichever is

less in the event one of the plans is an employee only plan), will be assessed to the contract chosen by regular officer, employee, or pensioner who is also receiving a survivor's pension.

5.20 A regular officer or employee called to active duty with the National Guard or Reserve for other than training purposes shall continue to receive state share toward health insurance coverage for a period of up to two years. Employee's share must be remitted to Benefit Representative or Human Resources Office for further processing.

5.21 In the event that the State has paid the employee share or any co-pays, coinsurance, deductibles or other amounts that OMB determines should have been paid by the regular officer or employee or covered spouse or dependent of the regular officer or employee upon prior written notice to such regular officer or employee (which shall not be less than sixty (60) days), the State, to the extent permissible under applicable law, may recover such amounts from such regular officer or employee by deducting the amount paid by the State from the after tax pay due to the regular officer or employee

5.21.1 the regular officer or employee shall be provided an opportunity to dispute such amounts owed to the State to the Statewide Benefits Office and

5.21.2 if the amount owed by the regular officer or employee exceeds $1,000 then the regular officer or employee shall be provided an opportunity to have the amount owed deducted in monthly installments over a period of time not less than twelve (12) months.

6 DE Reg. 690 (11/1/02)
12 DE Reg. 986 (01/01/09)
13 DE Reg. 126 (07/01/09)
13 DE Reg. 683 (11/01/09)
15 DE Reg. 225 (08/01/11)

6.0 Continuation Of Coverage

6.1 To continue coverage other than the First State Basic Plan, a covered employee must pay the difference between the State Share contribution and the cost of the coverage selected. Coverage will be terminated on the first day of the month employee did not make required payment.

6.2 An employee granted an unpaid authorized leave of absence can maintain membership in the group health plan by paying the full cost of coverage (State Share plus employee share) during the period of the leave as long as that leave of absence does not exceed two years. An employee who returns from an authorized leave of absence, whether he/she maintains coverage or not while on leave of absence, is authorized to receive State Share immediately upon return. (Eligibility for State Share begins upon return without fulfilling another three month qualification period). An employee on FMLA leave is entitled to have pre existing health insurance benefits (including the State Share) maintained while on an FMLA leave. If an employee was paying State Share and/or employee share of the premium payments prior to leave, the employee would continue to pay the same share during the leave period. Failure to make such payment within 30 days of the due date will result in termination of coverage.

6.3 Coverage other than the First State Basic Plan continues for teachers who are granted sabbatical leave provided they make the required payments for their share of the cost of their coverage; otherwise, their coverage reverts to the First State Basic Plan. (State Share continues while employee is on sabbatical leave.) Also see Eligibility and Enrollment Rule 5.15.

6.4 Employees leaving State employment, except for termination due to gross misconduct or whose application for LTD benefits under the DIP has been approved, are eligible for continuation under COBRA. Employees should contact their Benefits Representative or Human Resources Office for details of this continuation option.

6.5 An eligible employee or eligible dependent that loses coverage under the State Plan may continue coverage under COBRA. If a COBRA qualifying event occurs, the employee or the employee's dependent(s) must notify the employee's Benefit Representative or Human Resources Office or the State's COBRA Administrator to provide notice of the qualifying event within 60 days of its occurrence.

6.6 Upon expiration of the covered individual's COBRA eligibility, the individual may apply directly to the insurance company for a direct billed health insurance contract.

12 DE Reg. 986 (01/01/09)

7.0 Termination Of Coverage

7.1 Coverage ends on the last day of the month in which the employee terminates employment. A public school or higher education employee (less than 12 month employee) whose employment during a school year continues through the last scheduled work day of that school year shall retain coverage through August 31 of the same year so long as the required employee share has been paid. In the event an employee fails to make the required payment for any optional coverage selected, coverage will be terminated. If an employee works one day in the month in which he/she terminates, he/she shall earn State Share for the entire month. Coverage will be terminated on the first day of the month employee did not make required payment.

7.2 Coverage (and dependent coverage, if applicable) ends as of the end of the month in which the employee ceases to be an eligible employee for coverage (due to some change such as a reduction in the number of hours the employee works).

7.3 Coverage of dependents, except for dependents of pensioners and dependents eligible for a survivor's pension, ends as of the last day of the month of the employee's death. Dependents who lose coverage as a result of the employee's death are eligible for continuation under COBRA. Contact the State's COBRA administrator for details of this continuation option.

7.4 Ex spouses not employed by the State of Delaware are not eligible for coverage under the State Plan - even if a divorce decree, settlement agreement or other document requires an employee to provide coverage for an ex spouse. Coverage for the ex spouse will terminate on the day after the date of divorce. Premiums are paid on a monthly basis and not prorated. The regular officer or employee or eligible pensioner must remit the employee share for the plan which included the spouse for the entire month. The regular officer or employee or eligible pensioner must submit a signed application within 30 days prior to or 30 days following the date of divorce. If DSS terminates as a result of the divorce, each regular officer, employee or eligible pensioner must pay the employee contribution for the entire month that the divorce occurred. The State Plan will not be responsible for payment of claims when a dependent is no longer eligible for coverage.

7.5 Coverage for a dependent child/ren will end the earlier of the following:

7.5.1 The end of the month in which the dependent child/ren as defined in Section 2.1.1 attains age 26.

7.5.2 The end of the month in which the dependent child/ren as defined in Section 2.1.2 marries, or attains age 19 (or age 24 if full time student); or

7.5.3 The date the child/ren ceases to be dependent on the regular officer or employee or eligible pensioner for at least fifty (50) percent support per Sections 2.1.1.3, 2.1.1.4 and 2.1.1.5.

7.6 Coverage for a LTD recipient will end as of the end of the month in which their LTD benefits are terminated.

6 DE Reg. 690 (11/1/02)

6 DE Reg. 1515 (5/1/03)

12 DE Reg. 986 (01/01/09)

15 DE Reg. 225 (08/01/11)

8.0 Reinstatement of Coverage

8.1 Once a regular officer or employee or eligible pensioner has requested that his/ her coverage be canceled, he/she cannot rejoin the State Plan until the next annual Open Enrollment period unless such regular officer or employee or eligible pensioner qualifies for re-enrollment under the applicable exceptions to these Eligibility and Enrollment Rules.

8.2 An employee who returns from an authorized leave of absence not exceeding 24 months in duration who does not maintain coverage while on leave of absence, is permitted to enroll immediately upon return without waiting for the next Open Enrollment period, provided the employee requests enrollment within 30 days of return and completes the necessary paperwork required to enroll within 30 days of the request. Coverage will begin as of the date the employee returns from leave following completion

of the necessary paperwork and payment of any required employee share. Premiums are paid on a monthly basis and are not prorated.

8.3 Employees whose positions are involuntarily terminated after they have been employed for a full year (or full school year) will be eligible for State Share immediately if they return to full time State employment within 24 months of termination.

6 DE Reg. 690 (11/1/02)

12 DE Reg. 986 (01/01/09)

9.0 Miscellaneous

9.1 It is the responsibility of the regular officer, employee or eligible pensioner to keep his/her Benefit Representative or Human Resources Office informed of any change of address or change in status which results in the adding or dropping of dependent/s (marriage, divorce, birth, death, adoption, etc.) that affects his/her health care coverage. In turn, it is the responsibility of the Benefit Representative or Human Resources Office to make the necessary changes in the appropriate payroll system, or to notify the Statewide Benefits Office of these changes. Failure to do so may affect eligibility of coverage or extent of coverage for any participant and could impose an extreme hardship on a regular officer or employee or eligible pensioner. The State Plan will not be responsible for payment of premiums and/or claims in the event of ineligibility and/or the absence of a signed enrollment form/confirmation statement in the regular officer or employee or eligible pensioner's file.

9.2 If any provision of these Rules and Regulations or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or application of the Rules and Regulations which can be given effect without the invalid provision or application, to that end the provisions of these Rules and Regulations are declared to be severable

6 DE Reg. 690 (11/1/02)

12 DE Reg. 986 (01/01/09)

13 DE Reg. 126 (07/01/09)

10.0 Dental and Vision Plans

10.1 Employees electing to pay for and receive coverage under one of the Dental and/or Vision Plans should be aware of the following terms:

10.1.1 Dental and Vision Plans are not affected by Double State Share (DSS) ~~and Dental and/or Vision plans cannot be changed upon eligibility for DSS~~;

10.1.2 Employees may enroll in a Dental and/or Vision plan during the first of month after being hired, becoming eligible, or 90 days after the first of the following month after being hired;

10.1.3 The Dental and Vision Plans' effective date is always the first of the month and not on event date as for the health plan;

10.1.4 Dental and Vision Plans' refund rules are limited to 60 days or less because the Dental and Vision Plans are fully insured;

10.1.5 Dental and Vision Plans' term dates are limited to 60 days or less;

10.1.6 Dental and/or Vision Plan will be terminated in the event that employee is 60 days delinquent in payment of Dental and/or Vision Plans' premium and any paid claims in the same period will be reversed;

10.1.7 If an employee is terminated from employment and does not pay the Dental and/or Vision Plans' premium for the second half of the month in which terminated, coverage under the Dental and/or Vision Plans is terminated as of the first of the month, any claims paid for that month will be reversed and a refund will be given, if employee makes request for refund within 60 days;

10.1.8 School district employees (except those of Delaware Technical and Community College) who are offered school district dental and vision coverage are not eligible for coverage under the State Dental or Vision Plans;

10.1.9. Terminations in Dental and/or Vision coverage can only be made during the annual Open Enrollment period, except that a regular officer or employee or eligible pensioner may elect to drop Dental or Vision coverage for one or more dependents within the plan year due to same circumstances as noted in Section 4.7.5.

10.1.10 The employee's election of a Dental and/or Vision plan is binding for the plan year.

10.1.11 An employee on approved leave of absence without pay may waive participation in the Dental and/or Vision Plan. Employee must notify his/her Benefit Representative or Human Resources Office of request as waive must be designated in the appropriate enrollment system. When employee returns to work, participation must be reinstated in the appropriate enrollment system to be effective the first of the month following employee's return to work.

10.1.12 An employee on approved leave of absence without pay may continue to participate in the Dental and/or Vision Plan by making full payment of premium by end of each month or coverage will be terminated. Employee must make payment to Benefit Representative or Human Resources Office for further processing.

12 DE Reg. 986 (01/01/09)

15 DE Reg. 225 (08/01/11)

STATE OF DELAWARE GROUP HEALTH INSURANCE PROGRAM ELIGIBILITY TABLE

Employee Start Date	Coverage Start Date (Employee pays the full cost)	Eligible for State Share
January 2nd through February 1st	February 1st	May 1st
February 2nd through March 1st	March 1st	June 1st
March 2nd through April 1st	April 1st	July 1st
April 2nd through May 1st	May 1st	August 1st
May 2nd through June 1st	June 1st	September 1st
June 2nd through July 1st	July 1st	October 1st
July 2nd through August 1st	August 1st	November 1st
August 2nd through September 1st	September 1st	December 1st
September 2nd though October 1st	October 1st	January 1st
October 2nd through November 1st	November 1st	February 1st
November 2nd through December 1st	December 1st	March 1st
December 2nd through January 1st	January 1st	April 1st

STATE OF DELAWARE
EXECUTIVE DEPARTMENT
DOVER

EXECUTIVE ORDER NUMBER THIRTY-TWO

TO: Heads Of All State Departments And Agencies
RE: Amending Executive Order No. 32 To Allow Additional Time For Work By The Delaware Justice Reinvestment Task Force

WHEREAS, on July 25, 2011, I issued Executive Order No. 27, creating the Delaware Justice Reinvestment Task Force and tasking it with conducting a study of the Delaware criminal justice and correctional system; and

WHEREAS, since its creation, the Task Force has met four times and has held productive discussions concerning how the State might enhance public safety, hold offenders more accountable, improve probation and parole supervision, lower recidivism rates, and reevaluate the factors driving growth in prison expenses; and

WHEREAS, it is the consensus of the Task Force that time for additional meetings and discussions would aid the group in completing its deliberative and rigorous process of evaluating recommendations for legislative and policy changes that might benefit our State;

NOW THEREFORE, I, JACK A. MARKELL, by virtue of the authority vested in me as Governor of the State of Delaware, do hereby ORDER that:

1. aragraph 7 of Executive Order No. 27, issued July 25, 2011, is hereby rescinded.
2. The Task Force shall report its findings and recommendations for policy change and legislative action to the Governor, the Chief Justice of the Supreme Court, the President Pro Tempore of the Senate and the Speaker of the House no later than March 30, 2012.
3. Except as expressly amended herein, Executive Order No. 27 shall remain in effect. This Executive Order shall terminate at the same time and in the same manner as Executive Order No. 27.

APPROVED this 14th day of December, 2011

Jack A. Markell,
Governor

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

Statutory Authority: 31 Delaware Code, Section 512 (31 **Del.C.** §512)

PUBLIC NOTICE

Change To The Reimbursement Methodology For Supported Employment, Day Habilitation and Pre-Vocational Services

In compliance with the State's Administrative Procedures Act (APA - Title 29, Chapter 101 of the **Delaware Code**) and under the authority of Title 31 of the **Delaware Code**, Chapter 5, Section 512 and with 42 CFR §447.205, Delaware Health and Social Services (DHSS) / Division of Medicaid and Medical Assistance (DMMA) is proposing to change the reimbursement methodology for payment of Supported Employment, Day Habilitation and Pre-Vocational Services.

Any person who wishes to make written suggestions, compilations of data, testimony, briefs or other written materials concerning the proposed new regulations must submit same to Sharon L. Summers, Planning & Policy Development Unit, Division of Medicaid and Medical Assistance, 1901 North DuPont Highway, P.O. Box 906, New Castle, Delaware 19720-0906 or by fax to 302-255-4425 by January 31, 2012.

The action concerning the determination of whether to adopt the proposed regulation will be based upon the results of Department and Division staff analysis and the consideration of the comments and written materials filed by other interested persons.

SUMMARY OF PROPOSAL

The proposed is in response to a requirement by the Centers for Medicare and Medicaid Services (CMS) to establish an hourly rate for the reimbursement of Supported Employment, Day Habilitation and Pre-Vocational Services.

Statutory Authority

- Social Security Act §1915, *Provisions Respecting Inapplicability and Waiver of Certain Requirements of this Title*
- 42 CFR §435.217, *Individuals receiving home and community-based services*
- 42 CFR §441, Subpart G, *Home and Community-Based Services Waiver Requirements*

Background

The waiver to provide home and community-based services to developmentally disabled adults was developed by the Division of Developmental Disabilities Services (DDDS) and the Division of Social Services (DSS) in 1982, received approval from the Center for Medicare and Medicaid Services (CMS), and became effective on July 1, 1983. The waiver includes support services necessary to maintain individuals in the community as an alternative to institutionalization. The cost of the Home and Community-Based Services Waiver for the Developmentally Disabled (HCBS/DD) shall not exceed the cost of care of the Intermediate Care Facility for the Developmentally Disabled (ICF/DD).

DDDS is the agency that has primary responsibility for administering the HCBS/DD waiver as well as providing, or contracting for the provision of, most of the services. Providers of Pre-Vocational Training, Supported Employment and Residential Habilitation services are certified by DDDS and contract directly with the Delaware Medical Assistance Program (DMAP).

Summary of Proposal

As a result of recent discussions with CMS regarding renewal of the DDDS Home and Community-Based Medicaid waiver, it is necessary to establish an hourly rate for Supported Employment, Day Habilitation and Pre-

Vocational Services in addition to the current per diem rates. Therefore, as approved by CMS and effective January 1, 2012, the supported employment hourly rate will replace the current per diem rate. This will enable more than one type of waiver service to be billed in a day as authorized in the client's care plan. The hourly rate for Supported Employment is calculated using cost data as reported by providers of Supported Employment services. Total Medicaid allowable costs for each provider were determined and divided by total direct care staff (job coaches, employment specialists) hours worked to compute a cost per direct staff hour by provider. The provider unit costs were averaged to compute a single cost per hour across all providers. The hourly rates for Pre-vocational and Day Habilitation services were computed as part of the Inventory for Client and Agency Planning (ICAP) methodology.

This reimbursement policy change is initiated in order to compel supported employment providers to comply with CMS requirements that only services actually provided are billed to the HCBS waiver and also to allow providers to bill for more than one type of day program service in a single day. The proposed new hourly rate established is $49.02.

This proposed regulation is also published concurrently herein under "Emergency Regulations".

Fiscal Impact Statement

- Based on comparison of FY10 supported employment expenditures to FY11 expenditures adjusted to the new rate of $49.02 per hour.
- FY11 quarters 1 and 2 yielded a reduction in expenditures of $634.4 when compared to the same period in FY10.
- FY11 quarters 3 and 4 yielded a reduction in expenditures of $545.9 when compared to the same period in FY10.

It is expected that this pattern of increasing expenditures to continue as provider agencies become more acclimated to the new procedures.

Therefore, the estimated changes would be as follows:

FY12 quarters 1 and 2 - ($469.4)

FY12 quarters 3 and 4 - ($403.7)

FY13 - ($645.8).

Based on current funding sources, 34% of supported employment expenditures come from DDDS funds; the balance of 66% funded via Medicaid.

DEPARTMENT OF AGRICULTURE

HARNESS RACING COMMISSION

501 Harness Racing Rules and Regulations
PUBLIC NOTICE

The Delaware Harness Racing Commission, pursuant to 3 **Del.C.** §10005, proposes to change its Rule 7.1.4 and 8.3.5.9.4. The Commission will hold a public hearing on the proposed rule changes at Dover Downs on February 14, 2012 at 10:15 A.M.

Written comments should be sent to Hugh J. Gallagher, Executive Director of the Delaware Harness Racing Commission, Department of Agriculture, 2320 South DuPont Highway, Dover, Delaware 19901. Written comments will be accepted for thirty (30) days from the date of publication in the *Register of Regulations* on January 1, 2012.

The proposed changes are for the purpose of updating the Rules and to more accurately reflect current policies, practices and procedures. Copies are published online at the *Register of Regulations* website: http://regulations.delaware.gov/services/current_issue.html

A copy is also available for inspection at the Harness Racing Commission office.

DEPARTMENT OF EDUCATION

PUBLIC NOTICE

The State Board of Education will hold its monthly meeting on Thursday, January 19, 2012 at 1:00 p.m. in the Townsend Building, Dover, Delaware.

DEPARTMENT OF FINANCE

DIVISION OF UNCLAIMED PROPERTY

Regulation on Practices and Procedures for Appeals of Determinations of the Audit Manager
PUBLIC NOTICE

In accordance with procedures set forth in 29 **Del.C.**, Ch. 11, Subch. III and 29 **Del.C.**, Ch. 101, the Department of Finance is proposing to adopt a regulation on practices and procedures for appeals of determinations of the Audit Manager as described in 12 **Del.C.** §1156. The proposed regulation sets forth the rules governing practices and procedures for those appeals.

Members of the public may receive a copy of the proposed regulation at no charge by United States Mail by writing or calling Mr. Mark Udinski, Department of Finance, Escheator of the State of Delaware, Carvel State Building, 820 North French Street, P.O. Box 8763, Wilmington, Delaware 19899-8763, phone (302) 577-8260, or facsimile (302) 577-8565. Members of the public may present written comments on the proposed regulation by submitting such written comments to Mr. Mark Udinski at the address of the Delaware Department of Finance as set forth above. Written comments must be received on or before January 31, 2012.

DIVISION OF UNCLAIMED PROPERTY

Regulation on Practice and Procedure for Establishing Running of the Full Period of Dormancy for Certain Securities and Related Property
PUBLIC NOTICE

In accordance with procedures set forth in 29 **Del.C.**, Ch. 11, Subch. III and 29 **Del.C.**, Ch. 101, the Department of Finance is proposing to adopt a regulation on practices and procedures for establishing whether the full period of dormancy has run against certain securities related property as described in 12 **Del.C.** §1198. The proposed regulation sets forth the rules governing practices and procedures for those determinations.

Members of the public may receive a copy of the proposed regulation at no charge by United States Mail by writing or calling Mr. Mark Udinski, Department of Finance, Escheator of the State of Delaware, Carvel State

Building, 820 North French Street, P.O. Box 8763, Wilmington, Delaware 19899-8763, phone (302) 577-8260, or facsimile (302) 577-8565. Members of the public may present written comments on the proposed regulation by submitting such written comments to Mr. Mark Udinski at the address of the Delaware Department of Finance as set forth above. Written comments must be received on or before January 31, 2012.

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF LONG TERM CARE RESIDENTS PROTECTION

3310 Neighborhood Homes for Persons with Developmental Disabilities
PUBLIC NOTICE

The Division of Long Term Care Residents Protection (DLTCRP) in conjunction with the Division of Developmental Disability Services (DDDS) propose a revision of Regulation 3310, Neighborhood Homes for Persons with Developmental Disabilities**.**

Any person who wishes to make written suggestions, compilations of data, testimony, briefs or other written materials concerning the proposed new regulations must submit same to Deborah Gottschalk, Chief Policy Advisor, Office of the Secretary, Main Admin Building, 1901 North DuPont Highway, P.O. Box 906, New Castle, Delaware 19720-0906 or by fax to (302) 255-4429 by Monday, October 3, 2011.

The action concerning the determination of whether to adopt the proposed regulation will be based upon the results of Department and Division staff analysis and the consideration of the comments and written materials filed by other interested persons.

DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

EPSDT Dental Services
PUBLIC NOTICE

In compliance with the State's Administrative Procedures Act (APA - Title 29, Chapter 101 of the Delaware Code) and under the authority of Title 31 of the Delaware Code, Chapter 5, Section 512 and with 42 CFR §447.205, Delaware Health and Social Services (DHSS) / Division of Medicaid and Medical Assistance (DMMA) is proposing to amend the Title XIX Medicaid State Plan regarding Medicaid dental benefits for eligible recipients. Dental services are available only to clients under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program.

Any person who wishes to make written suggestions, compilations of data, testimony, briefs or other written materials concerning the proposed new regulations must submit same to Sharon L. Summers, Planning & Policy Development Unit, Division of Medicaid and Medical Assistance, 1901 North DuPont Highway, P.O. Box 906, New Castle, Delaware 19720-0906 or by fax to 302-255-4425 by January 31, 2012.

The action concerning the determination of whether to adopt the proposed regulation will be based upon the results of Department and Division staff analysis and the consideration of the comments and written materials filed by other interested persons.

DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

Change To The Reimbursement Methodology For Supported Employment, Day Habilitation and Pre-Vocational Services
PUBLIC NOTICE

In compliance with the State's Administrative Procedures Act (APA - Title 29, Chapter 101 of the **Delaware Code**) and under the authority of Title 31 of the **Delaware Code**, Chapter 5, Section 512 and with 42 CFR §447.205, Delaware Health and Social Services (DHSS) / Division of Medicaid and Medical Assistance (DMMA) is proposing to change the reimbursement methodology for payment of Supported Employment, Day Habilitation and Pre-Vocational Services.

Any person who wishes to make written suggestions, compilations of data, testimony, briefs or other written materials concerning the proposed new regulations must submit same to Sharon L. Summers, Planning & Policy Development Unit, Division of Medicaid and Medical Assistance, 1901 North DuPont Highway, P.O. Box 906, New Castle, Delaware 19720-0906 or by fax to 302-255-4425 by January 31, 2012.

The action concerning the determination of whether to adopt the proposed regulation will be based upon the results of Department and Division staff analysis and the consideration of the comments and written materials filed by other interested persons.

DIVISION OF PUBLIC HEALTH

4405 Free Standing Surgical Centers
PUBLIC NOTICE

The Office of Health Facilities Licensing and Certification, Health Systems Protection Section, Division of Public Health, Department of Health and Social Services, is proposing revisions to the State of Delaware Regulations Governing Free Standing Surgical Centers. Due to the extensive number of amendments the Division has concluded that the current regulations should be repealed and replaced in their entirety with the proposed regulations being published. The purpose of the amendments is to update the requirements so that they are in concert with current healthcare standards and to align them more closely with current federal requirements. On January 1, 2012, the Division plans to publish as proposed the amended regulations and hold them out for public comment per Delaware law.

Copies of the proposed regulations are available for review in the January 1, 2012 edition of the Delaware *Register of Regulations*, accessible online at: http://regulations.delaware.gov or by calling the Office of Health Facilities Licensing and Certification at (302) 283-7220.

Any person who wishes to make written suggestions, testimony, briefs or other written materials concerning the proposed regulations must submit same to Deborah Harvey by Monday, January 30, 2012 at:

Deborah Harvey
Division of Public Health
417 Federal Street
Dover, DE 19901
Email: Deborah.Harvey@state.de.us
Phone: (302) 744-4913

DIVISION OF SOCIAL SERVICES

Fair Hearings
DSSM 5311 - Notifying Appellants and Others of Hearings and DSSM 5312 - Responding to Fair Hearing Requests
PUBLIC NOTICE

In compliance with the State's Administrative Procedures Act (APA - Title 29, Chapter 101 of the Delaware Code) and under the authority of Title 31 of the Delaware Code, Chapter 5, Section 512, Delaware Health and Social Services (DHSS) / Division of Social Services is proposing to amend policies in the Division of Social Services Manual (DSSM) regarding Fair Hearings, specifically, *Notifying Appellants and Others of Hearings and Responding to Fair Hearing Requests*.

Any person who wishes to make written suggestions, compilations of data, testimony, briefs or other written materials concerning the proposed new regulations must submit same to Sharon L. Summers, Policy, Program & Development Unit, Division of Social Services, 1901 North DuPont Highway, P.O. Box 906, New Castle, Delaware 19720-0906 or by fax to (302) 255-4425 by January 31, 2012.

The action concerning the determination of whether to adopt the proposed regulation will be based upon the results of Department and Division staff analysis and the consideration of the comments and written materials filed by other interested persons.

DIVISION OF SOCIAL SERVICES
DSSM: 5000, 5501, 5502, 5600, 5600.1, 5601, 5602, 5603, 5604, 5605, 5606 and 5607
PUBLIC NOTICE

In compliance with the State's Administrative Procedures Act (APA - Title 29, Chapter 101 of the Delaware Code) and under the authority of Title 31 of the Delaware Code, Chapter 5, Section 512, Delaware Health and Social Services (DHSS) / Division of Social Services is proposing to amend policies in the Division of Social Services Manual (DSSM) regarding various Fair Hearing provisions.

Any person who wishes to make written suggestions, compilations of data, testimony, briefs or other written materials concerning the proposed new regulations must submit same to Sharon L. Summers, Policy, Program & Development Unit, Division of Social Services, 1901 North DuPont Highway, P.O. Box 906, New Castle, Delaware 19720-0906 or by fax to (302) 255-4425 by January 31, 2012.

The action concerning the determination of whether to adopt the proposed regulation will be based upon the results of Department and Division staff analysis and the consideration of the comments and written materials filed by other interested persons.

The proposal described below amends policies in the Division of Social Services Manual (DSSM) regarding various Fair Hearing provisions, including *Definitions, Public Access to Hearing Records, Admissible Evidence, Official Notice, Protocol, and Request for Continuance*.

DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION
3300 BOARD OF VETERINARY MEDICINE
PUBLIC NOTICE

Pursuant to 24 **Del.C.** §3306(a)(1), the Board of Veterinary Medicine has proposed revisions to its rules and regulations.

A public hearing will be held on February 14, 2012 at 1:15 p.m. in the second floor conference room A of the Cannon Building, 861 Silver Lake Boulevard, Dover, Delaware, where members of the public can offer comments. Anyone wishing to receive a copy of the proposed rules and regulations may obtain a copy from the Board of Veterinary Medicine, 861 Silver Lake Boulevard, Dover, Delaware 19904. Persons wishing to submit written comments may forward these to the Board at the above address. The final date to receive written comments will be at the public hearing.

The Board proposes amendments to Rule 2.0, addressing Unprofessional Conduct for Veterinarians. Specifically, Rule 2.1.17 is added to provide that, upon request of the client, directed to the veterinarian, the veterinarian shall disclose common side effects of the medications prescribed by the veterinarian.

The Board will consider promulgating the proposed rules and regulations at its regularly scheduled meeting following the public hearing.

DIVISION OF PROFESSIONAL REGULATION
5200 Board of Examiners of Nursing Home Administrators
PUBLIC NOTICE

The Delaware Board of Examiners of Nursing Home Administrators pursuant to 24 **Del.C.** §5206(1) proposes to revise their rules and regulations. The proposed revision to the rules defines a Preceptor, adds pre-Approval of a direct supervisor for the Administrator in Training Program, changes the percentages of the type of work done for

the Administrator in Training Program, changes the time periods for an expired license, and allows for continuing education credits for the appointees of the Board for their attendance at board meetings.

The Board will hold a public hearing on the proposed rule change on March 13, 2012 at 1.00 pm., Second floor Conference Room B, Cannon Office Building, 861 Silver Lake Blvd., Dover DE 19904. Written comments should be sent to Michele Howard, Administrator of the Delaware Board of Examiners of Nursing Home Administrators, Cannon Building, 861 Silver Lake Blvd., Dover DE 19904.

DIVISION OF PROFESSIONAL REGULATION

8800 Boxing, Sparring Matches and Exhibitions

PUBLIC NOTICE

The Department of State, in accordance with 28 Del. C. Chapter 1, is proposing to amend the regulations related to combative sports and combative sports entertainment.

Written comments should be submitted to James Collins, Director, Division of Professional Regulation, at the above address on or before February 4, 2012. Anyone wishing to obtain a copy of the proposed regulations or to submit written comments should contact Shauna Slaughter, Administrative Specialist, at the above address or by calling (302) 744-4502.

The Department through the Director may consider promulgating the proposed regulations immediately after closure of the public comment period.