NORTH Dakota | Health and Human Services
Be Legendary.

December 23, 2025

Sent via email: Keys.Cert@ssa.gov
Mr. Scott Logan
Social Security Administration
Office of Income Security Programs, Keys Section

Dear Mr. Logan:

As Interim Commissioner of the Department of Health and Human Services and in accordance with the requirements of Section 1616(e) of the Social Security Act (Keys Amendments), I hereby certify as follows:

1. The State of North Dakota establishes and enforces standards for residential facilities where significant numbers of Supplemental Security Income recipients reside;

2. The State of North Dakota makes a summary of these standards available for public review by including a summary of standards on the Department of Health and Human Services' website;

3. The State of North Dakota makes copies of the standards (and state enforcement procedures including any waivers and violations of the standards) available upon request; and

4. The State of North Dakota's standards outlined in law and administrative code are electronically available to any interested individual.

Attached are copies of the following updated chapters:

- NDAC 75-02-09 RATESETTING FOR PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES effective January 1, 2025

OFFICE OF THE COMMISSIONER

GOVERNOR
Kelly Armstrong

INTERIM COMMISSIONER
Pat Traynor

600 E Boulevard Ave Dept 325 | Bismarck ND 58505-0250 | 701.328.2538 | 800.472.2622 | 711 (TTY)
www.hhs.nd.gov

- NDAC 75-03-23 PROVISION OF HOME AND COMMUNITY-BASED SERVICES UNDER THE SERVICE PAYMENTS FOR ELDERLY AND DISABILED PROGRAM AND THE MEDICAID WAIVER FOR THE AGED AND DISABLED PROGRAM effective January 1, 2025

- NDAC 75-04-01 LICENSING OF PROGRAMS AND SERVICES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES – DEVELOPMENTAL DISABILITIES effective January 1, 2025

Sincerely,

J. Patrick Traynor
Interim Commissioner

Attachment
C: Jonathan Alm, chief legal officer, Health and Human Services

CHAPTER 75-02-09
RATESETTING FOR PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES

75-02-09-01. Definitions.

1. "Accrual basis" means the recording of revenue in the period when it is earned, regardless of when it is collected, and the recording of expenses in the period when incurred, regardless of when they are paid.

2. "Adjustment factor" means the legislatively approved inflation rate for psychiatric residential treatment facilities services.

3. "Allowable cost" means the facility's actual and reasonable cost after adjustments required by department rules.

4. "Capital asset" means a facility's buildings, land improvements, fixed equipment, movable equipment, leasehold improvements, and all additions to or replacements of those assets used directly for resident care.

5. "Chain organization" means a group of two or more health care facilities owned, leased, or, through any other device, controlled by one business entity. This includes not only proprietary chains, but also chains operated by various religious and other charitable organizations. A chain organization may also include business organizations engaged in other activities not directly related to health care.

6. "Cost category" means the classification or grouping of similar or related costs for purposes of reporting which are used in the determination of cost limitations and rates.

7. "Cost report" means the department-approved form for reporting costs, statistical data, and other relevant information to the department.

8. "Department" means the department of health and human services.

9. "Depreciation" means an allocation of the cost of an asset over its estimated useful life.

10. "Depreciation guidelines" means the American hospital association's depreciation guidelines as published by American hospital publishing, inc., in "Estimated Useful Lives of Depreciable Hospital Assets", revised 2021 edition.

11. "Desk rate" means the rate established by the department based upon a review of the cost report submission prior to an audit of the cost report.

12. "Direct costing" means identification of actual costs directly to a facility or cost category without use of any means of allocation.

13. "Education" means the cost of activities related to academic and vocational training generally provided by a school district.

14. "Facility" means an entity that is a licensed psychiatric residential treatment facility for children under chapter 75-03-17.

15. "Fair market value" means value at which an asset could be sold in the open market in a transaction between informed, unrelated parties.

16. "Final rate" means the rate established after any adjustments by the department, including adjustments resulting from cost report reviews and audits.

17. "Fringe benefits" means workers' compensation insurance, group health, dental or vision insurance, group life insurance, payment toward retirement plans, uniform allowances, employer's share of Federal Insurance Contributions Act, unemployment compensation taxes, and medical services furnished at facility expense.

18. "Generally accepted accounting principles" means the accounting principles approved by the American institute of certified public accountants.

19. "Historical costs" means the allowable costs incurred by the facility during the report year immediately preceding the rate year for which the established rate becomes effective.

20. "Hospital leave day" means any day that a resident is not in the facility, but is in an acute care or psychiatric hospital setting and admitted as an inpatient.

21. "In-house day" means a day that an individual was actually residing in the facility and was not on leave.

22. "Interest" means cost incurred for the use of borrowed funds.

23. "Leave day" means any day that an individual is not in the facility but is expected to return to the facility.

24. "Private-pay resident" means an individual on whose behalf the facility is not receiving medical assistance payments.

25. "Rate year" means the calendar year from January first through December thirty-first.

26. "Reasonable cost" means the cost that must be incurred by an efficiently and economically operated facility to provide services in conformity with applicable state and federal laws, rules, and quality and safety standards. Reasonable cost takes into account that the facility seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost-conscious buyer pays for a given item or service.

27. "Related organization" means an organization that a facility is, to a significant extent, associated with, affiliated with, able to control, or controlled by; and which furnishes services, facilities, or supplies to the facility. Control exists when an individual or organization has the

power, directly or indirectly, to significantly influence or direct the policies of an organization or facility.

28. "Report year" means fiscal year from July first through June thirtieth of the year immediately preceding the rate year.

29. "Resident day" means a day for which service is actually provided or for which payment is ordinarily sought.

30. "Special rate" means a desk rate or a final rate adjusted for nonrecurring or initial costs not included in the historical cost basis.

31. "Working capital debt" means debt incurred to finance facility operating costs, but does not include debt incurred to acquire or refinance a capital asset or to refund or refinance debt associated with acquiring a capital asset.

History: Effective May 1, 1994; amended effective October 1, 2011; January 1, 2025.
General Authority: NDCC 50-24.1-04
Law Implemented: 42 USC 1396a(a)(30)(A)

75-02-09-02. Financial reporting requirements.

1. Records.

   a. The facility shall maintain on the premises census records and financial information sufficient to provide for a proper audit or review. For any cost being claimed on the cost report, sufficient data must be available as of the audit date to fully support the report item.

   b. If several facilities are associated with a group and their accounting and reports are centrally prepared, added information must be submitted for those items known to be lacking support at the reporting facility prior to the audit or review of the facility. Accounting or financial information regarding a related organization must be readily available to substantiate cost.

   c. Each facility shall maintain, until any rate based upon a cost report is final and not subject to any appeal, but in any event, for a period of not less than five years following the date of submission of the cost report to the state agency, accurate financial and statistical records of the period covered by the cost report in sufficient detail to substantiate the cost data reported. Each facility shall make the records available upon reasonable demand to representatives of the department.

2. Accounting and reporting requirements.

   a. The accrual basis of accounting, in accordance with generally accepted accounting principles, must be used for cost reporting purposes. Ratesetting procedures will prevail if conflicts occur between ratesetting procedures and generally accepted accounting principles. A facility may maintain its accounting records on a cash basis during the year, but adjustments must be made to reflect proper accrual accounting procedures at yearend and when subsequently reported.

   b. To properly facilitate auditing, the accounting system must be maintained in a manner that allows cost accounts to be grouped by cost category and readily traceable to the cost report.

   c. The cost report must be submitted on or before October first. The report must contain all actual costs of the facility, adjustments for nonallowable costs, and resident days.

d. The department may impose a nonrefundable penalty of ten percent of any amount claimed for services furnished after the due date if the facility fails to file the cost report on or before the due date. The penalty may be imposed on the first day of the fourth month following the facility's fiscal yearend and continues to the end of the month in which the statement or report is received.

e. Upon request, the following information must be made available:

(1) A statement of ownership including the name, address, and proportion of ownership of each owner;

(2) Copies of leases, purchase agreements, appraisals, financing arrangements, and other documents related to the lease or purchase of the facility or a certification that the content of those documents remains unchanged since the most recent statement given pursuant to this subsection;

(3) Supplemental information reconciling the costs on the financial statements with costs on the cost report; or

(4) Copies of leases, purchase agreements, and other documents related to the acquisition of equipment, goods, and services claimed as allowable costs.

f. The facility must make all adjustments and allocations necessary to arrive at allowable costs. The department may reject any cost report when the information filed is incomplete or inaccurate. If a cost report is rejected, the department may impose the penalties described in subdivision d.

g. The department may grant one thirty-day extension of the reporting deadline to a facility. To receive an extension, a facility must submit a written request to the department's medical services division.

h. If a facility fails to file the required cost report on or before the due date, the department may reduce the current payment rate to eighty percent of the facility's most recently established rate. Reinstatement of the rate must occur on the first of the month beginning after receipt of the required information, but is not retroactive.

3. The department shall perform an audit of the latest available report year of each facility at least once every six years and retain for at least three years all audit-related documents, including cost reports, working papers, and internal reports on rate calculations used and generated by audit staff in the performance of audits and in the establishment of rates. Audits must meet generally accepted governmental auditing standards.

4. A false report is one where a facility knowingly supplies inaccurate or false information in a required report that results in an overpayment. If a false report is received, the department may:

a. Immediately adjust the facility's payment rate to recover the entire overpayment within the rate year;

b. Terminate the department's agreement with the facility;

d. Prosecute under applicable state or federal law; or

e. Use any combination of the foregoing actions.

5. The department may determine a report is a false report if a facility claims previously adjusted costs as allowable costs. Previously adjusted costs being appealed must be identified as

nonallowable costs. The facility may indicate that the costs are under appeal and not claimed under protest to perfect a claim should the appeal be successful.

History: Effective May 1, 1994; amended effective October 1, 2011; January 1, 2025.
General Authority: NDCC 50-24.1-04
Law Implemented: 42 USC 1396a(a)(30)(A)

75-02-09-03. General cost principles.

1. For ratesetting purposes, a cost must:

   a. Be ordinary, necessary, and related to resident care;

   b. Be no more than an amount a prudent and cost-conscious business person would pay for the specific good or service in the open market in an arm's-length transaction; and

   c. Be for goods or services actually provided by the facility.

2. The cost effects of transactions which circumvent these rules are not allowable under the principle that the substance of the transaction prevails over the form.

3. Reasonable resident-related costs will be determined in accordance with the ratesetting procedures set forth in this chapter and instructions issued by the department.

History: Effective May 1, 1994; amended effective October 1, 2011.
General Authority: NDCC 50-24.1-04
Law Implemented: 42 USC 1396a(a)(30)(A)

75-02-09-04. Ratesetting.

1. The established rate is based on prospective ratesetting procedures. The establishment of a rate begins with historical costs. Adjustments are then made for claimed costs not includable in allowable costs. Adjustment factors are then applied to allowable costs. Retroactive settlements for actual costs incurred during the rate year exceeding the final rate will not be made unless specifically provided in this chapter.

2. The department shall establish a desk rate, based on the cost report, which will be effective January first of each rate year or on an alternate effective date determined by the department.

   a. The desk rate will continue in effect until a final rate is established.

   b. The cost report will be reviewed taking into consideration the prior year's adjustments. A facility will be notified by telephone or electronic mail of any desk adjustments based on the desk review. Within seven working days after notification, the facility may submit information to explain why a desk adjustment should not be made. The department shall review the submitted information, make appropriate adjustments, including adjustment factors, and issue the desk rate.

   c. Reconsideration will not be given by the department for the desk rate unless the facility has been notified that the desk rate is the final rate.

   d. A desk rate may be adjusted at any time if subsection 4 applies to the facility.

3. The cost report may be field audited by the department to establish a final rate. If no field audit is performed, the desk rate will become the final rate upon notification to the facility from the department.

   a. The final rate will be effective as of the effective date of the desk rate.

b. The final rate will include any adjustments for nonallowable costs, errors, or omissions that result in a change from the desk rate of at least twenty-five cents per day.

c. Adjustments, errors, or omissions found after a final rate has been established will be included as an adjustment in the report year the adjustments, errors, or omissions are found.

d. The final rate may be adjusted at any time if subsection 4 applies.

4. A special rate will be established for a facility providing services for the first time, changing ownership, having a capacity increase or major renovation or construction, or having changes in services or staff.

a. The rate for a facility providing first-time services purchased by the department will be established using this subdivision for the first two fiscal years of the facility if that period is less than twenty-four months.

(1) The facility shall submit a budget, to the department's medical services division, for the first twelve months of operation. A final rate based on the budget and adjustments, if any, will be established for a rate period beginning on the first of the month in which the facility begins operation. This rate will remain in effect for eighteen months. Adjustment factors will not be included in the first year final rate. No retroactive settlements will be made.

(2) Upon completion of the first twelve months of operation, the facility must submit a cost report for the twelve-month period regardless of the fiscal yearend of the facility.

(a) The twelve-month cost report is due on or before the last day of the third month following the end of the twelve-month period.

(b) The twelve-month cost report will be used to establish a rate for the remainder of the second rate year. Appropriate adjustment factors will be used to establish the rate.

(3) The facility shall submit a cost report that will be used to establish rates in accordance with subsections 2 and 3 after the facility has been in operation for the entire twelve months of the facility's fiscal year.

b. For a facility with a change in ownership, the rate established for the previous owner must be retained until the end of the rate year in which the change of ownership occurs. The rate for the second rate year after a change in ownership occurs will be established as follows:

(1) For a facility with four or more months of operation under the new ownership during the report year, a cost report for the period since the ownership change occurred will be used to establish the rate for the next rate year; and

(2) For a facility with less than four months of operation under the new ownership in the reporting year, the prior report year's costs as adjusted for the previous owner will be indexed forward using the appropriate adjustment factor.

c. For a facility that increases licensed capacity by twenty percent or more or has a renovation or construction project in excess of fifty thousand dollars, the established desk or final rate may be adjusted for the period after the licensed capacity increase occurs or the construction or renovation is complete to include projected property costs.

(1) For the rate year in which the capacity increase occurs or construction or renovation is completed, an adjusted rate will be calculated based on a rate for historical costs, exclusive of property costs, as adjusted, divided by historical census, plus a rate for property costs based on projected property costs divided by projected census. The adjusted rate will be effective on the first day of the month in which the renovation or construction is complete or when the capacity increase is approved if no construction or renovation is necessary.

(2) For the rate year immediately following the rate year in which the capacity increase occurred or construction and renovation was completed, a rate will be established based on historical costs, exclusive of property costs, as adjusted for the report year, divided by reported census plus a rate for property costs, based on projected property costs, divided by projected census.

d. The department may provide for an increase in the established rate for additional costs necessary to add services or staff to the existing program.

(1) The facility shall submit information, to the department's medical services division, supporting the request for the increase in the rate. Information must include a detailed listing of new or additional staff or costs associated with the increase in services.

(2) The department shall review the submitted information and may request additional documentation or conduct onsite visits. The established rate will be adjusted if an increase in costs is approved. The effective date of the rate increase will be the later of the first day of the month following approval by the department or the first day of the month following the addition of services or staff. The adjustment will not be retroactive to the beginning of the rate year and will exclude adjustment factors provided for in subsection 8.

(3) For the rate year immediately following a rate year in which a rate was adjusted under paragraph 2, the facility may request consideration be given to additional costs. The facility shall demonstrate to the department's satisfaction that historical costs do not reflect twelve months of actual costs of the additional staff or added services in order to adjust the rate for the second rate year. The additional costs would be based on a projection of costs for the remainder of a twelve-month period, exclusive of adjustment factors provided for in subsection 8.

5. The final rate must be considered as payment for all accommodations that include items identified in section 75-02-09-06. For any resident whose rate is paid in whole or in part by the department, no payment may be solicited or received from the resident or any other person to supplement the rate as established.

6. When a facility terminates its participation in the program, whether voluntarily or involuntarily, the department may authorize the facility to receive continued payment until residents can be relocated.

7. Limitations.

a. The department shall accumulate and analyze statistics on costs incurred by psychiatric residential treatment facilities. Statistics may be used to establish reasonable ceiling limitations and incentives for efficiency and economy based on reasonable determination of standards of operations necessary for efficient delivery of needed services. Limitations and incentives may be established on the basis of cost of comparable facilities and services and may be applied as ceilings on the overall costs of providing services or on

specific areas of operations. The department may implement ceilings at any time based upon information available.

b. The department shall review, on an ongoing basis, aggregate payment to facilities to determine that payments do not exceed an amount that can be reasonably estimated would have been paid for these services under federally required payment principles. If aggregate payments to facilities exceed estimated payments under federally required payments principles, the department may make adjustments to rates so that aggregate payments do not exceed an amount that can be estimated would have been paid under an upper payment limit.

c. Allowable administration costs to be included in the established rate are the lesser of the actual cost of administration as direct costed or allocated to the facility or an amount equal to fifteen percent of the total allowable costs, exclusive of administration costs, for the facility.

8. An adjustment factor may be used to adjust historical allowable costs but may not be used to adjust property costs.

History: Effective May 1, 1994; amended effective October 1, 2011; January 1, 2025.
General Authority: NDCC 50-24.1-04
Law Implemented: 42 USC 1396a(a)(30)(A)

75-02-09-05. Resident census.

1. A daily census record must be maintained by the facility. Any day services are provided or for which payment is ordinarily sought for an available bed must be counted as a resident day. The day of admission and day of death are resident days. The day of discharge must be counted if payment is sought for that day. For a medical assistance resident, payment may not be sought for the day of discharge.

2. The daily census records must include:

   a. Identification of the resident;

   b. Entries for all days, and not just by exception;

   c. Identification of type of day, i.e., in-house or leave day; and

   d. Monthly totals by resident and by type of day.

3. A maximum of fifteen consecutive days per occurrence are allowed for payment by the medical assistance program for hospital leave. Hospital leave days in excess of fifteen consecutive days not billable to the medical assistance program are not resident days unless any payment is sought as provided for in subsection 2 of section 75-02-09-19.

History: Effective May 1, 1994; amended effective October 1, 2011; January 1, 2025.
General Authority: NDCC 50-24.1-04
Law Implemented: 42 USC 1396a(a)(30)(A)

75-02-09-06. Allowable costs by cost category.

1. Administration costs are the allowable costs of activities performed by the staff in which the direct recipient of the activity is the organization itself, including fiscal activities, statistical reporting, recruiting, and general office management indirectly related to reimbursable services provided. Administration personnel includes administrators, regional directors, program directors, accounting personnel, clerical personnel, secretaries, receptionists, data

processing personnel, purchasing personnel, and security personnel. Administration costs directly assignable to the facility must be reported as facility administration. Administration costs not directly assignable to the facility must be reported as other administration. Costs for administration include:

a. Salary and fringe benefits for individuals who provide services administrative in nature or who are not included specifically in any other cost category;

b. Office supplies;

c. Insurance, except property insurance and insurance included as a fringe benefit;

d. Postage and freight;

e. Professional fees for services such as legal, accounting, and data processing;

f. Central or home office costs;

g. Personnel recruitment costs;

h. Management consultants and fees;

i. Dues, license fees, and subscriptions;

j. Travel and training for employees, except for training for personnel required to maintain licensure, certification, or professional standards requirements;

k. Interest on funds borrowed for working capital if repayment of working capital debt is made within three years of the borrowing;

l. Startup costs;

m. Security personnel or services;

n. Telephone service not included in other cost categories; and

o. All costs not specifically identified in other cost categories.

2. Direct care costs are the allowable costs incurred for providing services for the maximum reduction of physical or mental disability and restoration of a resident to the best possible functional level and for providing for the personal needs of the resident. The services may include any medical or remedial service recommended by a physician or other licensed practitioner of the healing arts, within the scope of the practitioner's practice under state law. Direct care costs include:

a. Salaries and fringe benefits for individuals providing treatment or supervision of residents;

b. Personal supplies used by an individual resident;

c. Clothing necessary to maintain a resident's wardrobe;

d. School supplies and activity fees, when not provided by or at the expense of the school;

e. Costs incurred for providing recreation to the residents including subscriptions, sports equipment, and admission fees to sporting, recreation, and social events;

f. All costs related to transporting residents, and transportation costs that may include actual expenses of facility-owned vehicles or mileage paid to employees for use of personal vehicle;

g. The cost of services purchased and not provided at the facility, including case management, addiction, psychiatric, psychological, and other clinical evaluations, medication review, and partial care or day treatment; and

h. Training required to maintain licensure, certification, or professional standards requirements, and the related travel costs.

3. Dietary costs are the allowable costs associated with the preparation and serving of food. Dietary costs include:

a. Salaries and fringe benefits for all personnel involved with the preparation and delivery of food;

b. Food; and

c. Dietary supplies and utensils including paper products and noncapitalized dietary equipment.

4. Laundry costs are the allowable costs associated with gathering, transporting, sorting, and cleaning of linen and clothing. Laundry costs include:

a. Salaries and fringe benefits of personnel who gather, transport, sort, and clean linen and clothing;

b. The cost of laundry supplies; and

c. Contracted laundry services.

5. Plant and housekeeping costs are the allowable costs related to repairing, cleaning, and maintaining the facility's physical plant. Plant and housekeeping costs include:

a. Salaries and fringe benefits of personnel involved in cleaning, maintaining, and repairing the facility;

b. Supplies necessary to maintain the facility, including such items as cleaning supplies, paper products, and hardware goods;

c. Utility costs, including heating and cooling, electricity, water, sewer, garbage, and cable television;

d. Local telephone service to the living quarters and long distance telephone service directly related to providing treatment; and

e. Routine repairs and maintenance of property and equipment, including maintenance contracts and purchased services.

6. Property costs are the allowable capital costs associated with the physical plant of the facility. Property costs include:

a. Depreciation;

b. Interest;

c. Lease costs on equipment and buildings;

d. Property taxes; and

e. Property insurance on buildings and equipment.

History: Effective May 1, 1994; amended effective October 1, 2011; January 1, 2025.
General Authority: NDCC 50-24.1-04
Law Implemented: 42 USC 1396a(a)(30)(A)

75-02-09-07. Cost allocation.

1. Direct costing of allowable facility costs must be used whenever possible. If direct costing is not possible, the allocation methods for facility and nonfacility operations described in this subsection must be used.

   a. Salaries for direct care employees, which cannot be reported based on direct costing, must be allocated using time studies. Time studies must be conducted at least semiannually for a two-week period or quarterly for a one-week period. The time study must represent a typical period of time when employees are performing normal work activities in each of their assigned areas of responsibility. Allocation percentages based on the time studies must be used starting with the next pay period following completion of the time study or averaged for the report year.

   b. Salaries of supervisory personnel must be allocated based on full-time equivalents of the employees supervised or on a ratio of salaries.

   c. Fringe benefits must be allocated based on the ratio of salaries to total salaries.

   d. Plant and housekeeping expenses must be allocated based on square footage.

   e. Property costs must be allocated based on square footage.

   f. Administration costs must be allocated on the basis of the percentage of total costs, excluding the allocable administration, property, and utility costs.

   g. Dietary costs must be allocated based on meals served.

   h. Laundry costs must be allocated on the basis of pounds of laundry or in-house resident days.

   i. Vehicle expenses must be allocated based on mileage logs. Mileage logs must include documentation for all miles driven and purpose of travel. If sufficient documentation is not available to determine which cost category vehicle expenses are to be allocated, vehicle expenses must be allocated in total to administration.

   j. Costs not direct costed or allocable using methods identified in subdivisions a through i must be included as administration costs.

2. If the facility cannot use any of the allocation methods described in subsection 1, a waiver request may be submitted to the department's medical services division. The request must include an adequate explanation as to why the referenced allocation method cannot be used by the facility. The facility shall also provide a rationale for the proposed allocation method. Based on the information provided, the department shall determine the allocation method used to report costs.

History: Effective May 1, 1994; amended effective October 1, 2011; January 1, 2025.
General Authority: NDCC 50-24.1-04
Law Implemented: 42 USC 1396a(a)(30)(A)

75-02-09-08. Nonallowable costs.

Nonallowable costs include:

1. Promotional, publicity, and advertising expenses, exclusive of personnel procurement;
2. Political contributions;
3. Salaries or expenses of a lobbyist;
4. Basic research;
5. Fines or penalties including interest charges on the penalty, bank overdraft charges, and late payment charges;
6. Bad debts;
7. Compensation and expenses for officers, directors, or stockholders, except as provided for in section 75-02-09-15;
8. Contributions or charitable donations;
9. Costs incurred for activities directly related to influencing employees with respect to unionization;
10. Costs of membership or participation in health, fraternal, or social organizations such as eagles, country clubs, or knights of columbus;
11. Corporate costs such as organization costs, reorganization costs, costs associated with acquisition of capital stock, costs relating to the issuance and sale of capital stock or other securities, and other costs not related to resident services;
12. Home office costs that would be nonallowable if incurred directly by the facility;
13. Stockholder servicing costs incurred primarily for the benefit of stockholders or other investors, including annual meetings, annual reports and newsletters, accounting and legal fees for consolidating statements, stock transfer agent fees, and stockbroker and investment analyses;
14. The cost of any equipment, whether owned or leased, not exclusively used by the facility except to the extent the facility demonstrates to the satisfaction of the department that any particular use of equipment was related to resident care;
15. Costs, including by way of illustration and not by way of limitation, for legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies, attributed to the negotiation or settlement of the sale or purchase of any capital assets, whether by sale or merger, when the cost of the asset has been previously reported and included in the rate paid to any facility;
16. Depreciation expense for facility assets not related to resident care;
17. Personal expenses of owners and employees for items or activities including vacation, boats, airplanes, personal travel or vehicles, and entertainment;
18. Costs not adequately documented (adequate documentation includes written documentation of date of purchase, vendor name, listing of items or services purchased, cost of items purchased, account number to which the cost is posted, and a breakdown of any allocation of costs between accounts or facilities);

19. The following taxes, if levied on a facility:

    a. Federal income and excess profit taxes, including any interest or penalties paid thereon;

    b. State or local income and excess profit taxes;

    c. Taxes in connection with financing, refinancing, or refunding operations such as taxes in the issuance of bonds, property transfers, issuance or transfer of stocks, etc., which are generally either amortized over the life of the securities or depreciated over the life of the asset, but not recognized as tax expense;

    d. Taxes such as real estate and sales tax for which exemptions are available to the facility;

    e. Taxes on property not used in the provision of covered services; and

    f. Taxes such as sales taxes, levied, collected, and remitted by the facility;

20. The unvested portion of a facility's accrual for sick or annual leave;

21. Expenses or liabilities established through or under threat of litigation against the state of North Dakota or any of its agencies, provided that reasonable insurance expenses may not be limited by this subsection;

22. Fringe benefits, not within the definition of that term, which have not received written prior approval of the department;

23. Fringe benefits that discriminate in favor of certain employees, excluding any portion that relates to costs that benefit all employees;

24. Fundraising costs, including salaries, advertising, promotional, or publicity costs incurred for such a purpose;

25. Funeral and cemetery expenses;

26. Travel not directly related to professional conferences, state or federally sponsored activities, or resident services;

27. Items or services such as telephone, television, and radio located in a resident's room and furnished solely for the convenience of the resident;

28. Value of donated goods and services;

29. Religious salaries, space, and supplies;

30. Miscellaneous expenses not related to resident services;

31. Premiums for top management personnel life insurance policies, except that the premiums shall be allowed if the policy is included within a group policy provided for all employees, or if a policy is required as a condition of a mortgage or loan and the mortgagee or lending institution is listed as the beneficiary;

32. Travel costs involving the use of vehicles not exclusively used by the facility unless:

    a. Vehicle travel costs do not exceed the amount established by the internal revenue service;

    b. The facility supports vehicle costs related to resident care with sufficient documentation, including mileage logs for all miles, purpose of travel, and receipts for purchases; and

c. The facility documents all costs associated with a vehicle not exclusively used by the facility;

33. Vehicle and aircraft costs not directly related to facility business or resident services;

34. Nonresident-related operations and the associated administrative costs;

35. Costs related to income-producing activities regardless of the profitability of the activity;

36. Costs incurred by the facility's subcontractors or by the lessor of property the facility leases, and which become an element in the subcontractor's or lessor's charge to the facility, if such costs would not have been allowable had they been incurred by a facility directly furnishing the subcontracted services or owning the leased property;

37. All costs for services paid directly by the department to an outside facility;

38. Depreciation on the portion of assets acquired with government grants;

39. Costs incurred due to management inefficiency, unnecessary care or services, agreements not to compete, or activities not commonly accepted in the industry;

40. The cost of consumable food products, in excess of income from employees, guests, and nonresidents offset in accordance with subsection 1 of section 75-02-09-16, consumed by individuals other than residents or direct care personnel;

41. Payments to residents, whether in cash or in kind, for work performed or for bonuses or rewards based on behavior;

42. In-house education costs including:

    a. Compensation for teachers and teacher aides who provide academic training to residents in-house;

    b. Property and plant operation expenses for space used to provide in-house academic training to residents; and

    c. The cost of supplies and equipment used in a classroom normally provided by a school district as part of the academic training; and

43. Medical assistance noncovered services.

History: Effective May 1, 1994; amended effective October 1, 2011; January 1, 2025.
General Authority: NDCC 50-24.1-04
Law Implemented: 42 USC 1396a(a)(30)(A)

75-02-09-09. Depreciation.

1. Ratesetting principles require that payment for services should include depreciation on all depreciable type assets used to provide necessary services. This includes assets that may have been fully or partially depreciated on the books of the facility, but are in use at the time the facility enters the program. The useful lives of such assets are considered not to have ended and depreciation calculated on the revised extended useful life is allowable. Likewise, a depreciation allowance is permitted on assets used in a normal standby or emergency capacity. If any depreciated personal property asset is sold or disposed of for an amount different than its undepreciated value, the difference represents an incorrect allocation of the cost of the asset to the facility and must be included as a gain or loss on the cost report.

2. Depreciation methods.

a. The straight-line method of depreciation must be used. All accelerated methods of depreciation including depreciation options made available for income tax purposes, such as those offered under the asset depreciation range system, are unacceptable. The method and procedure for computing depreciation must be applied on a basis consistent from year to year, and detailed schedules of individual assets must be maintained. If the books of account reflect depreciation different than that submitted on the cost report, a reconciliation must be prepared by the facility.

b. A facility must use a minimum composite useful life of ten years for all equipment and land improvements, and four years for vehicles. Buildings and improvements to buildings are to be depreciated over the length of the mortgage or a minimum of twenty-five years, whichever is greater.

3. Acquisitions.

a. If a depreciable asset has at the time of its acquisition historical cost of at least one thousand dollars for each item, its cost must be capitalized and depreciated over the estimated useful life of the asset except as provided for in subsection 3 of section 75-02-09-11. Costs, such as architectural, consulting and legal fees, and interest, incurred during the construction of an asset must be capitalized as a part of the cost of the asset.

b. All repair or maintenance costs in excess of five thousand dollars per project on equipment or buildings must be capitalized and depreciated over the remaining useful life of the equipment or building or one-half of the original estimated useful life, whichever is greater.

4. Proper records must provide accountability for the fixed assets and also provide adequate means by which depreciation can be computed and established as an allowable resident-related cost. Tagging of major equipment items is not mandatory, but alternate records must exist to satisfy audit verification of the existence and location of the assets.

5. Basis for depreciation.

a. Determination of the cost basis of a facility's depreciable assets, which have not been involved in any programs funded in whole or in part by the department, depends on whether or not the transaction is a bona fide purchase. Should the issue arise, the purchaser has the burden of proving that the transaction was a bona fide purchase. Purchases where the buyer and seller are related organizations are not bona fide.

(1) If the purchase is bona fide, the cost basis will be the lower of the actual cost of the buyer or the fair market value of the asset at the time of the purchase.

(2) If the purchase is not bona fide, the cost basis will be the seller's cost basis less accumulated depreciation.

b. Cost basis of a facility's depreciable assets purchased as an ongoing operation will be the seller's cost basis less accumulated depreciation.

c. Cost basis of a facility's depreciable assets used in any programs funded in whole or in part by the department will be the cost basis used by the other program less accumulated depreciation.

d. Sale and leaseback transactions will be considered a related party transaction. The cost basis of a facility's depreciable assets purchased and subsequently leased to an entity who continues to operate the facility will be the seller's cost basis less accumulated depreciation.

History: Effective May 1, 1994; amended effective October 1, 2011.
General Authority: NDCC 50-24.1-04
Law Implemented: 42 USC 1396a(a)(30)(A)

75-02-09-10. Interest expense.

1. To be allowable under the program, interest must be:

   a. Supported by evidence of an agreement that funds were borrowed and that payment of interest and repayment of the funds are required. Repayment of operating loans must be made within two years of the borrowing;

   b. Identifiable in the facility's accounting records;

   c. Related to the reporting period in which the costs are incurred;

   d. Necessary and proper for the operation, maintenance, or acquisition of the facility. Necessary means that the interest be incurred on a loan made to satisfy a financial need of the facility and for a purpose reasonably related to resident care. Proper means that the interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in an arm's-length transaction. In addition, the interest must be paid to a lender not related to the facility through common ownership or control;

   e. Unrelated to funds borrowed to finance costs of assets in excess of the depreciable cost of the asset as recognized in section 75-02-09-09; and

   f. If associated with refinancing or refunding debt, interest expense associated with the original borrowing must have been allocable when the debt was initially incurred.

2. If it is necessary to issue bonds to finance the costs of assets, any bond premium or discount must be amortized on a straight-line basis over the life of the bond issue.

History: Effective May 1, 1994; amended effective October 1, 2011.
General Authority: NDCC 50-24.1-04
Law Implemented: 42 USC 1396a(a)(30)(A)

75-02-09-11. Taxes.

1. Taxes assessed against the facility in accordance with the levying enactments of the several states and lower levels of government and for which the facility is liable for payment are allowable costs except for those taxes identified as nonallowable in section 75-02-09-08.

2. Whenever exemptions to taxes are legally available, the facility is to take advantage of them. If the facility does not take advantage of available exemptions, the expense incurred for such taxes is not an allowable cost.

3. Special assessments in excess of one thousand dollars paid in a lump sum must be capitalized and depreciated. Special assessments not paid in a lump sum may be expensed as they are billed by the taxing authority.

History: Effective May 1, 1994; amended effective October 1, 2011.
General Authority: NDCC 50-24.1-04
Law Implemented: 42 USC 1396a(a)(30)(A)

75-02-09-12. Home office costs.

1. Home offices of chain organizations vary greatly in size, number of locations, staff, mode of operations, and services furnished to their member facilities. Although the home office of a

chain is normally not a facility in itself, it may furnish to the individual facility central administration or other services such as centralized accounting, purchasing, personnel, or management services. Only the home office's actual costs of providing services is includable in the facility's allowable costs under the program.

2. Costs not allowed in the facility are not allowed as home office costs allocated to the facility.

3. Any service provided by the home office included in costs as payments by the facility to an outside vendor or which duplicates costs for services provided by the facility is a duplication of costs and is not allowed.

4. Where the home office makes a loan to or borrows money from one of the components of a chain organization, the interest paid is not an allowable cost and interest income is not used to offset interest expense.

History: Effective May 1, 1994; amended effective October 1, 2011.
General Authority: NDCC 50-24.1-04
Law Implemented: 42 USC 1396a(a)(30)(A)

75-02-09-13. Related organizations.

1. Costs applicable to services, buildings, equipment, and supplies furnished to a facility by a related organization may not exceed the lower of the costs to the related organization or the price of comparable services, buildings, equipment, or supplies purchased elsewhere primarily in the local market. A facility must identify such related organizations and costs. If any such costs are allocated, the allocation methods and statistics supporting the allocations must be submitted with the cost report.

2. A facility may lease buildings or equipment from a related organization within the meaning of ratesetting principles. In such a case, the rent paid to the lessor by the facility is not allowable as cost unless the rent paid is less than the allowable costs of ownership. If rent paid exceeds the allowable costs of ownership, the facility may include only the allowable costs of ownership. These costs are property insurance, depreciation, interest on the mortgage, real estate taxes, and plant operation expenses incurred by the lessor.

History: Effective May 1, 1994; amended effective October 1, 2011.
General Authority: NDCC 50-24.1-04
Law Implemented: 42 USC 1396a(a)(30)(A)

75-02-09-14. Startup costs.

In the first stages of operation, a new facility incurs certain costs in developing its ability to care for residents prior to their admission. Staff is obtained and organized, and other operating costs are incurred during this time of preparation which cannot be allocated to resident care during that period because there are not residents receiving services. These costs are commonly referred to as startup costs. The startup costs are to be capitalized and will be recognized as allowable administration costs amortized over sixty consecutive months on a straight-line basis starting with the month the first resident is admitted.

History: Effective May 1, 1994; amended effective October 1, 2011.
General Authority: NDCC 50-24.1-04
Law Implemented: 42 USC 1396a(a)(30)(A)

75-02-09-15. Compensation.

Reasonable compensation for an individual with a minimum of five percent ownership, individuals on the governing board, or family members of top management personnel, including spouses and

individuals in the following relationship to top management personnel or their spouses: parent, stepparent, child, stepchild, grandparent, stepgrandparent, grandchild, stepgrandchild, brother, sister, half-brother, half-sister, stepbrother, and stepsister will be considered an allowable cost if services are actually performed and required to be performed. The amount allowed must be in an amount not to exceed the average of salaries paid to individuals in like positions in all psychiatric residential treatment facilities that are nonprofit organizations and have no top management personnel who have a minimum of five percent ownership or are on the governing board. Salaries used to determine the average must be based on the latest information available to the department. Reasonableness also requires that functions performed be necessary in that, had the services not been rendered, the facility would have to employ another individual to perform them.

History: Effective May 1, 1994; amended effective October 1, 2011; January 1, 2025.
General Authority: NDCC 50-24.1-04
Law Implemented: 42 USC 1396a(a)(30)(A)

75-02-09-16. Revenue offsets.

A facility must identify income to offset facility costs when applicable so state financial participation does not supplant or duplicate other funding sources. Any income whether in cash or in any other form received by the facility, with the exception of the established rate, income from payments made under the Workforce Investment Act, donations, and income from charges for private rooms, special services, or bed holds will be offset up to the total of the appropriate actual costs. If actual costs are not identifiable, income will be offset in total to the appropriate cost category. If costs relating to income are reported in more than one cost category, the income must be offset based on the ratio of costs in each of the cost categories. Sources of income include:

1. Income received from or on behalf of employees, guests, or other nonresidents for meals or snacks, or the income received for food and related costs from other government programs such as the United States department of agriculture or the department of public instruction must be offset against dietary costs.

2. Income received from the sale of beverages, candy, or other food items must be offset against dietary costs.

3. Any amount received from insurance for a loss incurred must be offset against the appropriate cost category regardless of when the cost was incurred if the facility did not adjust the basis for depreciable assets.

4. Any refund, rebate, or discount received for a reported cost must be offset against the appropriate cost.

5. Any amount received for use of the facility's vehicles must be offset against transportation costs.

6. Gain on the sale of an asset must be offset against depreciation expense.

7. Revenue received from outside sources for the use of facility buildings or equipment will be offset against property expenses.

8. Any amount received by the facility from outside sources for services provided by facility employees will be offset against salaries.

9. Revenue from investments will be offset against interest expense.

10. Grants, gifts, restricted donations, and awards from the federal, state, local, or philanthropic agencies will be offset against the appropriate cost.

11. Gifts or endowment income designated by a donor for paying specific operating costs incurred in providing contract services must be offset against costs in the year the cost is incurred regardless of when the gift or endowment is received.

12. Other cost-related income or miscellaneous income, including amounts generated through the sale of a previously expensed item, e.g., supplies or equipment, must be offset against the cost category where the item was expensed.

13. Other income to the facility from local, state, or federal units of government may be determined by the department to be an offset against costs.

History: Effective May 1, 1994; amended effective October 1, 2011.
General Authority: NDCC 50-24.1-04
Law Implemented: 42 USC 1396a(a)(30)(A)

75-02-09-17. Private pay rates.

1. The medical assistance rate may not exceed the rate charged to nonmedical assistance residents for the same service. The rate being charged nonmedical assistance residents at the time the services are provided will govern. In cases where the residents are not charged a daily rate, a daily rate will be computed by dividing the total nonmedical assistance charges for each month by the total nonmedical assistance census for each month.

2. If the established medical assistance rate exceeds the rate charged to nonmedical assistance residents for a service, on any given date, the facility shall immediately report that fact to the department and charge the department at the lower rate. If payments were received at the higher rate, the facility shall, within thirty days, refund the overpayment. The refund must be the difference between the established rate and the rate charged to nonmedical assistance residents times the number of medical assistance resident days paid during the period in which the established rate exceeded the nonmedical assistance rate plus interest calculated at two percent over the Bank of North Dakota prime rate on any amount not repaid within thirty days. Interest charges on these refunds are not allowable costs.

History: Effective May 1, 1994; amended effective October 1, 2011.
General Authority: NDCC 50-24.1-04
Law Implemented: 42 USC 1396a(a)(30)(A)

75-02-09-18. Reconsiderations and appeals.

1. **Reconsiderations.**

   a. A facility dissatisfied with the final rate established must request a reconsideration of the final rate before a formal appeal may be made. Any requests for reconsideration must be filed with the department's medical services division within thirty days of the date of the rate notification.

   b. A request for reconsideration must include:

      (1) A statement of each disputed item and the reason or basis for the dispute;

      (2) The dollar amount of each item that is disputed; and

      (3) The statute or rule upon which the facility is relying for each disputed item.

   c. The department may request additional documentation or information relating to a disputed item. If additional documentation is not provided within fourteen days of the department's request, the department shall make its determination based on the

information and documentation available as of the fourteenth day following the date the department requested additional documentation.

d. The department's medical services division shall make a determination regarding the reconsideration within forty-five days of receiving the reconsideration filing and any requested documentation.

2. **Appeals.**

a. A facility dissatisfied with the final rate established may appeal upon completion of the reconsideration process as provided in subsection 1. An appeal must be filed with the department within thirty days of the date on the written notice of the determination by the medical services division with respect to a request for reconsideration.

b. An appeal under this section is timely perfected only if accompanied by written documents, including:

(1) A copy of the letter received from the department's medical services division advising of that division's decision on the request for reconsideration;

(2) A statement of each disputed item and the reason or basis for the dispute;

(3) A computation and the dollar amount which reflects the appealing party's claim as to the correct computation and dollar amount for each disputed item;

(4) The authority in statute or rule upon which the appealing party relies for each disputed item; and

(5) The name, address, and telephone number of the person upon whom all notices will be served regarding the appeal.

History: Effective May 1, 1994; amended effective October 1, 2011.
General Authority: NDCC 50-24.1-04
Law Implemented: 42 USC 1396a(a)(30)(A)

75-02-09-19. Participation requirement.

1. A facility shall have an effective provider agreement with the department.

2. A facility may charge to hold a bed for a period in excess of the period covered under subsection 3 of section 75-02-09-05, if:

a. The resident, or a person acting on behalf of the resident, has requested the bed be held and the facility informs the person making the request, at the time of the request, of the amount of the charge; and

b. For a medical assistance resident, the payment comes from sources other than the resident's monthly income.

History: Effective January 1, 2025.
General Authority: NDCC 50-24.1-04
Law Implemented: 42 USC 1396a(a)(30)(A)

CHAPTER 75-03-23
PROVISION OF HOME AND COMMUNITY-BASED SERVICES UNDER THE SERVICE PAYMENTS FOR ELDERLY AND DISABLED PROGRAM AND THE MEDICAID WAIVER FOR THE AGED AND DISABLED PROGRAM

75-03-23-01. Definitions.

The terms used in this chapter have the same meaning as in North Dakota Century Code chapter 50-06.2. In addition, as used in this chapter:

1. "Activities of daily living" means the daily self-care personal activities that include bathing, dressing or undressing, eating or feeding, toileting, continence, transferring in and out of bed or chair or on and off the toilet, and mobility inside the home.

2. "Adaptive assessment" means an evaluation to identify adaptive devices, equipment, or modifications that enhance the independence and functional capabilities of an individual who may otherwise be unable to remain in the individual's home.

3. "Aged" means sixty-five years of age or older.

4. "Congenital disability" means a disability that exists at birth or shortly thereafter, and is not attributable to a diagnosis of either mental retardation or a closely related condition of mental retardation.

5. "Department" means the North Dakota department of health and human services.

6. "Designee" means a person that enrolls as a qualified service provider to provide case management services for the Medicaid waiver program.

7. "Disability due to trauma" means a disability that results from an injury or assault to the body by an external force.

8. "Disability that is acquired" means a disability that results from an assault that occurs internally within the body.

9. "Disabled" means under age sixty-five with a congenital disability, a disability due to trauma, or a disability that is acquired.

10. "Eligible individual" means an individual who meets the eligibility requirements and is receiving services reimbursed under North Dakota Century Code chapter 50-06.2 or this chapter.

11. "Functional assessment" means an instrument used to record basic demographic and medical information about an individual, including age, date of birth, spoken language, marital status, individuals residing with, emergency contacts, medical resources, health care coverage, and source and reason for referral; and to secure measurable information regarding:

    a. Physical health;

    b. Cognitive and emotional functioning;

    c. Activities of daily living;

    d. Instrumental activities of daily living;

    e. Informal supports;

    f. Need for twenty-four-hour supervision;

    g. Social participation;

    h. Physical environment;

    i. Financial resources;

    j. Adaptive equipment;

    k. Environmental modification; and

    l. Other information about the individual's condition not recorded elsewhere.

12. "Functional impairment" means the inability to perform, either by oneself or with adaptive aids or with human help, specific activities of daily living or instrumental activities of daily living.

13. "Home and community-based services" means the array of services under the SPED program and Medicaid waiver defined in the comprehensive human service plan and the other services the department determines to be essential and appropriate to sustain individuals in their homes and in their communities, and to delay or prevent institutional care.

14. "Institution" means a hospital, swing bed facility, nursing facility, or other provider-operated living arrangement receiving prior approval from the department.

15. "Instrumental activities of daily living" means activities requiring cognitive ability or physical ability, or both. Instrumental activities of daily living include preparing meals, shopping, managing money, housework, laundry, taking medicine, transportation, using the telephone, and mobility outside the home.

16. "Medicaid waiver program" means the federal Medicaid waiver for the aged and disabled program, as defined in subpart G of 42 CFR 441, under which the department is authorized to provide specific home and community-based services to individuals sixty-five years and older, and individuals who are disabled who are at risk of being institutionalized.

17. "Natural supports" means an informal, unpaid caregiver that provides care to an applicant or eligible individual.

18. "Pattern of absenteeism" means an agency or individual provider who has been absent three or more times without notifying the eligible individual or their legal decisionmaker or rescheduling the appointment.

19. "Sanction" means an action taken by the department against a qualified service provider for noncompliance with a federal or state law, rule, or policy, or with the provisions of the Medicaid provider agreement.

20. "Service fee" means the amount a SPED-eligible individual is required to pay toward the cost of the eligible individual's SPED services.

21. "Service payment" means the payment issued by the department to a qualified service provider for the provision of authorized home and community-based services to eligible individuals sixty-five years and older, and individuals who are disabled.

22. "SPED program" means the service payments for elderly and disabled program, a state program which authorizes the department to reimburse qualified service providers for the provision of covered home and community-based services to eligible individuals sixty-five years and older, and individuals who are disabled.

23. "SPED program pool" means the list maintained by the department which contains the names of eligible individuals for whom SPED program funding is available when the eligible individuals' names are transferred from the SPED program pool to SPED program active status.

History: Effective June 1, 1995; amended effective January 1, 2009; October 1, 2014; January 1, 2018; January 1, 2020; July 1, 2020; January 1, 2022; January 1, 2024.
General Authority: NDCC 50-06.2-03(6)
Law Implemented: NDCC 50-06.2-01(3), 50-06.2-03(5)

75-03-23-02. Eligibility criteria.

1. An applicant must be entered in the SPED program pool before service payments may be authorized. The department shall allow entry into the SPED program pool to occur:

   a. When the department's designee submits a form in the manner prescribed by the department; or

   b. When the applicant meets the special circumstances provided in subsection 4, 5, or 6 of section 75-03-23-03.

2. An applicant's resources may not exceed fifty thousand dollars for the applicant to be eligible for services under the SPED program. For purposes of this section, resources are cash or similar assets, except recovery rebates authorized by section 2201 of the federal Coronavirus Aid, Relief, and Economic Security Act of 2020 [Pub. L. 116-136], that can be readily converted to cash and include residences owned by the applicant other than the applicant's primary residence.

3. An applicant eighteen years of age or older is eligible for the SPED program pool if:

   a. The applicant has a functional impairment as specified by the department in policies and procedures to indicate applicant eligibility;

   b. The applicant's functional impairment has lasted, or can be expected to last, three months or longer;

c. The applicant's functional impairment is not the result of a mental illness or a condition of mental retardation, or a closely related condition;

d. The applicant is living in North Dakota in a housing arrangement commonly considered a private residence and not in an institution;

e. The applicant is not eligible for services under the Medicaid waiver program or the Medicaid state plan option of personal care services unless the applicant's estimated monthly benefits under this chapter, excluding the cost of case management, are between the current medically needy income level for a household of one plus the disregard established in North Dakota Century Code section 50-24.1-02.3, and the lowest level of the fee schedule for services under North Dakota Century Code chapter 50 06.2, or unless the individual is receiving a service that is not available under Medicaid or the Medicaid waiver;

f. The applicant would receive one or more of the covered services under department policies and procedures for the specific service;

g. The applicant agrees to the plan of care developed for the provision of home and community-based services;

h. The applicant is not responsible for one hundred percent of the cost of the covered service provided, under the SPED program sliding fee scales based on family size and income; and

i. The applicant has not made a disqualifying transfer of assets.

4. An applicant under eighteen years of age is eligible for the SPED program pool if the applicant is determined to need nursing facility level of care as provided for in section 75-02-02-09 and the applicant's care need is not the result of a mental illness or the condition of mental retardation, or a closely related condition.

5. An applicant under eighteen years of age:

   a. Must meet the eligibility requirements of subsections 3 and 4.

   b. Is not eligible to receive personal care services under this chapter.

   c. Is not eligible for service payments unless:

      (1) Care provided to the applicant by the applicant's parent or the applicant's spouse is provided under family home care.

      (2) The applicant is unable to regularly attend school or is severely limited in the amount of time the applicant is able to attend school.

6. An applicant must be capable of directing self-care or must have a legally responsible party to act on the applicant's behalf.

7. An applicant is not eligible for service payments if the care provided is court-ordered.

8. An applicant is eligible to receive covered services reimbursed under North Dakota Century Code chapter 50-06.2 or this chapter even if the applicant has natural supports.

History: Effective June 1, 1995; amended effective January 1, 2009; October 1, 2014; April 1, 2016; January 1, 2018; May 19, 2020; January 1, 2022.
General Authority: NDCC 50-06.2-03(6)
Law Implemented: NDCC 50-06.2-01(3), 50-06.2-03(5), 50-06.2-04(3)

75-03-23-03. Eligibility determination - Authorization of services.

1. An individual transferred to SPED program active status from the SPED program pool shall continue to meet the eligibility criteria of section 75-03-23-02 in order to remain eligible for services funded under the SPED program.

2. The department is responsible for:

   a. Verifying that the individual transferred to active status continues to meet the eligibility criteria for placement into the SPED program pool;

   b. Developing a care plan;

   c. Authorizing covered services in accordance with department policies and procedures;

   d. Verifying the financial eligibility criteria in relation to income, assets, and deductions; and

   e. Assuring that other potential federal and third-party funding sources for similar services are sought first.

3. A recipient of services under the Medicaid waiver program, who becomes ineligible for the Medicaid waiver program because evaluation shows that the recipient no longer requires a nursing facility level of care, does not have to go through the SPED program pool to receive services through the SPED program provided the individual meets all eligibility criteria in section 75-03-23-02.

4. A recipient of services under the Medicaid personal care service option, who becomes ineligible for services under the Medicaid personal care service option, does not have to go through the SPED program pool to receive services through the SPED program provided the individual meets all eligibility criteria in section 75-03-23-02.

5. A recipient of services under the expanded service payments for elderly and disabled program, who becomes ineligible for services under the expanded service payments for elderly and disabled program, does not have to go through the SPED program pool to receive services through the SPED program provided the individual meets all eligibility criteria in section 75-03-23-02.

6. An individual who is discharged from an inpatient hospital stay, skilled nursing facility, swing-bed facility, long-term care facility, or basic care facility or who has been off of the SPED program for fewer than ninety days, does not have to go through the SPED program pool to receive services through the SPED program provided the individual meets all eligibility criteria in section 75-03-23-02.

History: Effective June 1, 1995; amended effective January 1, 2009; July 1, 2020; January 1, 2022; January 1, 2024.
General Authority: NDCC 50-06.2-03(6)
Law Implemented: NDCC 50-06.2-01(3), 50-06.2-03(5)

75-03-23-04. Eligibility criteria for Medicaid waiver program.

An applicant is eligible to receive services funded by the Medicaid waiver program if:

1. The applicant is sixty-five years and older; or

2. The applicant is under age sixty-five with a congenital disability, a disability due to trauma, or a disability that is acquired and:

a. The disability must not be the result of mental illness as the primary diagnosis or the result of mental retardation, or a closely related condition; and

b. The disability must meet the social security administration's definition of disability or the individual must be determined physically disabled by the state review team under section 75-02-02.1-14.

3. The applicant is receiving Medicaid;

4. The applicant is evaluated to be in need of a nursing facility level of care;

5. The applicant's needs may be met by one or more of the covered services, as determined by an assessment conducted in accordance with department policies and procedures;

6. The applicant's service provider is not the applicant's spouse, except when allowed by an approved waiver, or, if the applicant is less than eighteen years old, the applicant's service provider is not the applicant's parent, stepparent, or a person legally responsible for the care of the individual unless allowed by an approved waiver;

7. The applicant agrees to accept services provided under the Medicaid waiver program instead of nursing home care; and

8. The applicant agrees to the plan of care developed for the provision of home and community-based services.

History: Effective June 1, 1995; amended effective January 1, 2009; January 1, 2024.
General Authority: NDCC 50-06.2-03(6)
Law Implemented: NDCC 50-06.2-01(3), 50-06.2-03(5), 50-06.2-03(6)

75-03-23-05. Services covered under the SPED program - Programmatic criteria.

The department may not include room and board costs in the SPED service payment. The following categories of services are covered under the SPED program and may be provided to an eligible individual:

1. The department may provide adult day care services to an eligible individual:

   a. Who requires assistance in activities of daily living or instrumental activities of daily living;

   b. Who is able to participate in group activities; and

   c. Who, if the eligible individual does not live alone, has a primary caregiver who will benefit from the temporary relief of care giving.

2. The department may provide adult foster care using a licensed adult foster care provider to an eligible individual eighteen years of age or older:

   a. Who resides in a licensed adult foster care home;

   b. Who requires care or supervision;

   c. Who would benefit from a family or shared living environment; and

   d. Whose required care does not exceed the capability of the foster care provider.

3. The department may provide chore services to an eligible individual for one-time, intermittent, or occasional activities which would enable the eligible individual to remain in the home. Activities such as heavy housework and periodic cleaning, professional extermination, snow removal, and emergency response systems may be provided. Eligible individuals receiving

emergency response services must be cognitively and physically capable of activating the emergency response system. The activity must be the responsibility of the eligible individual and not the responsibility of the landlord.

4. The department may provide environmental modification to an eligible individual:

   a. Who owns or rents the home to be modified. If the home is rented the property owner shall approve the modification consistent with the property owner's obligations pursuant to section 804(f)(3)(A) of the Fair Housing Act [42 U.S.C. 3604(f)(3)(A)] before the installation of the environmental modification; and

   b. When the modification will enable the eligible individual to complete the eligible individual's own personal care or to receive care and allow the eligible individual to safely stay in the home.

5. a. The department may provide extended personal care services to an eligible individual who:

      (1) Requires skilled or nursing care that requires training by a nurse licensed under North Dakota Century Code chapter 43-12.1; and

      (2) Has a cognitive or physical impairment that prevents the eligible individual from completing the required activity.

   b. Extended personal care services do not include assistance with activities of daily living or instrumental activities of daily living.

6. The department may provide family home care services to an eligible individual who:

   a. Lives in the same residence as the care provider on a twenty-four-hour basis;

   b. Agrees to the provision of services by the care provider; and

   c. Is the spouse of the care provider or the current or former spouse of one of the following relatives of the eligible individual: parent, grandparent, adult child, adult sibling, adult grandchild, adult niece, or adult nephew.

7. The department may provide home and community-based services case management services to an eligible individual who needs a functional assessment and the coordination of cost-effective delivery issues. A social worker licensed under North Dakota Century Code chapter 43-41 or a registered nurse licensed under North Dakota Century Code chapter 43-12.1 may provide the case management services.

8. The department may provide home-delivered meals to an eligible individual who lives alone and is unable to prepare an adequate meal for themselves, or who lives with an individual who is unable or not available to prepare an adequate meal for the eligible individual.

9. The department may provide homemaker services to an eligible individual who needs assistance with environmental maintenance activities including light housekeeping, laundry, meal planning and preparation, and shopping on an intermittent or occasional basis. The department may pay a provider for laundry, shopping, meal preparation, money management, or communication, if the activity benefits the eligible individual. The department may pay a provider for housekeeping activities involving the eligible individual's personal private space and if the eligible individual is living with an adult, the eligible individual's share of common living space. The homemaker services funding cap applies to a household and may not be exceeded regardless of the number of eligible individuals residing in that household.

10. The department may provide nonmedical transportation services to eligible individuals who are unable to provide their own transportation and need transportation to access essential community services such as grocery stores or pharmacies. "Nonmedical transportation services" are transportation services not related to the receipt of medical care.

11. The department may provide personal care services to an eligible individual who needs help or supervision with personal care activities if:

    a. The eligible individual is at least eighteen years of age; and

    b. The services are provided in the eligible individual's home or in a provider's home if the provider meets the definition of a relative as defined in subdivision c of subsection 6 of section 75-03-23-05.

12. a. The department may provide respite care services to an eligible individual in the eligible individual's home, in the provider's home, in a nursing home, in a swing-bed facility, in a basic care facility, or in a hospital, if:

        (1) The eligible individual has a full-time primary caregiver;

        (2) The eligible individual needs a qualified caregiver or it would be inappropriate to use an unqualified caregiver in the absence of the primary caregiver;

        (3) The primary caregiver's need for the relief is intermittent or occasional; and

        (4) The primary caregiver's need for relief is not due to the primary caregiver's employment or attendance at school as a part-time or full-time student.

    b. An eligible individual who is a resident of an adult foster care may choose a respite provider and is not required to use a relative of the adult foster care provider as the eligible individual's respite provider.

13. The department may provide companionship services up to ten hours per month to eligible individuals who live alone and could benefit from services to help reduce social isolation.

14. The department may provide other services as the department determines appropriate.

History: Effective June 1, 1995; amended effective January 1, 2009; October 1, 2014; April 1, 2016; January 1, 2020; January 1, 2022; January 1, 2024; January 1, 2025.
General Authority: NDCC 50-06.2-03(6)
Law Implemented: NDCC 50-06.2-01(3), 50-06.2-03(5)

75-03-23-06. Services covered under the Medicaid waiver program - Programmatic criteria.

The department may not include room and board costs in the Medicaid waiver service payment. The following services are covered under the Medicaid waiver program and may be provided to an eligible individual:

1. The department may provide adult day care services to an eligible individual:

    a. Who requires assistance in activities of daily living or instrumental activities of daily living;

    b. Who is able to participate in group activities; and

    c. If the eligible individual does not live alone, the eligible individual's primary caregiver will benefit from the temporary relief of care giving.

2. The department may provide adult foster care, using a licensed adult foster care provider, to an eligible individual who resides in a licensed adult foster care home who:

   a. Is eighteen years of age or older;

   b. Requires care or supervision;

   c. Would benefit from a family or shared living environment; and

   d. Requires care that does not exceed the capability of the foster care provider.

3. The department may provide residential care to an eligible individual who:

   a. Has chronic moderate to severe memory loss; or

   b. Has a significant emotional, behavioral, or cognitive impairment.

4. The department may provide chore services to an eligible individual for one-time, intermittent, or occasional activities that would enable the eligible individual to remain in the home, such as heavy housework and periodic cleaning, professional extermination, and snow removal. The activity must be the responsibility of the eligible individual and not the responsibility of the landlord.

5. The department may provide an emergency response system to an eligible individual who lives alone or with an adult who is incapacitated, or who lives with an individual whose routine absences from the home present a safety risk for the eligible individual, and the eligible individual is cognitively and physically capable of activating the emergency response system.

6. The department may provide environmental modification to an eligible individual, if the eligible individual owns or rents the home to be modified and when the modification will enable the eligible individual to complete the eligible individual's own personal care or to receive care and will allow the eligible individual to safely stay in the home for a period of time that is long enough to offset the cost of the modification. If the home is rented the property owner shall approve the modification consistent with the property owner's obligations pursuant to section 804(f)(3)(A) of the Fair Housing Act [42 U.S.C. 3604(f)(3)(A)] before the installation of the environmental modification.

7. a. The department may provide family personal care to an eligible individual who:

      (1) Lives in the same residence as the care provider on a twenty-four-hour basis;

      (2) Agrees to the provision of services by the care provider; and

      (3) Is the legal spouse of the care provider or is a relative identified within the definition of "family home care" under subsection 4 of North Dakota Century Code section 50-06.2-02.

   b. The department may not provide family personal care payment for assistance with the activities of communication, community integration, laundry, meal preparation, money management, shopping, social appropriateness, or transportation unless the activity benefits the eligible individual. The department may not provide a family personal care payment for assistance with the activity of housework unless the activity is for the eligible individual's personal space or if the eligible individual is living with an adult, the eligible individual's share of common living space.

8. The department may provide home and community-based services case management services to an eligible individual who needs a comprehensive assessment or care coordination to ensure cost-effective delivery of services. A social worker licensed under North Dakota

Century Code chapter 43-41, a registered nurse licensed under North Dakota Century Code chapter 43-12.1, or another approved provider with substantially similar credentials as defined in the Medicaid waiver program may provide case management services under this subsection.

9. The department may provide home-delivered meals to an eligible individual who lives alone and is unable to prepare an adequate meal for themselves or who lives with an individual who is unable or not available to prepare an adequate meal.

10. The department may provide homemaker services to an eligible individual who needs assistance with environmental maintenance activities, including light housekeeping, laundry, meal planning and preparation, and shopping on an intermittent or occasional basis. The department may pay a provider for laundry, shopping, meal preparation, money management, or communication, if the activity benefits the eligible individual. The department may pay a provider for housekeeping activities involving the eligible individual's personal private space and if the eligible individual is living with an adult, the eligible individual's share of common living space. The homemaker service funding cap applies to a household and may not be exceeded regardless of the number of eligible individuals residing in that household.

11. a. The department may provide extended personal care services to an eligible individual who:

    (1) Requires skilled or nursing care that requires training by a nurse licensed under North Dakota Century Code chapter 43-12.1; and

    (2) Has a cognitive or physical impairment that prevents the eligible individual from completing the required activity.

    b. Extended personal care services do not include assistance with activities of daily living and instrumental activities of daily living.

12. The department may provide nonmedical transportation services to an eligible individual who is unable to provide their own transportation and who needs transportation to access essential community services such as grocery stores or pharmacies. "Nonmedical transportation services" are transportation services not related to the receipt of medical care.

13. The department may provide up to twenty-four hours per day of supervision to an eligible individual who has a cognitive or physical impairment that results in the eligible individual needing monitoring to assure the eligible individual's continued health and safety.

14. a. The department may provide respite care services to an eligible individual in the eligible individual's home, in the provider's home, in a nursing home, in a swing-bed facility, in a basic care facility, or in a hospital, if:

    (1) The eligible individual has a full-time primary caregiver;

    (2) The eligible individual needs a qualified caregiver or it would be inappropriate to use an unqualified caregiver in the absence of the primary caregiver;

    (3) The primary caregiver's need for the relief is intermittent or occasional; and

    (4) The primary caregiver's need for relief is not due to the primary caregiver's employment or attendance at school as a part-time or full-time student.

    b. An eligible individual who is a resident of an adult foster care home may choose a respite provider and is not required to use a relative of the adult foster care provider as the eligible individual's respite provider.

15. The department may provide specialized equipment and supplies to an eligible individual, if:

    a. The eligible individual's need for the items is based on an adaptive assessment;

    b. The items directly benefit the eligible individual's ability to perform personal care or household activities;

    c. The items will reduce the intensity or frequency of human assistance required to meet the eligible individual care needs;

    d. The items are necessary to prevent the eligible individual's institutionalization;

    e. The items are not available under the Medicaid state plan; and

    f. The eligible individual is motivated to use the item.

16. The department may provide supported employment to an eligible individual who is unlikely to obtain competitive employment at or above the minimum wage; who, because of the eligible individual's disabilities, needs intensive ongoing support to perform in a work setting; and who has successfully completed the supported employment program available through the North Dakota vocational rehabilitation program.

17. The department may provide transitional living services to an eligible individual who needs supervision, training, or assistance with self-care, communication skills, socialization, sensory and motor development, reduction or elimination of maladaptive behavior, community living, and mobility. The department may provide these services until the eligible individual's independent living skills development has been met or until an interdisciplinary team determines the service is no longer appropriate for the eligible individual.

18. The department may provide community transition services to an eligible individual who is transitioning from an institution or another provider-operated living arrangement to a living arrangement in a private residence where the eligible individual is directly responsible for their own living expenses and needs nonrecurring set-up expenses. Community transition services include one-time transition costs and transition coordination.

    a. Allowable expenses are those necessary to enable an eligible individual to establish a basic household that do not constitute room and board and may include:

        (1) Security deposits that are required to obtain a lease on a private residence;

        (2) Essential household furnishings required to occupy and use a private residence, including furniture, window coverings, food preparation items, and bed and bath linens;

        (3) Setup fees or deposits for utility or service access, including telephone, electricity, heating, and water;

        (4) Services necessary for the eligible individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy;

        (5) Moving expenses;

        (6) Necessary home accessibility adaptations; and

        (7) Activities to assess need and to arrange for and procure need resources.

b. Community transition services do not include monthly rental or mortgage expenses, escrow, specials, insurance, food, regular utility or service access charges, household appliances, or items that are intended for purely diversional or recreational purposes.

c. Community transition services are furnished only to the extent that they are reasonable and necessary as determining through the service plan development process, clearly identified in the service plan and the eligible individual is unable to meet such expense, or when the services cannot be obtained from other sources.

19. The department may provide other services as permitted by an approved waiver.

20. The department may provide residential habilitation up to twenty-four hours per day to an eligible individual who needs formalized training and supports and requires some level of ongoing daily support. This service is designed to assist with and develop self-help, socialization, and adaptive skills that improve the eligible individual's ability to independently reside and participate in an integrated community. Residential habilitation may be provided in an agency foster home for adults facility or in a private residence owned or leased by an eligible individual or their family member.

21. The department may provide community support services up to twenty-four hours per day to an eligible individual who requires some level of ongoing daily support. This service is designed to assist with self-care tasks and socialization that improves the eligible individual's ability to independently reside and participate in an integrated community. Community support services may be provided in an agency foster home for adults facility or in a private residence owned or leased by an eligible individual or their family member.

22. The department may provide companionship services up to ten hours per month to eligible individuals who live alone and could benefit from services to help reduce social isolation.

23. The department may provide personal care services to an eligible individual who needs supervision and help with personal care services.

History: Effective June 1, 1995; amended effective January 1, 2009; October 1, 2014; April 1, 2016; January 1, 2018; January 1, 2020; January 1, 2022; January 1, 2024; January 1, 2025.
General Authority: NDCC 50-06.2-03(6)
Law Implemented: NDCC 50-06.2-01(3), 50-06.2-03(5)

75-03-23-07. Qualified service provider standards and agreements.

1. An individual or agency seeking designation as a qualified service provider shall complete and submit the applicable forms supplied by the department in the form and manner prescribed. The qualified service provider, including any employees of an agency designated as a qualified service provider, shall meet all licensure, certification, or competency requirements applicable under state or federal law and departmental standards necessary to provide care to eligible individuals whose care is paid by public funds. An application is not complete until the individual or agency submits all required information and required provider verifications to the department.

2. A provider or an individual seeking designation as a qualified service provider:

   a. Must have the basic ability to read, write, and verbally communicate;

   b. Must not be an individual who has been found guilty of, pled guilty to, or pled no contest to:

      (1) An offense described in North Dakota Century Code chapter 12.1-16, homicide; 12.1-18, kidnapping; 12.1-27.2, sexual performances by children; or 12.1-41, Uniform

Act on Prevention of and Remedies for Human Trafficking; or North Dakota Century Code section 12.1-17-01, simple assault, if a class C felony under subdivision a of subsection 2 of that section; 12.1-17-01.1, assault; 12.1-17-01.2, domestic violence; 12.1-17-02, aggravated assault; 12.1-17-03, reckless endangerment; 12.1-17-04, terrorizing; 12.1-17-06, criminal coercion; 12.1-17-07.1, stalking; 12.1-17-12, assault or homicide while fleeing peace officer; 12.1-20-03, gross sexual imposition; 12.1-20-03.1, continuous sexual abuse of a child; 12.1-20-04, sexual imposition; 12.1-20-05, corruption or solicitation of minors; 12.1-20-05.1, luring minors by computer or other electronic means; 12.1-20-06, sexual abuse of wards; 12.1-20-06.1, sexual exploitation by therapist; 12.1-20-07, sexual assault; 12.1-20-12.3, sexual extortion; 12.1-21-01, arson; 12.1-22-01, robbery; or 12.1-22-02, burglary, if a class B felony under subdivision b of subsection 2 of that section; 12.1-29-01, promoting prostitution; 12.1-29-02, facilitating prostitution; 12.1-31-05, child procurement; 12.1-31-07, endangering a vulnerable adult; 12.1-31-07.1, exploitation of a vulnerable adult; 14-09-22, abuse of a child; 14-09-22.1, neglect of a child; subsection 1 of section 26.1-02.1-02.1, fraudulent insurance acts; or an offense under the laws of another jurisdiction which requires proof of substantially similar elements as required for conviction under any of the enumerated North Dakota statutes; or

(2) An offense, other than a direct-bearing offense identified in paragraph 1 of subdivision b of subsection 2, if the department determines that the individual has not been sufficiently rehabilitated.

(a) The department may not consider a claim that the individual has been sufficiently rehabilitated until any term of probation, parole, or other form of community corrections or imprisonment has elapsed, unless sufficient evidence is provided of rehabilitation.

(b) An individual's completion of a period of three years after final discharge or release from any term of probation, parole, or other form of community corrections or imprisonment, without subsequent charge or conviction, is prima facie evidence of sufficient rehabilitation;

c. In the case of an offense described in North Dakota Century Code section 12.1-17-01, simple assault, if a felony; 12.1-17-01.1, assault; 12.1-17-01.2, domestic violence, if a misdemeanor; 12.1-17-03, reckless endangerment; 12.1-17-04, terrorizing; 12.1-17-06, criminal coercion; 12.1-17-07.1, stalking; 12.1-18-03, unlawful imprisonment; 12.1-20-05, corruption or solicitation of minors, if a misdemeanor; 12.1-20-07, sexual assault, if a misdemeanor; or equivalent conduct in another jurisdiction which requires proof of substantially similar elements as required for conviction, the department may determine that the individual has been sufficiently rehabilitated if five years have elapsed after final discharge or release from any term of probation, parole, or other form of community corrections or imprisonment;

d. Shall maintain confidentiality;

e. Shall, using applicable forms and providing documentation as required by the department:

(1) Revalidate qualified service provider enrollment except as provided in paragraph 3, within the time period as required by the Medicaid state plan option for personal care services or Medicaid waiver program, whichever occurs first; and

(2) Provide evidence of competency, except as provided in paragraph 3, at least every sixty months for an agency enrolled as a qualified service provider or at least every

thirty months for an individual enrolled as a qualified service provider, and within the time period as required by the Medicaid state plan option for personal care services or Medicaid waiver program, whichever occurs first; or

(3) Revalidate qualified service provider enrollment only every sixty months for an individual enrolled as a qualified service provider providing family home care services under the SPED program and expanded service payments for elderly and disabled;

f. Must be physically capable of performing the service for which they were contracted with or hired as an independent contractor; and

g. Must be at least eighteen years of age.

h. A representative of an enrolled qualified service provider agency or an individual qualified service provider shall complete a department-approved qualified service provider orientation prior to initial enrollment.

3. If the physical, cognitive, social, or emotional health capabilities of an applicant or provider appear to be questionable, the department may require the applicant or provider to present evidence of the applicant's or provider's ability to provide the required care based on a formal evaluation. The department is not responsible for costs of any required evaluation.

4. The offenses enumerated in paragraph 1 of subdivision b of subsection 2 have a direct bearing on an individual's ability to be enrolled as a qualified service provider.

a. An individual enrolled as a qualified service provider prior to January 1, 2009, who has been found guilty of, pled guilty to, or pled no contest to, an offense considered to have a direct bearing on the individual's ability to provide care may be considered rehabilitated and may continue to provide services if the individual has had no other offenses and provides sufficient evidence of rehabilitation to the department.

b. The department may not approve, deny, or renew an application for an individual or employee of an agency who is applying to enroll or re-enroll as a qualified service provider and who has been charged with an offense considered to have a direct bearing on the individual's ability to provide care or an offense in which the alleged victim was under the applicant's care, until final disposition of the criminal case against the individual.

5. Evidence of competency for adult foster care providers serving eligible individuals eligible for the developmental disability waiver must be provided in accordance with subdivision b of subsection 2 of section 75-03-21-08.

6. A provider of services for adult day care, adult foster care, community support services, extended personal care, family personal care, nurse assessment, personal care, residential care, respite care, residential habilitation, supervision, and transitional living care shall provide evidence of competency in generally accepted procedures for:

a. Infection control and proper handwashing methods;

b. Handling and disposing of body fluids;

c. Tub, shower, and bed bathing techniques;

d. Hair care techniques, sink shampoo, and shaving;

e. Oral hygiene techniques of brushing teeth and cleaning dentures;

f. Caring for an eligible individual who is incontinent;

g. Feeding or assisting an eligible individual with eating;

h. Basic meal planning and preparation;

i. Assisting an eligible individual with the self-administration of medications;

j. Maintaining a kitchen, bathroom, and other rooms used by an eligible individual in a clean and safe condition, including dusting, vacuuming, floor care, garbage removal, changing linens, and other similar tasks;

k. Laundry techniques, including mending, washing, drying, folding, putting away, ironing, and related work;

l. Assisting an eligible individual with bill paying and balancing a check book;

m. Dressing and undressing an eligible individual;

n. Assisting with toileting;

o. Routine eye care;

p. Proper care of fingernails;

q. Caring for skin;

r. Turning and positioning an eligible individual in bed;

s. Transfer using a belt, standard sit, or bed to wheelchair;

t. Assisting an eligible individual with ambulation; and

u. Making wrinkle-free beds.

7. An applicant for qualified service provider status for adult foster care, extended personal care, family personal care, nurse assessment, personal care, residential care, supervision, transitional living care, respite care, or adult day care shall secure written verification that the applicant is competent to perform procedures specified in subsection 5 from a physician, chiropractor, registered nurse, licensed practical nurse, occupational therapist, physical therapist, or an individual with a professional degree in specialized areas of health care. Written verification of competency is not required if the individual holds one of the following licenses or certifications in good standing: physician, physician assistant, chiropractor, registered nurse, licensed practical nurse, registered physical therapist, registered occupational therapist, or certified nurse assistant. A certificate or another form of acknowledgment of completion of a program with a curriculum that includes the competencies in subsection 5 may be considered evidence of competence.

8. The department may approve global and eligible individual-specific endorsements to provide particular procedures for a provider based on written verification of competence to perform the procedure from a physician, chiropractor, registered nurse, occupational therapist, physical therapist, or other individual with a professional degree in a specialized area of health care or approved within the scope of the individual's health care license or certification.

9. Competence may be demonstrated in the following ways:

a. A demonstration of the procedure being performed;

b. A detailed verbal explanation of the procedure; or

c. A detailed written explanation of the procedure.

10. The department shall notify the individual or the agency of its decision on designation as a qualified service provider.

11. The department shall maintain a list of qualified service providers. Once the eligible individual's need for services has been determined, the eligible individual selects a provider from the list and the department's designee issues an authorization to provide services to the selected qualified service provider.

12. The department may issue a service payment to a qualified service provider that bills the department after the delivery of authorized services.

13. Agency providers who employ nonfamily members shall have a department-approved quality improvement program that includes a process to identify, address, and mitigate harm to the eligible individuals they serve.

14. Agency providers who have accepted an authorization to provide twenty-four-hour supports to an eligible individual shall give a thirty-day written notice before they can involuntarily discharge the eligible individual from their care, unless otherwise approved by the department.

History: Effective June 1, 1995; amended effective March 1, 1997; January 1, 2009; October 1, 2014; April 1, 2016; January 1, 2018; January 1, 2020; January 1, 2022; October 1, 2022; January 1, 2024; January 1, 2025.
General Authority: NDCC 50-06.2-03(6)
Law Implemented: NDCC 50-06.2-03(5)

75-03-23-08. Denial of application to become a qualified service provider.

The department may deny an application to become a qualified service provider if:

1. The applicant voluntarily withdraws the application;

2. The applicant is not in compliance with applicable state laws, state regulations, or program issuances governing providers;

3. The applicant, if previously enrolled as a qualified service provider, was not in compliance with the terms set forth in the application or provider agreement;

4. The applicant, if previously enrolled as a qualified service provider, was not in compliance with the provider certification terms on the claims submitted for payment;

5. The applicant, if previously enrolled as a qualified service provider, had assigned or otherwise transferred the right to payment of a program claim, except as provided in 42 U.S.C. 1396a(a)(32);

6. The applicant, if previously enrolled as a qualified service provider, had demonstrated a pattern of submitting inaccurate billings or cost reports;

7. The applicant, if previously enrolled as a qualified service provider, had demonstrated a pattern of submitting billings for services not covered under department programs;

8. The applicant has been debarred or the applicant's license or certificate to practice in the applicant's profession or to conduct business has been suspended or terminated;

9. The applicant has delivered goods, supplies, or services that are of an inferior quality or are harmful to individuals;

10. The applicant has been convicted of an offense determined by the department to have a direct bearing upon the applicant's ability to be enrolled as a qualified service provider, or the department determines, following conviction of any other offense, the applicant is not sufficiently rehabilitated;

11. The applicant, if previously enrolled as a qualified service provider, owes the department money for payments incorrectly made to the provider;

12. The qualified service provider is currently excluded from participation in Medicare, Medicaid, or any other federal health care program;

13. The applicant has not provided sufficient evidence to the department, after obtaining a formal evaluation under subsection 3 of section 75-03-23-07, that the applicant is physically, cognitively, socially, or emotionally capable of providing the care;

14. The applicant previously has been terminated for inactivity and does not have a prospective public pay-eligible individual;

15. The applicant previously has been terminated for inactivity and has not provided valid reason for the inactivity; or

16. For other good cause.

History: Effective June 1, 1995; amended effective January 1, 2009; October 1, 2014; April 1, 2016; January 1, 2020; January 1, 2022; October 1, 2022; January 1, 2024.
General Authority: NDCC 50-06.2-03(6)
Law Implemented: NDCC 50-06.2-03(5)

75-03-23-08.1. Sanctions and termination of qualified service providers.

1. The department may impose sanctions against a qualified service provider for any of the reasons listed under section 75-02-05-05 or subdivisions b though g of subsection 4. Prior to imposing sanctions, the department may require provider education or a business integrity agreement.

2. The department may consider the following in determining the sanction to be imposed:

   a. Seriousness of the qualified service provider's offense.

   b. Extent of the qualified service provider's violations.

   c. Qualified service provider's history of prior violations.

   d. Prior imposition of sanctions against the qualified service provider.

   e. Prior provision of information and training to the qualified service provider.

   f. Qualified service provider's agreement to make restitution to the department.

   g. Actions taken or recommended by peer groups or licensing boards.

   h. Access to care for eligible individuals.

   i. Qualified service provider's self-disclosure or self-audit discoveries.

   j. Qualified service provider's willingness to enter a business integrity agreement.

3. The department may impose any of the sanctions listed in subsections 8 or 9 of section 75-02-05-07.

4. The department may terminate a qualified service provider if:

   a. The qualified service provider voluntarily withdraws from participation as a qualified service provider.

   b. The qualified service provider is not in compliance with applicable state laws, state regulations, or program issuances governing providers.

   c. The qualified service provider is not in compliance with the terms set forth in the application or provider agreement.

   d. The qualified service provider is not in compliance with the provider certification terms on the claims submitted for payment.

   e. The qualified service provider has assigned or otherwise transferred the right to payment of a program claim, except as provided in 42 U.S.C. 1396a(a)(32).

   f. The qualified service provider has demonstrated a pattern of submitting inaccurate billings or cost reports.

   g. The qualified service provider has demonstrated a pattern of submitting billings for services not covered under department programs.

   h. The qualified service provider has been debarred or the provider's license or certificate to practice in the provider's profession or to conduct business has been suspended or terminated.

   i. The qualified service provider has delivered goods, supplies, or services that are of an inferior quality or are harmful to individuals.

   j. The qualified service provider has been convicted of an offense determined by the department to have a direct bearing upon the provider's ability to be enrolled as a qualified service provider, or the department determines, following conviction of any other offense, the provider is not sufficiently rehabilitated.

   k. The qualified service provider is currently excluded from participation in Medicare, Medicaid, or any other federal health care program.

   l. The qualified service provider has not provided sufficient evidence to the department, after obtaining a formal evaluation under subsection 3 of section 75-03-23-07 that the provider is physically, cognitively, socially, or emotionally capable of providing the care.

   m. The qualified service provider refuses to repay or make arrangements for the repayment of identified overpayments or otherwise erroneous payments.

   n. There has been no billing activity within the twelve months since the qualified service provider's enrollment or most recent re-enrollment date.

   o. The qualified service provider has demonstrated a pattern of absenteeism by failing to provide care they have been authorized and agreed to provide per subsection 11 of section 75-03-23-07 to an eligible individual.

   p. For other good cause.

History: Effective January 1, 2020; amended effective January 1, 2022; October 1, 2022; January 1, 2024.
General Authority: NDCC 50-06.2-03(6)
Law Implemented: NDCC 50-06.2-03(5)

75-03-23-09. Payment under the SPED program and the Medicaid waiver program.

1. The department shall establish provider rates for home and community-based service in accordance with a procedure that factors in:

   a. Whether a provider is an individual or an agency; and

   b. The range of rates submitted by various providers.

2. The rate for a specific qualified service provider is established at the time the provider agreement is signed.

3. The department shall grant a request for a rate decrease when the department receives a written request for the decrease from the qualified service provider.

4. The department shall grant in full or in part, or shall deny, a request for a rate increase when the department receives a written request for the rate increase from the qualified service provider.

5. The department shall determine the maximum amount allowable per eligible individual each month for a specific service.

6. The department shall establish the aggregate maximum amount allowable per eligible individual each month for all services. The aggregate maximum amount per eligible individual depends on whether the eligible individual is receiving services under the SPED program, under the Medicaid waiver program, or under both programs.

7. The department or designee may grant approval to exceed the monthly service program maximum for a specific eligible individual who is only receiving SPED funds and no Medicaid funds if the eligible individual has a special or unique circumstance; the SPED-eligible individual is not eligible for Medicaid; and the need for additional service program funds will not initially exceed three months. Under emergency conditions, the department may grant a one-time extension not to exceed an additional three months.

8. The department may grant approval to exceed the monthly service program maximum for a specific eligible individual who is receiving SPED funds and Medicaid funds or only Medicaid funds if the eligible individual has a special or unique circumstance; and the need for additional service program funds does not exceed three months. Under emergency conditions, the department may grant a one-time extension not to exceed an additional three months.

9. The department's designee shall notify the eligible individual of the department's determination regarding the request to exceed the monthly service program maximum. If the department denies the request to exceed the monthly aggregate maximum, the department's designee shall inform the eligible individual in writing of the reason for the denial, the eligible individual's right to appeal, and the appeal process, as provided in chapter 75-01-03.

10. The department will grant approval to exceed the monthly program maximum or service maximum for eligible individuals receiving SPED funds or Medicaid funds, or both, whose service units exceed the program caps as a result of the qualified service provider rate increase. This extension is limited to eligible individuals who were receiving services prior to July 1, 2007.

11. Upon written application and good cause shown to the satisfaction of the department, the department may grant a variance to the three months extension and one-time extension limitation in subsections 7 and 8 upon such terms as the department may prescribe, except no variance may permit or authorize a danger to the health or safety of a client and no variance

may be granted except at the discretion of the department. A refusal to grant a variance is not subject to appeal.

History: Effective June 1, 1995; amended effective September 27, 2007; January 1, 2009; October 1, 2022; January 1, 2024.
General Authority: NDCC 50-06.2-03(6)
Law Implemented: NDCC 50-06.2-03(5)

75-03-23-10. Department to recover funds upon establishment of noncompliance.

A qualified service provider shall not submit a claim for payment or receive service payments for services that have not been delivered in accord with department policies and procedures. The department shall recover all payments received by a qualified service provider who fails to deliver the services in accord with the provider agreement or department policy and procedure.

History: Effective June 1, 1995.
General Authority: NDCC 50-06.2-03(6)
Law Implemented: NDCC 50-06.2-03(5), 50-06.2-03(6)

75-03-23-11. Denial, reduction, and termination of services - Appeal.

1. The department or its designee shall inform an individual who is determined to be ineligible for covered services or who becomes ineligible while receiving services in writing of the denial, termination, or reduction, the reasons for the denial, termination, or reduction, the right to appeal, and the appeal process as provided in chapter 75-01-03.

2. An eligible individual must receive ten calendar days' written notice before termination of services occurs. The ten-day notice is not required if:

   a. The eligible individual enters a basic care facility or a nursing facility;

   b. The termination is due to changes in federal or state law;

   c. The eligible individual requests termination of services; or

   d. The eligible individual moves from the service area.

3. An applicant denied services or an eligible individual terminated from services should be given an appropriate referral to other public or private service providers and should be assisted in finding other resources.

4. The department shall deny or terminate SPED program and Medicaid waiver program services when service to the eligible individual presents an immediate threat to the health or safety of the eligible individual, the provider of services, or others or when services that are available are not adequate to prevent a threat to the health or safety of the eligible individual, the provider of services, or others. Examples of health and safety threats include physical abuse of the provider by the eligible individual, eligible individual self-neglect, an unsafe living environment for the eligible individual, or contraindicated practices, like smoking while using oxygen.

History: Effective June 1, 1995; amended effective January 1, 2009; July 1, 2020; January 1, 2024.
General Authority: NDCC 50-06.2-03(6)
Law Implemented: NDCC 50-06.2-03(5), 50-06.2-03(6), 50-06.2-04(1), 50-06.2-04(3)

75-03-23-12. Provider - Request for review.

A qualified service provider may request a review of denial of payment in accordance with North Dakota Century Code section 50-24.1-24.

History: Effective January 1, 2009; amended effective January 1, 2020.
General Authority: NDCC 50-06.2-03, 50-24.1-24
Law Implemented: NDCC 50-06.2-03, 50-24.1-24

75-03-23-13. Provider - Appeals.

An applicant or provider may appeal a decision to deny or revoke a qualified service provider enrollment by filing a written appeal with the department within ten days of receipt of written notice of the denial or revocation. Upon receipt of a timely appeal, an administrative hearing may be conducted in the manner provided in chapter 75-01-03. A provider or applicant who receives notice of termination or denial of the individual's qualified service provider status and requests a timely review of that decision is not eligible to provide services until a final decision has been made by the department that reverses the decision to terminate or deny qualified service provider status.

History: Effective January 1, 2009.
General Authority: NDCC 50-06.2-03
Law Implemented: NDCC 50-06.2-03

75-03-23-14. Disqualifying transfers.

1. An individual is not eligible for SPED benefits under this chapter if the department determines that the individual or the spouse of the individual has made any assignment or transfer of any asset for the purpose of making the individual eligible for benefits before or after making application for SPED services except as provided in subsection 2.

2. An individual is not ineligible for SPED benefits under this chapter by reason of subsection 1 to the extent that:

   a. The value of the transferred assets when added to the value of the individual's other assets would not otherwise make the individual ineligible for SPED or does not decrease the individual's service fee.

   b. The asset transferred was a home, and title to the home was transferred to:

      (1) The individual's spouse; or

      (2) The individual's son or daughter who is under the age of twenty-one or who is blind or disabled.

   c. The assets:

      (1) Were transferred to the individual's spouse or to another person for the sole benefit of the individual's spouse; or

      (2) Were transferred from the individual's spouse to another person for the sole benefit of the individual's spouse.

   d. The individual makes a satisfactory showing that:

      (1) The individual intended to dispose of the assets at fair market value or for other valuable consideration, and the individual had an objectively reasonable belief that fair market value or its equivalent was received;

      (2) The assets were transferred exclusively for a purpose other than to qualify for SPED benefits under this chapter; or

      (3) All assets transferred for less than fair market value have been returned to the individual.

e. If a disqualifying transfer occurred five years prior to the date an individual initially applies for SPED services, the department will presume that the transfer was not for the purpose of obtaining SPED benefits.

3. There is a presumption that a transfer was made for purposes of making an individual eligible for SPED services under this chapter:

   a. If an inquiry about SPED benefits or benefits under this chapter was made, by or on behalf of the individual to any other individual, before the date of transfer;

   b. If the individual or the individual's spouse was an applicant for or an eligible individual of SPED benefits under this chapter before the date of transfer;

   c. If a transfer is made by or on behalf of the individual's spouse, if the value of the transferred asset, when added to the value of the individual's other assets, would exceed SPED asset limits; or

   d. If the transfer was made, on behalf of the individual or the individual's spouse, by a guardian, conservator, or attorney-in-fact, to the guardian, conservator, or attorney-in-fact or to any spouse, child, grandchild, brother, sister, niece, nephew, parent, or grandparent, by birth, adoption, or marriage, of the guardian, conservator, or attorney-in-fact.

4. An applicant or eligible individual who claims that assets were transferred exclusively for a purpose other than to qualify for SPED benefits under this chapter must show a desire to receive SPED benefits under this chapter played no part in the decision to make the transfer and must rebut any presumption arising under subsection 3.

5. If the transferee of any assets is the child, grandchild, brother, sister, niece, nephew, parent, grandparent, stepparent, stepchild, son-in-law, daughter-in-law, or grandchild-in-law of the individual or the individual's spouse, services or assistance furnished by the transferee to the individual or the individual's spouse may not be treated as consideration for the transferred asset unless the transfer is made pursuant to a valid written contract entered into prior to rendering the services.

6. A transfer is complete when the individual, or the individual's spouse, making the transfer has no lawful means of undoing the transfer or requiring a restoration of ownership.

7. For purposes of this section, fair market value is received:

   a. When one hundred percent of apparent fair market value is received for an asset whose value is not subject to reasonable dispute, such as cash, bank deposits, stocks, and fungible commodities;

   b. When seventy-five percent of estimated fair market value is received for an asset whose value may be subject to reasonable dispute; and

   c. When one hundred percent of fair market value is received for an asset considered to be income to the individual or individual's spouse.

8. If an applicant or eligible individual is denied Medicaid based on a disqualifying transfer of assets, the SPED applicant or eligible individual is also ineligible for SPED-funded services.

History: Effective January 1, 2009; amended effective January 1, 2024.
General Authority: NDCC 50-06.2-07
Law Implemented: NDCC 50-06.2-07

75-03-23-15. Application - Applicant required to provide proof of eligibility.

1. An individual wishing to apply for benefits under this chapter must have the opportunity to do so, without delay.

2. An application is a request made to the department or its designee by an individual seeking services under this chapter, or by an individual properly seeking services on behalf of another individual. "An individual properly seeking services" means an individual of sufficient maturity and understanding to act responsibly on behalf of the individual for whom services are sought.

3. An application must include a functional assessment.

4. The individual seeking services under this chapter, or an individual properly seeking services on behalf of that individual, shall sign the application.

5. The department or its designee shall provide information concerning eligibility requirements, available services, and the rights and responsibilities of individuals seeking services under this chapter and of eligible individuals to all who require it.

6. The date of application is the date the department or its designee receives the properly signed application.

7. The individual seeking services under this chapter shall provide information sufficient to establish eligibility for benefits, including a social security number and proof of age, identity, residence, blindness, disability, functional limitation, financial eligibility, and other information required under this chapter.

History: Effective October 1, 2014; amended effective July 1, 2020; January 1, 2024.
General Authority: NDCC 50-06.2-03
Law Implemented: NDCC 50-06.2-03

75-03-23-16. Reapplication after denial or termination.

A provider or applicant whose qualified service provider status has been terminated or denied may not reapply if:

1. The provider's or applicant's status as a qualified service provider has been denied or revoked within the twelve months prior to the date of the current application; except that in the case of an individual who has been denied or terminated under subparagraph a of paragraph 2 of subdivision b of subsection 2 of section 75-03-23-07, the individual may reapply after completion of the term of probation; or

2. The provider's or applicant's status as a qualified service provider has been denied or revoked three or more times and the most recent revocation or denial occurred within the three years immediately preceding the application date.

History: Effective October 1, 2014; amended effective January 1, 2020.
General Authority: NDCC 50-06.2-03
Law Implemented: NDCC 50-06.2-03

75-03-23-17. Functional assessment.

1. An initial functional assessment, using the form required by the department, must be completed as a part of the application for benefits under this chapter. A functional assessment must be completed at least semiannually in conjunction with the eligibility redetermination.

2. The functional assessment must include an interview with the individual in the home where the individual resides.

History: Effective October 1, 2014.
General Authority: NDCC 50-06.2-03
Law Implemented: NDCC 50-06.2-03

ARTICLE 75-04
DEVELOPMENTAL DISABILITIES

CHAPTER 75-04-01
LICENSING OF PROGRAMS AND SERVICES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES - DEVELOPMENTAL DISABILITIES

75-04-01-01. Definitions.

In this chapter, unless the context or subject matter requires otherwise:

1. "Accreditation" means accredited by a department-approved national organization of a licensee's compliance with a set of specified standards.

2. "Applicant" means an entity that has requested licensure from the North Dakota department of health and human services pursuant to North Dakota Century Code chapter 25-16 and this chapter.

3. "Application" means a request in the form and manner prescribed by the department signed by the applicant or principal officer on behalf of the applicant.

4. "Authorized representative" means a person who has legal authority, either designated or granted, to make decisions on behalf of the eligible individual.

5. "Day habilitation" means a day program of scheduled activities, formalized training, and staff supports to promote skill development for the acquisition, retention, or improvement in self-help, socialization, and adaptive skills. Activities should focus on improving a an eligible individual's sensory, motor, cognitive, communication, and social interaction skills.

6. "Department" means the North Dakota department of health and human services.

7. "Developmental disability" means a severe, chronic disability of an individual which:

    a. Is attributable to a mental or physical impairment or combination of mental and physical impairments, including Down syndrome and fetal alcohol spectrum disorders, including fetal alcohol syndrome, partial fetal alcohol syndrome, and alcohol-related neurodevelopmental disorder;

    b. Is manifested before the individual attains age twenty-two;

    c. Is likely to continue indefinitely;

    d. Results in substantial functional limitations in three or more of the following areas of major life activity:

        (1) Self-care;

        (2) Receptive and expressive language;

        (3) Learning;

(4) Mobility;

(5) Self-direction;

(6) Capacity for independent living; and

(7) Economic sufficiency; and

e. Reflects the individual's needs for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.

8. "Developmental disability services" means those services required to be provided by an entity in order to obtain and maintain a license.

9. "Eligible individual" means an individual found eligible as determined through the application of chapter 75-04-06 for services coordinated through intellectual disabilities - developmental disabilities program management, on whose behalf services are provided or purchased.

10. "Employment support" means ongoing supports to assist eligible individuals in obtaining and maintaining paid employment at or above minimum wage in an integrated setting. Services are designed for eligible individuals who need intensive ongoing support to perform in a work setting. Service includes on-the-job or off-the-job employment-related support for eligible individuals needing intervention to assist them in maintaining employment, including job development. Employment support includes individual employment support and small group employment support.

11. "Family member" means relatives of a an eligible individual to the second degree of kinship.

12. "Family support services" means a family-centered support service contracted based on the eligible individual's or primary caregiver's need for support in meeting the health, developmental, and safety needs to remain in an appropriate home environment. Family support services includes parenting support, respite, extended home health care, in-home supports, and family care option.

13. "Governing body" means the individual or individuals designated in the articles of incorporation of a corporation, bylaws, or constitution of a legal entity as being authorized to act on behalf of the entity.

14. "Group home" means any community residential service facility, licensed by the department pursuant to North Dakota Century Code chapter 25-16 and this chapter, housing more than three individuals with developmental disabilities. "Group home" does not include a community complex with self-contained rental units.

15. "Infant development" means a systematic application of an individualized family service plan designed to alleviate or mediate developmental delay of the eligible individual from birth through age two.

16. "Intellectual disability" means a diagnosis of the condition of intellectual disability, based on an individually administered standardized intelligence test and standardized measure of adaptive behavior as accepted by the American psychiatric association, and made by an appropriately licensed professional.

17. "Intermediate care facility for individuals with intellectual disabilities" means a residential health facility operated pursuant to title 42, Code of Federal Regulations, parts 442 and 483, et seq.

18. "License" means authorization by the department to provide a service to eligible individuals, pursuant to North Dakota Century Code chapter 25-16 and this chapter.

19. "Licensee" means that entity which has received authorization by the department, pursuant to North Dakota Century Code chapter 25-16 and this chapter and who has executed a Medicaid agreement with the department, to provide a service or services to eligible individuals.

20. "Prevocational services" means formalized training, experiences, and staff supports designed to prepare eligible individuals for paid employment in integrated community settings. Services are structured to develop general abilities and skills that support employability in a work setting. Services are not directed at teaching job-specific skills, but at specific habilitative goals outlined in the eligible individual's person-centered service plan.

21. "Primary caregiver" means a responsible person providing continuous care and supervision to an eligible individual that prevents institutionalization in meeting the needs of the eligible individual and who is not employed by or working under contract of a licensee pursuant to this chapter.

22. "Principal officer" means the presiding member of a governing body, a chairperson, or president of a board of directors.

23. "Program management" means a process of interconnected steps which will assist an eligible individual in gaining access to needed services, including medical, social, educational, and other services, regardless of the funding source for the services to which access is gained.

24. "Resident" means an individual receiving services provided through any licensed residential facility or service.

25. "Residential services" means formalized training and supports provided to eligible individuals to assist with and develop self-help, socialization, and adaptive skills that improve the eligible individual's ability to independently reside and participate in an integrated community. Residential services include residential rehabilitation and independent habilitation.

26. "Standards" means requirements which result in accreditation and, if applicable, certification as an intermediate care facility for individuals with intellectual disabilities.

History: Effective April 1, 1982; amended effective June 1, 1986; December 1, 1995; April 1, 2000; July 1, 2001; July 1, 2012; April 1, 2018; April 1, 2020; January 1, 2025.
General Authority: NDCC 25-01.2-18, 25-16-06, 50-06-16
Law Implemented: NDCC 25-01.2-18, 25-16-06

75-04-01-02. License required and renewal.

1. No individual, association of individuals, partnership, limited liability company, or corporation shall offer or provide a service or own, manage, or operate a facility offering or providing a service to more than two individuals with developmental disabilities without first having obtained a license from the department unless the facility is:

   a. Exempted by North Dakota Century Code section 15.1-34-02; or

   b. Operated by a nonprofit corporation that receives no payments from the state or any political subdivision and provides only day supports for six or fewer individuals with developmental disabilities. "Payment" does not include donations of goods and services or discounts on goods and services.

2. Licensure does not create an obligation for the state to purchase services from the licensee.

3. At the discretion of the department, the department may issue a single license for a discrete service or issue multiple licenses by service location.

4. A license is nontransferable, expires not more than one year from the effective date of the license, and is valid for the services or locations identified therein.

5. A license issued by the department must include the legal name of the licensee, the address or location where services are provided, the occupancy or service limitations, the unique services authorized, the region and counties where services are provided, and the expiration date of the license.

6. A licensee shall submit to the department an application for a license no later than sixty days prior to the expiration date of a valid license. If the licensee is not able to provide the application within this time frame, a request to waive the sixty days submission timeline must be submitted to the department prior to the license expiration date. If the licensee continues to meet all standards established by North Dakota Century Code chapters 25-01.2 and 25-16 and the rules of the department, the department shall issue a license renewal.

7. The licensee shall place the license in an area accessible to the public where it may be readily seen, except in residences or residential areas of a facility where a license must be available to the public or the department upon request.

8. Licensees shall sign a Medicaid provider agreement and required addendums with the department to provide services to eligible individuals.

9. A licensee who voluntarily terminates a license shall submit a new application to reapply for licensure.

History: Effective April 1, 1982; amended effective June 1, 1986; December 1, 1995; July 1, 2001; July 1, 2012; April 1, 2018; January 1, 2025.
General Authority: NDCC 25-01.2-18, 25-16-06, 50-06-16
Law Implemented: NDCC 25-01.2-18, 25-16-02, 25-16-03

75-04-01-03. Application.

1. An applicant shall submit an application for a license to provide services or operate a facility to the department in the form and manner prescribed by the department.

2. An application is not complete until all required information and verifications are submitted to the department. The department may declare an application withdrawn if an applicant fails to submit all required information and verifications within thirty days of the department's notification to the applicant the application is incomplete.

3. Within sixty days from the date of the receipt of the completed application, the department shall notify the applicant of the department's intent to grant or deny a license.

History: Effective April 1, 1982; amended effective January 1, 2025.
General Authority: NDCC 25-16-06, 50-06-16
Law Implemented: NDCC 25-16-03

75-04-01-03.1. Types of licenses.

A license issued pursuant to North Dakota Century Code chapter 25-16 and this chapter must be identified as a provisional, unrestricted, or restricted license.

1. A "provisional license" may be issued to an applicant who complies with the rules of the department, North Dakota Century Code chapters 25-01.2 and 25-16, and who has engaged

in obtaining accreditation. The licensee shall obtain accreditation by the expiration of the provisional license. A provisional license may be extended for an additional six months only upon the department's determination the licensee has made significant progress toward obtaining accreditation.

2. An "unrestricted license" may be issued to an applicant who complies with the rules of the department and North Dakota Century Code chapters 25-01.2 and 25-16, and who is accredited.

3. A "restricted license" may be issued to a licensee upon a finding of noncompliance with the rules of the department and North Dakota Century Code chapters 25-01.2 and 25-16.

   a. The department may not issue a restricted license to a licensee whose practices or facilities pose a clear and present danger to the health and safety of eligible individuals.

   b. The department may issue a restricted license for any or all services provided, or facilities operated by the licensee.

   c. Upon a finding that the licensee is not in compliance, the department shall notify the licensee, in writing, of its intent to issue a restricted license. The notice must provide the reasons for the action, the specific services that are affected by the restricted license, and describe the corrective actions required of the licensee.

   d. The licensee shall, within ten days of the receipt of notice under subdivision c, submit to the department, on a form provided, a plan of correction. The plan of correction must include the elements of noncompliance, a description of the corrective action to be undertaken, and a date certain of compliance. The department may accept, modify, or reject the licensee's plan of correction and shall notify the licensees of its decision within thirty days. If the plan of correction is not submitted or it is rejected, the department shall notify the licensee the license has been revoked. The department may conduct periodic inspection of the facilities and operations of the licensee to evaluate the implementation of the plan of correction.

   e. The department shall terminate a restricted license and issue an unrestricted license to the licensee upon successful completion of an accepted plan of correction.

   f. A restricted license may be extended for an additional six months only upon the department's determination the licensee has made significant progress toward meeting the standards identified in the plan of correction or the licensee has shown good cause for failure to implement the plan of correction.

History: Effective January 1, 2025.
General Authority: NDCC 25-01.2-18, 25-16-06, 50-06-16
Law Implemented: NDCC 25-01.2-18, 25-16-02, 25-16-03

75-04-01-04. License denial or revocation.

The department may deny a license to an applicant or licensee or revoke an existing license upon a finding of noncompliance with North Dakota Century Code chapter 25-01.2 or 25-16 or the rules of the department.

1. If the department denies a license, the applicant or licensee may not reapply for a license for a period of six months from the date of denial. After the six-month period has elapsed, the applicant or licensee may submit a new application to the department.

2. If the department revokes a license, the licensee may not reapply for a license for a period of one year from the date of the revocation. After the one-year period has elapsed, the licensee may submit a new application to the department.

3. A license denial or revocation may affect all or some of the services and facilities operated by a licensee.

4. Notification is made upon mailing or upon electronic transmission. The notice must identify any law, rule, or standard alleged to have been violated, the factual basis for the allegation, the specific service or facility responsible for the violation, the date after which the denial or revocation is final, and the procedure for appealing the action.

5. If an action to revoke a license is appealed, the licensee may continue to provide services until the final appeal decision is rendered unless continued operations would jeopardize the health and safety of eligible individuals.

6. The licensee, upon final revocation notification, shall destroy the license.

History: Effective April 1, 1982; amended effective June 1, 1986; April 1, 2018; January 1, 2025.
General Authority: NDCC 25-01.2-18, 25-16-06, 50-06-16
Law Implemented: NDCC 25-01.2-18, 25-16-03, 25-16-08

75-04-01-05. Notification of license.

Repealed effective January 1, 2025.

75-04-01-06. Disclosure of criminal record.

1. Each member of the governing body of the applicant, the chief executive officer, and any employees, volunteers, or agents who receive and disburse funds on behalf of the governing body, or who provide any direct service to eligible individuals, shall disclose to the department if they have been found guilty of, pled guilty to, or pled no contest to a criminal offense or been placed on the Medicaid exclusion list.

2. The applicant or licensee shall conduct federal and state criminal background checks on all individuals employed who work with eligible individuals, including volunteers. If the applicant or licensee is contracting or subcontracting with other entities, there must be an agreement ensuring federal and state criminal background checks have been completed on all individuals employed who work with eligible individuals, including volunteers.

3. The applicant or licensee shall disclose to the department the names, type of offenses, dates of having been found guilty of, pled guilty to, or pled no contest to a criminal offense, and position and duties within the applicant's organization of employees and volunteers with a criminal record.

4. Disclosure may not disqualify the applicant from licensure or an individual from employment or volunteering, unless the applicant or individual has been found guilty of, pled guilty to, or pled no contest to, a crime having direct bearing on the capacity of the applicant, employee, or volunteer to provide a service under the provision of this chapter or the convicted applicant, employee, or volunteer is not sufficiently rehabilitated.

5. The department shall determine the effect of an applicant, employee, or volunteer having been found guilty of, pled guilty to, or pled no contest to, a criminal offense.

History: Effective April 1, 1982; amended effective June 1, 1986; December 1, 1995; April 1, 2000; April 1, 2018; January 1, 2025.

General Authority: NDCC 25-16-06, 50-06-16
Law Implemented: NDCC 25-16-03.1

75-04-01-06.1. Criminal conviction - Effect on operation of licensee or employment by licensee.

1. A licensee may not employ in any capacity that involves or permits contact between the employee or volunteer and any individual cared for by the licensee, an individual who is known to have been found guilty of, pled guilty to, or pled no contest to:

   a. An offense described in North Dakota Century Code chapters 12.1-16, homicide; 12.1-18, kidnapping; 12.1-27.2, sexual performances by children; or 12.1-41, Uniform Act on Prevention of and Remedies for Human Trafficking; or in North Dakota Century Code sections 12.1-17-01, simple assault, if a class C felony under subdivision a of subsection 2 of that section; 12.1-17-01.1, assault; 12.1-17-01.2, domestic violence; 12.1-17-02, aggravated assault; 12.1-17-03, reckless endangerment; 12.1-17-04, terrorizing; 12.1-17-06, criminal coercion; 12.1-17-07.1, stalking; 12.1-17-12, assault or homicide while fleeing a police officer; 12.1-20-03, gross sexual imposition; 12.1-20-03.1, continuous sexual abuse of a child; 12.1-20-04, sexual imposition; 12.1-20-05, corruption or solicitation of minors; 12.1-20-05.1, luring minors by computer or other electronic means; 12.1-20-06, sexual abuse of wards; 12.1-20-06.1, sexual exploitation by therapist; 12.1-20-07, sexual assault; 12.1-20-12.3, sexual extortion; 12.1-21-01, arson; 12.1-22-01, robbery; or 12.1-22-02, burglary, if a class B felony under subdivision b of subsection 2 of that section; 12.1-29-01, promoting prostitution; 12.1-29-02, facilitating prostitution; 12.1-31-05, child procurement; 12.1-31-07, endangering a vulnerable adult; 12.1-31-07.1, exploitation of a vulnerable adult; 14-09-22, abuse of child; 14-09-22.1, neglect of child; subsection 1 of section 26.1-02.1-02.1, fraudulent insurance acts; or an offense under the laws of another jurisdiction which requires proof of substantially similar elements as required for conviction under any of the enumerated North Dakota statutes; or

   b. An offense, other than an offense identified in subdivision a, if the department determines that the individual has not been sufficiently rehabilitated.

2. For purposes of subdivision b of subsection 1, an offender's completion of a period of three years after final discharge or release from any term of probation, parole, or other form of community correction, or imprisonment, without subsequent charge or conviction, is prima facie evidence of sufficient rehabilitation.

3. The department has determined that the offenses enumerated in subdivision a of subsection 1 have a direct bearing on the individual's ability to serve the public in a capacity involving the provision of services to eligible individuals.

4. In the case of an offense described in North Dakota Century Code sections 12.1-17-01, simple assault, if a felony; 12.1-17-01.1, assault; 12.1-17-01.2, domestic violence, if a misdemeanor; 12.1-17-03, reckless endangerment; 12.1-17-04, terrorizing; 12.1-17-06, criminal coercion; 12.1-17-07.1, stalking; 12.1-18-03, unlawful imprisonment; 12.1-20-05, correction or solicitation of minors, if a misdemeanor; 12.1-20-07, sexual assault, if a misdemeanor; or equivalent conduct in another jurisdiction which requires proof of substantially similar elements as required for conviction, the department may determine the individual has been sufficiently rehabilitated if five years have elapsed after final discharge or release from any term of probation, parole, or other form of community corrections or imprisonment.

5. An individual is known to have been found guilty of, pled guilty to, or pled no contest to an offense when it is:

a. Common knowledge in the community;

b. Acknowledged by the individual;

c. Reported to the licensee as the result of an employee background check; or

d. Discovered by the department or licensee.

History: Effective July 1, 2001; amended effective April 1, 2018; January 1, 2025.
General Authority: NDCC 25-01.2-18, 25-16-06, 50-06-16
Law Implemented: NDCC 25-16-03, 25-16-03.1

75-04-01-07. Content of license.

Repealed effective January 1, 2025.

75-04-01-08. Types of licenses.

Repealed effective January 1, 2025.

75-04-01-09. Restricted license.

Repealed effective January 1, 2025.

75-04-01-10. Provisional license.

Repealed effective January 1, 2025.

75-04-01-11. License renewal.

Repealed effective January 1, 2025.

75-04-01-12. Display of license.

Repealed effective January 1, 2025.

75-04-01-12.1. Provider agreement.

Repealed effective January 1, 2025.

75-04-01-13. Purchase of service or recognition of unlicensed entities.

The department may not recognize or approve the activities of unlicensed entities in securing public funds from the United States, North Dakota, or any of its political subdivisions. The department may not purchase any service from such entities.

History: Effective April 1, 1982; amended effective June 1, 1986; April 1, 2018.
General Authority: NDCC 25-16-06, 50-06-16
Law Implemented: NDCC 25-18-03

75-04-01-14. Unlicensed entities - Notification.

Upon a determination that activities subject to licensure are occurring or have occurred, the department shall notify the parties that the activities are subject to licensure. The notice must include a

citation of the applicable provisions of these rules, an application for a license, a date by which the application must be submitted, and, if applicable, a request for the parties to explain that the activities identified in the notification are not subject to licensure. The parties must receive notification within seven days and the entity is required to submit a complete application to the department within thirty days of notice.

History: Effective April 1, 1982; amended effective December 1, 1995; April 1, 2018.
General Authority: NDCC 25-16-06, 50-06-16
Law Implemented: NDCC 25-16-02

75-04-01-15. Standards of the department.

The department herein adopts and makes a part of this chapter for all licensees the current standards used for accreditation, additionally, for intermediate care facilities for individuals with intellectual disabilities, standards for certification under title 42, Code of Federal Regulations, parts 442 and 483 et seq. If a licensee fails to meet an accreditation standard, the department may analyze the licensee's failure using the appropriate current standards. Infant development licensees who have attained accreditation status are not required to maintain accreditation status.

History: Effective April 1, 1982; amended effective June 1, 1986; December 1, 1995; April 1, 2000; May 1, 2006; July 1, 2012; April 1, 2018; January 1, 2025.
General Authority: NDCC 25-01.2-18, 25-16-06, 50-06-16
Law Implemented: NDCC 25-01.2-02, 25-01.2-18, 25-16-06

75-04-01-16. Imposition of the standards.

The licensee, at the request of the department, shall submit copies of reports generated by the accreditation process.

History: Effective April 1, 1982; amended effective June 1, 1986; January 1, 2025.
General Authority: NDCC 25-01.2-18, 25-16-06, 50-06-16
Law Implemented: NDCC 25-01.2-02, 25-01.2-18, 25-16-06

75-04-01-17. Identification of developmental disability services subject to licensure.

1. Developmental disability services provided to eligible individuals must be identified and licensed by the following titles:
    a. Residential services:
        (1) Residential habilitation; or
        (2) Independent habilitation;
    b. Day habilitation;
    c. Intermediate care facility for individuals with intellectual disabilities;
    d. Employment supports:
        (1) Individual employment supports; or
        (2) Small group employment supports;
    e. Prevocational services;
    f. Family support services:
        (1) Parenting supports;

(2) In-home supports;

(3) Respite;

(4) Extended home health care; or

(5) Family care option; or

g. Infant development services.

2. For services that allow a virtual service delivery option, the licensee shall identify that option on the license application.

History: Effective April 1, 1982; amended effective June 1, 1986; December 1, 1995; July 1, 1996; July 1, 2001; July 1, 2012; April 1, 2018; April 1, 2020; January 1, 2025.
General Authority: NDCC 25-16-06, 50-06-16
Law Implemented: NDCC 25-16-06

75-04-01-18. Identification of ancillary services subject to registration.

Repealed effective June 1, 1986.

75-04-01-19. Licensure of intermediate care facilities for the developmentally disabled.

Repealed effective June 1, 1986.

75-04-01-20. Applicant guarantees and assurances.

1. Applicants shall submit, in a manner prescribed by the department, evidence that policies and procedures approved by the governing body are written and implemented in a manner which:

   a. Guarantees each eligible individual a person-centered service plan pursuant to the provisions of North Dakota Century Code section 25-01.2-14;

   b. Guarantees each eligible individual, authorized representative, or advocate receives written notice of the eligible individual's rights in the manner provided by North Dakota Century Code section 25-01.2-16;

   c. Guarantees each eligible individual has a right to appropriate treatment, services, and habilitation and these are provided in the least restrictive appropriate setting pursuant to North Dakota Century Code section 25-01.2-02;

   d. Guarantees the eligible individual the right to receive authorized services and supports included in his or her person-centered service plan in a timely manner and the opportunity to fully participate in the benefits of community living, vote, worship, socialize, freely communicate, have visitors, own and use personal property, and unrestricted access to legal counsel, and guarantees that all rules regarding such conduct are posted or made available pursuant to North Dakota Century Code sections 25-01.2-03, 25-01.2-04, and 25-01.2-05;

   e. Guarantees any restrictions implemented are based upon an eligible individual's assessed need and are imposed pursuant to the provisions of due process and a person-centered service plan;

   f. Guarantees the confidentiality of all eligible individual records;

g. Guarantees the eligible individual receives adequate remuneration for compensable labor, that subminimum wages are paid only pursuant to title 29, Code of Federal Regulations, part 525, et seq., that the eligible individual has the right to seek meaningful employment in integrated settings, that restrictions upon eligible individual access to money are subject to the provisions of a person-centered service plan, that assets managed by the applicant on behalf of the eligible individual inure solely to the benefit of that eligible individual, that each eligible individual is assessed on the individual's ability to manage the individual's finances, and that, in the event the applicant or licensee is a representative payee of an eligible individual, the informed consent of the eligible individual is obtained and documented;

h. Guarantees the eligible individual timely access to preferred and qualified medical and dental services, adequate protection from infectious and communicable diseases, and receives safe and effective administration of medications, as well as prevention of drug use as a substitute for programming;

i. Guarantees the eligible individual freedom from corporal punishment, imposition of isolation, seclusion, chemical, physical, or mechanical restraint, except as prescribed by North Dakota Century Code section 25-01.2-10 or this chapter, and guarantees the eligible individual freedom from psychosurgery, sterilization, medical behavioral research, pharmacological research, and electroconvulsive therapy, except as prescribed by North Dakota Century Code sections 25-01.2-09 and 25-01.2-11;

j. Guarantees, where applicable, a nutritious diet, approved by a qualified dietitian, will be provided in sufficient quantities to meet the eligible individual's dietary needs and preferences;

k. Guarantees the eligible individual the right to choose and refuse services, who provides the services, the right of the eligible individual and the eligible individual's representatives to be informed of the possible consequences of the refusal, alternative services available, and specifically, the extent to which such refusal may impact the eligible individual or others;

l. Assures the eligible individual safe and sanitary living and working arrangements and provides for emergencies or disasters and first-aid training for staff;

m. Assures the existence and operation of both behavior management and human rights committees;

n. Assures the residential provider agency will coordinate with services outside the residential setting in which an eligible individual lives;

o. Assures adaptive equipment, where appropriate for mobility, activities of daily living, or communication is provided consistent with the person-centered service plan;

p. Assures all staff demonstrate basic professional competencies as required by their job descriptions and complies with all required trainings, credentialing, and professional development activities;

q. Assures at least annually, outcomes are evaluated to determine whether an eligible individual is achieving the individual's goals and objectives;

r. Assures all vehicles providing transportation to eligible individuals are routinely inspected and maintained, licensed by the department of transportation, transport no more individuals than the manufacturer's recommended maximum capacity, handicapped accessible, where appropriate, and are driven by individuals who hold a valid state

driver's license. Additionally, all vehicles owned by the licensee must be equipped with a first-aid kit and a fire extinguisher;

s. Assures an annual inspection is conducted to ensure environments are sanitary and hazard free;

t. Guarantees incidents of alleged abuse, neglect, and exploitation are thoroughly investigated and reported to the governing body, chief executive officer, authorized representative, or advocate, the protection and advocacy project, and the department with written records of these proceedings being retained for three years; guarantees that all incidents of restraint utilized to control or modify an eligible individual's behavior are recorded and reported to the governing body; guarantees any incident resulting in injury to the eligible individual or staff that requires medical attention or hospitalization must be recorded and reported to the governing body immediately, and as soon thereafter as possible to the authorized representative or advocate; and guarantees incidents resulting in injury to the eligible individual or staff that requires extended hospitalization, endangers life, or results in permanent disability must also be reported to the department immediately; and guarantees corrective action plans are implemented;

u. Guarantees a grievance procedure, reviewed and approved by the department, affords the eligible individual or the authorized representative or advocate the right to have any grievance addressed; and guarantees that grievance records are maintained and must note the nature of the grievance, individuals submitting the grievance, and the resolution of the grievance;

v. Assures policies and procedures are established and maintained for the management and maintenance of property and equipment purchased or depreciated with state funds. The applicant shall make the records, and items identified in them, available for inspection by the department, or designee, upon request to facilitate a determination of the adequacy with which the applicant is managing property and equipment;

w. Assures policies and procedures regarding admission to their services and termination of services are in conformance with the rules of the department;

x. Assures all documentation, data reporting requirements, rules, regulations, and policies are conducted as required by the department; and

y. Assures all applicable federal and state laws and regulations are being abided by.

2. Licensees shall submit evidence, satisfactory to the department, of accreditation.

3. The department shall determine the degree to which the unaccredited applicant's policies and procedures are in compliance with the standards.

History: Effective April 1, 1982; amended effective June 1, 1986; December 1, 1995; April 1, 2018; January 1, 2025.
General Authority: NDCC 25-01.2-18, 25-16-06, 50-06-16
Law Implemented: NDCC 25-01.2-02, 25-01.2-03, 25-01.2-04, 25-01.2-05, 25-01.2-06, 25-01.2-07, 25-01.2-09, 25-01.2-10, 25-01.2-11, 25-01.2-14, 25-01.2-16, 25-01.2-18, 25-16-06

75-04-01-20.1. Wages of eligible individuals.

Licensees paying subminimum wages for work performed shall submit to the department a true, correct, and current copy of a certificate from the United States department of labor authorizing the payment of subminimum wages.

History: Effective December 1, 1995; amended effective January 1, 2025.

General Authority: NDCC 25-01.2-18, 25-16-06, 50-06-16
Law Implemented: NDCC 25-01.2-06, 25-01.2-18, 25-16-06

75-04-01-20.2. Recording and reporting abuse, neglect, exploitation, and use of restraint.

1. Licensees shall implement policies and procedures to assure incidents of alleged abuse, neglect, exploitation, and restraints:

   a. Are reported to the governing body, chief executive officer or designee of the licensee, authorized representative, advocate, and the protection and advocacy project;

   b. Are thoroughly investigated, the findings reported to the governing body, chief executive officer or designee of the licensee, authorized representative, advocate, and the protection and advocacy project and that the report and the action taken are recorded in writing and retained for three years; and

   c. Are immediately reported to the department.

2. Incidents resulting in injury to the staff or an eligible individual, requiring medical attention, hospitalization, endangering life, or result in a permanent disability must be recorded and reported to the governing body, chief executive officer or designee of the licensee, and to the department immediately, and as soon thereafter as possible to the authorized representative or advocate.

History: Effective December 1, 1995; amended effective April 1, 2018; January 1, 2025.
General Authority: NDCC 25-01.2-18, 25-16-06, 50-06-16
Law Implemented: NDCC 25-01.2-18, 25-16-06, 50-25.1-02

75-04-01-21. Legal status of applicant.

The applicant shall submit, in a form or manner prescribed by the department, the following items:

1. A correct and current statement of their articles of incorporation, bylaws, license issued by a local unit of government, partnership agreement, or any other evidence of legal registration of the entity;

2. A correct and current statement of tax exempt or taxable status under the laws of North Dakota or the United States;

3. A current list of partners or members of the governing body and any advisory board with their contact information, principal occupation, term of office, and status as an eligible individual or authorized representative and any changes in this list since last submission for all nonprofit applicants and licensees;

4. A statement disclosing the owner of record of any buildings, facilities, or equipment used by the applicant, the relationship of the owner to the applicant, and the cost, if any, of such use to the applicant and the identity of the entity responsible for the maintenance and upkeep of the property;

5. A statement disclosing any financial benefit which may accrue to the applicant or to be diverted to personal use, including director's fees or expenses, dividends, return on investment, rent or lease proceeds, salaries, pensions or annuities, or any other payments or gratuities; and

6. The amount of any payments made to any member or members of the governing body of the applicant, or board or body of a related organization, exclusive of reimbursement for actual and reasonable personal expenses.

History: Effective April 1, 1982; amended effective June 1, 1986; December 1, 1995; April 1, 2018; January 1, 2025.
General Authority: NDCC 25-01.2-08, 25-16-06, 50-06-16
Law Implemented: NDCC 25-01.2-08, 25-16-06

75-04-01-22. Applicant's buildings.

Applicants or licensees occupying buildings, whether owned or leased, shall provide the department with a license or registration certificate properly issued pursuant to North Dakota Century Code chapter 15.1-34 or 50-11 or with:

1. The written report of an authorized fire inspector, following an initial or subsequent annual inspection of a building pursuant to section 75-04-01-23, which states:

   a. Rated occupancy and approval of the building for occupancy; or

   b. Existing hazards and recommendations for correction which, if followed, would result in approval of the building for occupancy;

2. A written statement prepared by the appropriate county or municipal official having jurisdiction that the premises are in compliance with local zoning laws and ordinances; and

3. For existing buildings, floor plans drawn to scale showing the use of each room or area and a site plan showing the source of utilities and waste disposal; or

4. Plans and specifications of buildings and site plans for facilities, proposed for use, but not yet constructed, showing the proposed use of each room or area and the source of utilities and waste disposal.

History: Effective April 1, 1982; amended effective June 1, 1986; December 1, 1995; April 1, 2018; January 1, 2022; January 1, 2025.
General Authority: NDCC 25-16-06, 50-06-16
Law Implemented: NDCC 25-16-06

75-04-01-23. Safety codes.

1. Applicant's or licensee's intermediate care facilities for individuals with intellectual disabilities shall meet the provisions of either the health care occupancies chapters or the residential board and care occupancies chapter of the Life Safety Code of the national fire protection association, 2012 edition.

2. Applicant's or licensee's group home facilities which are not intermediate care facilities for individuals with intellectual disabilities shall meet the applicable life safety standards established by the local governing municipality's ordinances. If the local governing municipality has no ordinances establishing life safety standards, the group home facilities shall meet the one-family and two-family dwellings chapter of the Life Safety Code of the national fire protection association, 2012 edition.

3. Upon written application, and good cause shown to the satisfaction of the department, the department may grant a variance from any specific requirement of the Life Safety Code, upon terms the department may prescribe, except no variance may permit or authorize a danger to the health or safety of the residents of the facility.

4. Applicant's or licensee's facilities housing individuals with multiple physical disabilities or impairments of mobility shall conform to American National Standards Institute Standard No. A117.1 (1980), or, if remodeled or newly constructed after July 1, 1995, with appropriate standards as required by the Americans with Disabilities Act of 1990, Public Law 101-336.

5. Applicant's or licensee's buildings used to provide day services must conform to the appropriate occupancy chapters of the Life Safety Code of the national fire protection association, 2012 edition, and must meet applicable accessibility standards as required by the Americans with Disabilities Act of 1990, Public Law 101-336. The selection of an appropriate Life Safety Code chapter shall be determined considering:

   a. Primary activities in the facility;

   b. The ability of eligible individuals occupying the facility to take action for self-preservation in an emergency; and

   c. Assistance available to eligible individuals occupying the facility for evacuation in an emergency.

6. All licensed day service facilities must be surveyed for Life Safety Code compliance at least annually. The department must be notified and a resurvey may be required if any of the following conditions are present between annual inspections:

   a. Occupancy increases of ten percent or more;

   b. Primary usage of the facility changes;

   c. Hazardous materials or processes are introduced into the facility;

   d. Building alterations or modifications take place;

   e. Eligible individuals requiring substantial assistance to evacuate in an emergency are enrolled;

   f. There are public or eligible individual concerns about safety conditions; or

   g. Other changes occur in physical facilities, activities, materials and contents, or numbers and capabilities of eligible individuals enrolled which may affect safety in an emergency.

History: Effective April 1, 1982; amended effective June 1, 1986; August 1, 1987; December 1, 1995; April 1, 2000; May 1, 2004; July 1, 2012; April 1, 2020; January 1, 2025.
General Authority: NDCC 25-16-06, 50-06-16
Law Implemented: NDCC 25-16-06

75-04-01-24. Entry, access to records, and inspection.

1. The applicant or licensee shall affirm the right of the department, or designee, to enter any of the buildings or facilities and access to its records to determine compliance with the rules of the department, to facilitate verification of the information submitted with an application for licensure, and to investigate complaints.

2. The licensee shall authorize the department, or designee, entry to its facilities and access to its records in the event the licensee declares bankruptcy, transfers ownership, ceases operations, evicts residents of its facilities, or the contract with the department is terminated by either of the parties. The department's entry is for the purpose of facilitating the orderly transfer of eligible individuals to an alternative service or the maintenance of appropriate service until an orderly transfer can be made.

History: Effective April 1, 1982; amended effective December 1, 1995; April 1, 2018; January 1, 2025.
General Authority: NDCC 25-01.2-08, 25-16-06, 50-06-16
Law Implemented: NDCC 25-01.2-08, 25-16-06

75-04-01-25. Access to records.

Repealed effective January 1, 2025.

75-04-01-26. Denial of access to facilities and records.

Any applicant or licensee which denies the department, or designee, access to a facility or its records, may have its license revoked or its application denied.

History: Effective April 1, 1982; amended effective December 1, 1995; April 1, 2018; January 1, 2025.
General Authority: NDCC 25-01.2-08, 25-16-06, 50-06-16
Law Implemented: NDCC 25-01.2-08, 25-16-06

75-04-01-27. Group home design.

1. Group home facilities shall be small enough and of a modest design, minimizing the length of hallways, the number of exterior corners, and the complexity of construction, to ensure the development of meaningful interpersonal relationships and the provision of proper programming, services, and direct care. New or remodeled homes completed after July 1, 1985, are limited to occupancy by no more than eight individuals with developmental disabilities.

2. Group home facilities shall simulate the most homelike atmosphere possible in order to encourage a personalized environment.

3. Group home facilities shall provide, at a minimum, enough living space, based on the needs of both males and females, with provisions for privacy and appropriate access to quiet areas where an individual can be alone.

4. Group home facilities shall provide arrangement of space for all eligible individuals to participate in various activities, both in groups and singly. Space must be arranged to minimize noise for communication at normal conversational levels.

5. Group home facilities shall be accessible to nonambulatory eligible individuals, visitors, and employees.

History: Effective June 1, 1986; amended effective December 1, 1995; January 1, 2025.
General Authority: NDCC 25-16-06, 50-06-16
Law Implemented: NDCC 25-16-03

75-04-01-28. Group home location.

1. Group home facilities must be located at least three hundred feet [91.44 meters] from hazardous areas, including bulk fuel or chemical storage, anhydrous ammonia facilities, or other fire hazards or sources of noxious or odoriferous emissions.

2. Group home facilities may not be located in areas subject to adverse environmental conditions, including mud slides, harmful air pollution, smoke or dust, sewage hazards, rodent or vermin infestations, excessive noise, vibrations, or vehicular traffic.

3. Group home facilities may not be located in an area within the one-hundred-year base flood elevations unless:

   a. The facility is covered by flood insurance as required by 42 U.S.C. 4101; or

b. The finished lowest floor elevation is above the one-hundred-year base flood elevation and the facility is free from significant adverse effects of the velocity of moving water or by wave impact during the one-hundred-year flood.

4. Group home facilities must be located in residential neighborhoods reasonably accessible to shops, commercial facilities, and other community facilities; and shall be located not less than six hundred feet [182.88 meters] from existing group homes or day service facilities licensed by the department, schools for individuals with disabilities, long-term care facilities, or other institutional facilities. Upon written application, and good cause shown, the department may grant a variance from the provisions of this subsection upon terms the department may prescribe.

History: Effective June 1, 1986; amended effective December 1, 1995; January 1, 2025.
General Authority: NDCC 25-16-06, 50-06-16
Law Implemented: NDCC 25-16-03

75-04-01-29. Group home bedrooms.

1. Bedrooms in group home facilities must accommodate no more than two individuals.

2. Bedrooms in group home facilities must provide at least eighty square feet [7.43 square meters] per individual in a single occupancy bedroom, and at least sixty square feet [5.57 square meters] per individual in a double occupancy bedroom, both exclusive of closet and bathroom space. Bedrooms in newly constructed homes or existing homes converted to group home facilities completed after July 1, 1985, must provide at least one hundred square feet [9.29 square meters] per individual in a single occupancy bedroom, and at least eighty square feet [7.43 square meters] per individual in a double occupancy bedroom, both exclusive of closet and bathroom space.

3. Bedrooms in group home facilities must be located on outside walls and separated from other rooms and spaces by walls extending from floor to ceiling and be at or above grade level.

4. Bedrooms in group home facilities must not have doors with vision panels and must be capable of being locked from the inside of the bedroom, except when justified by a specific assessed need and documented in the person-centered service plan.

5. Each eligible individual must have the opportunity to furnish and decorate their bedrooms as they choose, including a chest of drawers, table, or desk.

6. Bedrooms in group home facilities must provide storage space for clothing in the bedroom which is accessible to all, including nonambulatory individuals.

History: Effective June 1, 1986; amended effective December 1, 1995; April 1, 2018; January 1, 2025.
General Authority: NDCC 25-16-06, 50-06-16
Law Implemented: NDCC 25-16-03

75-04-01-30. Group home kitchens.

A kitchen in a group home facility must:

1. Provide sufficient space for participation by both staff and eligible individuals in the preparation of food.

2. Provide appropriate space and equipment, including a two-compartment sink, to adequately serve the food preparation and storage requirements of the facility.

3. Have hot water supplied to sinks in the range of one hundred ten to one hundred forty degrees Fahrenheit [47.22 to 60 degrees Celsius], as controlled by a tempering valve, located to preclude eligible individual access.

History: Effective June 1, 1986; amended effective December 1, 1995; January 1, 2025.
General Authority: NDCC 25-16-06, 50-06-16
Law Implemented: NDCC 25-16-03

75-04-01-31. Group home bathrooms.

1. A bathroom in a group home facility must:

   a. Be located in places that facilitate maximum self-care by eligible individuals.

   b. Provide showers, bathtubs, toilets, and lavatories approximating normal patterns found in homes, unless specifically contraindicated by program needs.

   c. Support only up to four individuals each.

   d. Have hot water supplied to lavatories and bathing facilities in the range of one hundred ten to one hundred forty degrees Fahrenheit [47.22 to 60 degrees Celsius], as controlled by a tempering valve, located to preclude eligible individual access.

2. At least one bathroom per group home facility must be accessible and usable by nonambulatory eligible individuals, visitors, and employees.

History: Effective June 1, 1986; amended effective December 1, 1995; January 1, 2025.
General Authority: NDCC 25-16-06, 50-06-16
Law Implemented: NDCC 25-16-03

75-04-01-32. Group home laundry.

1. Laundry space within group home facilities must provide a washer and dryer, storage for laundry supplies, accommodations for ironing, and counterspace for folding clothing and linen.

2. Hot water supplied to clothes washers must be in the range of one hundred thirty-five to one hundred forty degrees Fahrenheit [57.22 to 60 degrees Celsius].

History: Effective June 1, 1986; amended effective December 1, 1995.
General Authority: NDCC 25-16-06, 50-06-16
Law Implemented: NDCC 25-16-03

75-04-01-33. Group home use of space.

1. Group home facilities shall provide free use of space within the living unit, with due regard for privacy, personal possessions, and programs; with limitations of personal areas of supervisory staff.

2. Group home facilities shall provide for an individual to personalize the individual's portion of the living unit and mount pictures on the walls.

History: Effective June 1, 1986; amended effective December 1, 1995.
General Authority: NDCC 25-16-06, 50-06-16
Law Implemented: NDCC 25-16-03

75-04-01-34. Group home staff accommodations.

Repealed effective December 1, 1995.

75-04-01-35. Water supply.

1. Group home facilities for individuals with developmental disabilities shall be located in areas where public or private water supplies approved by the department of environmental quality are available. Approved public water supplies must be used where available.

2. When a private water supply is used, water samples must be submitted at the earliest possible date prior to occupancy and every six months thereafter to determine chemical and bacteriological acceptability.

History: Effective June 1, 1986; amended effective December 1, 1995.
General Authority: NDCC 25-16-06, 50-06-16
Law Implemented: NDCC 25-16-03

75-04-01-36. Sewage disposal.

1. Group home facilities for individuals with developmental disabilities shall be located in areas where public or private sewage disposal systems approved by the department of environmental quality are available. Approved public sewage disposal systems must be used, where available.

2. Plans and specifications for proposed private sewage disposal system or alteration to such systems must be approved by the department of environmental quality prior to the construction, maintenance, and operation of such systems.

History: Effective June 1, 1986; amended effective December 1, 1995.
General Authority: NDCC 25-16-06, 50-06-16
Law Implemented: NDCC 25-16-03

75-04-01-37. Emergency plans.

There must be written plans and procedures, that are clearly communicated to and periodically reviewed with staff and eligible individuals for meeting emergencies, including fire, serious illness, severe weather, and missing individuals. Applicable requirements of state law and regulations by the state fire marshal and applicable licensing authorities must be met.

History: Effective June 1, 1986; amended effective December 1, 1995; January 1, 2025.
General Authority: NDCC 25-16-06, 50-06-16
Law Implemented: NDCC 25-16-03

75-04-01-38. Insurance and bond requirements.

1. Licensees shall secure and maintain insurance and bonds appropriate for the size of the programs, including:

   a. A blanket fidelity bond equal to not less than ten percent of the total operating costs of the program;

   b. Property insurance covering all risks at replacement costs and costs of extra expense for loss of use;

   c. Liability insurance covering bodily injury, property damage, personal injury, teacher liability, professional liability, and umbrella liability as applicable; and

   d. Automobile or vehicle insurance covering property damage, comprehensive, collision, uninsured motorist, bodily injury, and no fault.

2. The department shall determine the adequacy of the insurance coverages maintained by the applicant.

History: Effective June 1, 1986; amended effective December 1, 1995.
General Authority: NDCC 25-16-06, 50-06-16
Law Implemented: NDCC 25-16-03

75-04-01-39. Variance.

Upon written application and good cause shown to the satisfaction of the department, the department may grant a variance, to an institutional intermediate care facility for individuals with intellectual disabilities, or group homes, from subsection 1 of section 75-04-01-27, subsections 1, 2, and 3 of section 75-04-01-29, and subsection 3 of section 75-04-01-31, except no variance may permit or authorize a danger to the health or safety of an individual served by the facility.

History: Effective July 1, 1996; amended effective July 1, 2012; April 1, 2018.
General Authority: NDCC 25-16-06, 50-06-16
Law Implemented: NDCC 25-16-06

75-04-01-40. Documentation and data reporting requirements.

1. A licensee shall submit and retain all requisite documentation to demonstrate the right to receive payment for all services and supports and comply with all federal and state laws, regulations, and policies necessary to disclose the nature and extent of services provided and all information to support claims submitted by, or on behalf of, the licensee.

2. The department may require a licensee to submit a statement of policies and procedures, and evidence of the implementation of the statement, in order to facilitate a determination the licensee is in compliance with the rules of the department and with North Dakota Century Code chapters 25-01.2 and 25-16.

3. A licensee shall maintain program records, fiscal records, and supporting documentation, including:

   a. Authorization from the department for each eligible individual for whom service is billed;

   b. Attendance sheets and other records documenting the days and times the eligible individuals received the billed services from the licensee; and

   c. Records of all bills submitted to the department for payment.

4. A licensee shall report the results of designated quality and performance indicators, as requested by the department.

5. A licensee shall retain a copy of the records required for six years from the date of the bill unless an audit in process requires a longer retention.

6. The department maintains the right to withhold a payment for services or suspend or terminate Medicaid enrollment if the licensee has failed to abide by terms of the Medicaid contract, federal and state laws, regulations, and policies regarding documentation or data reporting.

History: Effective April 1, 2018; amended effective January 1, 2025.
General Authority: NDCC 25-16-06, 50-06-16
Law Implemented: NDCC 25-16-03

75-04-01-41. Appeals.

An applicant or licensee principal officer may appeal a decision to deny or revoke a license by filing a written appeal with the department. The appeal must be postmarked or received by the department within ten calendar days of the applicant's or licensee's receipt of written notice of the decision to deny or revoke the license. Upon receipt of a timely appeal, an administrative hearing may be conducted in the manner prescribed by chapter 75-01-03.

History: Effective January 1, 2025.
General Authority: NDCC 25-16-06, 50-06-16
Law Implemented: NDCC 25-16-03