Senate Counsel, Research, and Fiscal Analysis

G-17 STATE CAPITOL
75 REV. DR. MARTIN LUTHER KING, JR. BLVD.
ST. PAUL, MN 55155-1606
(651) 296-4791
FAX: (651) 296-7747
JO ANNE ZOFF SELLNER
DIRECTOR

Senate

State of Minnesota

S.F. No. 1520 - Exempting Certain Refugees and Asylees from Participating in the Diversionary Work Program

Author: Senator Steve Dille

Prepared by: Joan White, Senate Counsel (651/296-3814)

Date: April 1, 2005

S.F. No. 1520 amends the section of law relating to the eligibility requirements for the diversionary work program, by exempting certain refugees and asylees from the diversionary work program, and allowing them to enroll directly in the MFIP program. The eligible refugees and asylees are individuals who; 1) have been assigned to a local refugee resettlement agency; 2) have a case manager; or 3) are enrolled in a federal matching refugee assistance program. This bill also requires that refugees be given the option of being assigned to an agency that has employees who are familiar with their culture, speak their language, and have years of experience in assisting refugees find employment.

If a case manager determines that the refugee or asylee has a certain level of English proficiency, the case manager may enroll the refugee or asylee in the diversionary work program. Refugees may also be referred to the federal refugee employment programs.

This bill is effective the day following final enactment.

JW:rdr

Senators Dille and Moua introduced--

S.F. No. 1520: Referred to the Committee on Health and Family Security.

A bill for an act

relating to human services; exempting certain refugees and asylees from participating in the diversionary work program; amending Minnesota Statutes 2004, section 256J.95, subdivision 3.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2004, section 256J.95, subdivision 3, is amended to read:

Subd. 3. [ELIGIBILITY FOR DIVERSIONARY WORK PROGRAM.] (a) Except for the categories of family units listed below, all family units who apply for cash benefits and who meet MFIP eligibility as required in sections 256J.11 to 256J.15 are eligible and must participate in the diversionary work program. Family units that are not eligible for the diversionary work program include:

(1) child only cases;

(2) a single-parent family unit that includes a child under 12 weeks of age. A parent is eligible for this exception once in a parent's lifetime and is not eligible if the parent has already used the previously allowed child under age one exemption from MFIP employment services;

(3) a minor parent without a high school diploma or its equivalent;

(4) an 18- or 19-year-old caregiver without a high school diploma or its equivalent who chooses to have an employment plan

with an education option;

(5) a caregiver age 60 or over;

(6) family units with a caregiver who received DWP benefits in the 12 months prior to the month the family applied for DWP, except as provided in paragraph (c);

(7) family units with a caregiver who received MFIP within the 12 months prior to the month the family unit applied for DWP;

(8) a family unit with a caregiver who received 60 or more months of TANF assistance; and

(9) a family unit with a caregiver who is disqualified from DWP or MFIP due to fraud.

(b) A two-parent family must participate in DWP unless both caregivers meet the criteria for an exception under paragraph (a), clauses (1) through (5), or the family unit includes a parent who meets the criteria in paragraph (a), clause (6), (7), (8), or (9).

(c) Once DWP eligibility is determined, the four months run consecutively. If a participant leaves the program for any reason and reapplies during the four-month period, the county must redetermine eligibility for DWP.

(d) Newly arrived refugees and asylees as defined in Code of Federal Regulations, title 45, chapter IV, section 400.13, who (1) have been assigned to a local refugee resettlement agency, (2) have a case manager, or (3) are enrolled in the federal matching grant program under United States Code, title 8, chapter 12, section 1522, are exempt from participating in the diversionary work program and may enroll directly into the MFIP program. Refugees must have the option of being assigned to an agency that has employees who are familiar with their culture, speak their language, and have years of experience in assisting refugees in finding employment. If a case manager determines that a refugee or asylee has English language skills at or above a spoken language proficiency level of SPL6 or its equivalent, as measured by a nationally recognized test, the case manager may enroll the refugee or asylee in the

diversionary work program. Refugees may be referred to the federal refugee employment programs.

[EFFECTIVE DATE.] This section is effective the day following final enactment.

Lutheran Social Service
for changing lives

Office of Public Policy & Advocacy

Exempting Newly Arrived Refugees from Mandatory Participation in the Diversionary Work Program (DWP)

SF 1520 Dille, Moua
HF 793 Thao, Abeler

All MN Resettlement Agencies support:
Catholic Charities
International Institute
Jewish Family Services
Jewish Family & Children's Services
Lutheran Social Service
Minnesota Council of Churches
World Relief
Also in support:
Jewish Community Relations Council

Background

- 5,800 refugees are expected in 2004-2005 – In the 5 years prior to 9/11 Minnesota welcomed 2,000 annually.
- DWP was enacted while post 9/11 immigration restrictions were still in place and thus refugee-specific issues were not brought forward.

DWP pilot program in Dakota County, on which the state DWP is based, allowed for the exemption of limited English speakers.

Exempting Newly Arrived Refugees from Mandatory Participation in DWP would:

- Allow for more efficient transitions when services are provided by one agency
- Make for the most effective transitions to settled housing and employment
- Apply to approximately 2,000 individuals (estimating that half of refugees will be families, and therefore eligible for MFIP, and parents will make up half of family unit).

How are Refugees Different from other DWP Participants?

Federal rules that help new refugees and provide for public health safety take time
All adult refugees must work on specific self-sufficiency activities:

- Apply for Social Security card (customarily takes 6 weeks to receive)
- Schedule and take medical exams and health screenings, get immunizations
- Participate in cultural orientations
- Enroll children in school
- Following assessment, establish an employment plan to become self-sufficient.

Refugees receive a ONE time cash grant of $400 for household essentials upon arrival in Minnesota. Refugees pay all taxes that any other Minnesotan pays.

- Many refugees arrive in Minnesota with little more than a suitcase.
- The one time Federal assistance grant of $400.00 is provided to assist with refugees with their immediate needs upon arrival.
- Many stay with relatives during the first few months so they never receive the financial assistance DWP provides. DWP only provides vendor payments - for housing and utilities.
- MFIP provides the same assistance amount, only in the form of cash instead of a voucher, which allows the newly refugee more flexibility to purchase items that are needed to become self-sufficient (work clothes, shoes, tools, basic household items, etc).

2004 Experience Applying DWP to Refugees

as of November 2004

- **Ramsey Co:** 130 participants **no jobs found**

as of March 2004

- **Hennepin Co:** 233 participants **35 found jobs**

Fewer Employers are Willing to Hire Newly Arrived Refugees with Limited English Skills

- Resettlement agencies report having increased difficulty placing refugees in jobs because they are competing with applicants who speak English more proficiently, are familiar with US employment expectations and have work experience in the US, and are able to pass tests that some employers require.

DWP Duplicates the Work of the Matching Grant Program—in existence for 25 years

The "Matching Grant" Program is a public-private partnership program that diverts the most "work ready" refugees from public assistance into job search–

- Uses Federal funds matched by private donor and refugee contributions
- Operates as a 4 month diversionary program
- Allows the resettlement agencies to find employment for those that are most employable.
  - Achieves success with 70-75% of work ready refugees
  - The remaining refugees have multiple language and cultural barriers to work and are least likely to succeed in a DWP plan.
- LSS expects to serve 130 refugees through Matching Grant in 2004-2005)

Kate Maher, Policy Analyst and Liaison, Office of Public Policy and Advocacy kmaher@lssmn.org
Lutheran Social Service of Minnesota www.lssmn.org/advocate

Senate Counsel, Research, and Fiscal Analysis

G-17 STATE CAPITOL
75 REV. DR. MARTIN LUTHER KING, JR. BLVD.
ST. PAUL, MN 55155-1606
(651) 296-4791
FAX: (651) 296-7747
JO ANNE ZOFF SELLNER
DIRECTOR

Senate

State of Minnesota

S.F. No. 1600 - MFIP Overview of Employment and Training Services

Author: Senator Mee Moua

Prepared by: Joan White, Senate Counsel (651/296-3814)

Date: April 1, 2005

S.F. No. 1600 amends the overview of MFIP employment and training services provided to participants by job counselors, by adding that the job counselor explain to the participant the probationary employment period that most new employees must serve after being hired, and also offer job retention services.

JW:rdr

Senators Moua and Anderson introduced--

S.F. No. 1600: Referred to the Committee on] **Health & Family**

A bill for an act

relating to human services; modifying MFIP overview of employment and training services; amending Minnesota Statutes 2004, section 256J.515.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2004, section 256J.515, is amended to read:

256J.515 [OVERVIEW OF EMPLOYMENT AND TRAINING SERVICES.]

During the first meeting with participants, job counselors must ensure that an overview of employment and training services is provided that:

(1) stresses the necessity and opportunity of immediate employment;

(2) outlines the job search resources offered;

(3) outlines education or training opportunities available;

(4) describes the range of work activities, including activities under section 256J.49, subdivision 13, clause (18), that are allowable under MFIP to meet the individual needs of participants;

(5) explains the requirements to comply with an employment plan;

(6) explains the consequences for failing to comply;

(7) explains the services that are available to support job search and work and education; and

(8) provides referral information about shelters and

programs for victims of family violence and the time limit exemption for family violence victims; and

(9) explains the probationary employment periods most new employees must serve after being hired and offers assistance with job retention services.

Failure to attend the overview of employment and training services without good cause results in the imposition of a sanction under section 256J.46.

An applicant who requests and qualifies for a family violence waiver is exempt from attending a group overview. Information usually presented in an overview must be covered during the development of an employment plan under section 256J.521, subdivision 3.

Senator ..... moves to amend S.F. No. 1600 as follows:

Page 1, after line 5, insert:

"Section 1. Minnesota Statutes 2004, section 181.55, is amended to read:

181.55 [WRITTEN STATEMENT TO EMPLOYEES BY EMPLOYERS.]

When a contract of employment is consummated between an employer and an employee for work to be performed in this state, or for work to be performed in another state for an employer localized in this state, the employer shall give to the employee a written and signed agreement of hire, which shall clearly and plainly state:

(1) The date on which the agreement was entered into;

(2) The date on which the services of the employee are to begin;

(3) The rate of pay per unit of time, or of commission, or by the piece, so that wages due may be readily computed;

(4) The number of hours a day which shall constitute a regular day's work, and whether or not additional hours the employee is required to work shall constitute overtime and be paid for, and, if so, the rate of pay for overtime work; ~~and~~

(5) A statement of any special responsibility undertaken by the employee, not forbidden by law, which, if not properly performed by the employee, will entitle the employer to make deductions from the wages of the employee, and the terms upon which such deductions may be made;

(6) Whether the employee is subject to a probationary period of employment and if so, the duration and terms of the probationary period; and

(7) Whether the employment is temporary or not, and if the employment is temporary, whether and under what conditions the employee might be hired to fill a position of indefinite duration.

Sec. 2. Minnesota Statutes 2004, section 181.56, is amended to read:

181.56 [NO STATEMENT GIVEN; BURDEN OF PROOF.]

Where no such written agreement is entered into the burden

of proof shall be upon the employer to establish the terms of the verbal agreement, including any terms of probationary employment and any conditions under which a temporary employee might be hired to fill a position of indefinite duration, in case of a dispute with the employee as to its terms.

Sec. 3. Minnesota Statutes 2004, section 181.57, is amended to read:

181.57 [APPLICATION OF SECTIONS 181.55 AND 181.56.]

Sections 181.55 and 181.56 shall not apply to farm labor, ~~nor to casual employees temporarily employed,~~ nor employers employing less than ten employees.

Sec. 4. [181.575] [CIVIL ACTIONS.]

Subdivision 1. [CIVIL ACTIONS PERMITTED.] Any employee claiming to be aggrieved by a violation of section 181.55 may bring a civil action for damages and injunctive relief against the employee's employer.

Subd. 2. [JUDGMENT; DAMAGES.] If the court finds that any defendant has violated the provisions of section 181.55, the court shall enter judgment for the actual damages incurred by the plaintiff or the appropriate penalty as provided by subdivision 3, whichever is greater. The court may also award court costs and a reasonable attorney's fee.

Subd. 3. [PENALTY.] If an employer has given an employee a written agreement of hire that is signed by the employee, but the court finds that the agreement fails to comply with the requirements of section 181.55, the penalty is $250."

Page 2, after line 13, insert:

"Sec. 6. [EFFECTIVE DATE.]

Sections 1 to 3 are effective for all contracts of employment consummated on or after August 1, 2005."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

Senate Counsel, Research, and Fiscal Analysis

G-17 State Capitol
75 Rev. Dr. Martin Luther King, Jr. Blvd.
St. Paul, MN 55155-1606
(651) 296-4791
FAX: (651) 296-7747
Jo Anne Zoff Sellner
Director

Senate

State of Minnesota

S.F. No. 1973 - Medical Use of Marijuana

Author: Senator Steve Kelley

Prepared by: Katie Cavanor, Senate Counsel (651/296-3801) KTC

Date: April 5, 2005

S.F. No. 1973 establishes the legality of the medical use of marijuana.

Section 1 (152.22) defines the following terms: "commissioner," "debilitating medical condition," "medical use," "practitioner," "primary caregiver," "qualifying patient," "registry identification card," "usable marijuana," and "written certification."

Section 2 (152.23) creates protections for the medical use of marijuana.

Subdivision 1 states that a qualifying patient who has a registry identification card in possession shall not be arrested, prosecuted, or subject to any penalty for the medical use of marijuana, so long as the patient does not possess more than 12 marijuana plants and 2.5 ounces of usable marijuana.

Subdivision 2 provides the same protection as described in subdivision 1 to a primary caregiver for assisting a qualifying patient to whom the caregiver is connected through the registration process with the medical use of marijuana.

Subdivision 3 states that no school, employer, or landlord may penalize a person solely because of the person's status as a qualifying patient or a registered primary caregiver.

Subdivision 4 creates a presumption that a qualifying patient or primary caregiver is engaged in the medical use of marijuana if the patient or caregiver is: (1) in possession of a registry identification card; and (2) in possession of an amount of marijuana that does not exceed the amount permitted. States that this presumption may be rebutted by evidence showing that

conduct related to the marijuana was not for the purpose of alleviating the patient's medical condition or symptoms.

Subdivision 5 permits a primary caregiver to receive reimbursement for costs associated with assisting with a registered patient's medical use of marijuana. States that such compensation does not constitute a sale of a controlled substance.

Subdivision 6 provides protection from arrest , prosecution, or penalty solely for providing written certifications or stating that in the practitioner's opinion the potential benefits of the medical use of marijuana would likely outweigh the health risks for a patient.

Subdivision 7 states that any interest in or right to property that is used in connection with the medical use of marijuana is not forfeited. States that a law enforcement agency that seizes and does not return usable marijuana to a registered patient or caregiver is liable to the cardholder for the fair market value of the marijuana.

Subdivision 8 states that no person shall be subject to arrest or prosecution for any offense for being in the presence or vicinity of the medical use of marijuana or for assisting a registered patient with using or administering marijuana.

Subdivision 9 provides reciprocity for a registry identification card or its equivalent issued by another state, territory, or District of Columbia that permits the medical use of marijuana by a qualifying patient or permits a person to assist with a patient's medical use of marijuana.

Section 3 (152.24) requires the Commissioner of Health to adopt rules no later than 90 days after the effective date regarding petitions from the public to add debilitating medical conditions and regarding applications for and renewals of registry identification cards for qualifying patients and caregivers.

Section 4 (152.25) describes the registry identification cards.

Subdivision 1, paragraph (a), requires the commissioner to issue registry identification cards to qualifying patients who submit:

(1) a written certification;

(2) an application or renewal fee;

(3) the name, address, and date of birth of the patient unless the patient is homeless;

(4) the name, address, and telephone number of the patient's practitioner; and

(5) the name, address, and date of birth of each primary caregiver of the patient.

Paragraph (b) states that the commissioner shall not issue a registry identification card to a qualifying patient under the age of 18 unless:

(1) the practitioner has explained the risks and benefits to the patient and to a parent or guardian of the patient; and

(2) a parent or legal guardian consents in writing to:

(i) allow the patient's use of marijuana;

(ii) serve as one of the patient's primary caregivers; and

(iii) control the acquisition, dosage, and frequency of the medical use of marijuana by the patient.

Paragraph (c) requires the commissioner to verify the information contained in an application or renewal submitted under this section and approve or deny the application or renewal within 15 days of receiving it. Permits the commissioner to deny an application or renewal only if the applicant did not provide the information required or the information was falsified. States that a rejection is a final agency action subject to judicial review and jurisdiction and venue are vested in the district court.

Paragraph (d) requires the commissioner to issue a registry identification card to each primary caregiver who is named on a patient's approved application up to a maximum of two primary caregivers per qualifying patient.

Paragraph (e) requires that the registry identification card be issued within five days of approving an application or renewal. States that the card expires one year after the date of issuance. States what information the card must contain.

Subdivision 2, paragraph (a), requires a qualifying patient to notify the commissioner within ten days of any change in the patient's name, address, or primary caregiver or if the patient ceases to have a debilitating medical condition.

Paragraph (b) states that failure to notify the commissioner of theses changes is a civil violation, punishable by a fine of no more than $150. States that the card is null and void if the patient ceases to have a debilitating medical condition and is liable for any other penalties that may apply to the nonmedical use of marijuana.

Paragraph (c) requires the registered primary caregiver to notify the commissioner within ten days of any change in the caregiver's name or address, and failure to do this is a civil violation punishable by a fine of no more than $150.

Paragraph (d) requires the commissioner to issue a new registry identification card within ten days of receiving updated information from a qualifying patient or primary caregiver and a $10 fee.

Paragraph (e) states that when a registered qualifying patient ceases to use the assistance of a registered primary caregiver, the commissioner must notify the caregiver within ten days and the caregiver's protections expire ten days after notification.

Subdivision 3 requires a registered qualifying patient or caregiver who loses a registry identification card to notify the commissioner and submit a $10 fee within ten days of losing the card. Requires the commissioner to issue a new card with a new random number within five days.

Subdivision 4 states that the possession of, or application for, a registry identification card does not constitute probable cause or reasonable suspicion nor shall it be used to support searching a person or property of the person or otherwise subject the person or property of the person to inspection by any governmental agency.

Subdivision 5, paragraph (a), states that the registration applications and supporting information submitted are confidential.

Paragraph (b) requires the commissioner to maintain a confidential list of persons who have been issued registry identification cards. The individual names and other identifying information are private data on individuals and are not subject to disclosure except to authorized employees of the department, as necessary.

Paragraph (c) states that verification of a registry identification card shall be done by confirming the random identification card number.

Paragraph (d) states that it is a crime punishable by up to 180 days in jail and a $1,000 fine for breaching the confidentiality of this information. Any falsified or fraudulent information submitted to the commissioner shall be reported to law enforcement.

Subdivision 6 requires the commissioner to report annually to the Legislature on the number of applications for cards, the number of patients and caregivers approved, the nature of the debilitating medical conditions, the number of cards revoked, and the number of practitioners providing written certification.

Subdivision 7 states that any state or local law enforcement who knowingly cooperates with federal law enforcement official to arrest, investigate, prosecute, or search a registered qualifying patient or caregiver or a patient's or caregiver's property acting in compliance with these sections shall result in the official's employment being suspended or terminated.

Section 5 (152.26) clarifies that these sections do not permit:

(1) a person to undertake a task while under the influence of marijuana, which might constitute negligence or malpractice;

(2) smoking of marijuana in a school bus or other public transportation, on school grounds, in a correctional facility, or in any public place; and

(3) a person to operate a motor vehicle, aircraft, or motorboat while under the influence of marijuana.

The medical assistance program or private health insurer is not required to reimburse a person for the cost associated with the medical use of marijuana. An employer is not required to accommodate the medical use of marijuana in any workplace.

Section 6 (152.27) states that any fraudulent representation to a law enforcement official of any fact or circumstance relating to the medical use of marijuana to avoid arrest or prosecution is punishable by a fine of $500 in addition to any other applicable penalties.

Section 7 (152.28) establishes affirmative defenses that may be asserted as a defense to any prosecution involving marijuana.

Section 8 (152.29) permits a qualifying patient to commence an action against the commissioner if the commissioner fails to adopt rules within 120 days of the effective date to implement these sections. If the commissioner fails to issue a valid registry identification card in response to a valid application within 20 days of its submission, the card shall be deemed granted and a copy of the application shall be deemed a valid registry identification card.

Section 9 (152.30) provides a severability clause.

Section 10 (152.31) creates a registration system for organizations that acquire, possess, cultivate, manufacture, deliver, transfer, transport, supply, or dispense marijuana, equipment, or supplies to registered qualified patients and caregivers.

Subdivision 1 defines a "registered organization."

Subdivision 2, paragraph (a), requires the commissioner to issue a registered organization license within 20 days to any person who meets the adopted rules and who provides:

(1) the established fee;

(2) the name of the organization;

(3) the addresses of the organization and any other real property where marijuana is to be possessed, cultivated, manufactured, supplied, or dispensed; and

(4) the name, address, and date of birth of any person who is an agent of or employed by the organization.

Paragraph (b) requires the commissioner to issue each agent and employee of a registered organization a registry identification card for a cost of $10 each within ten days of receipt of the identifying information and the fee.

Subdivision 3 states that the license for a registered organization and each employee or agent expires one year after the date of issuance.

Subdivision 4 requires the commissioner to adopt rules no later than 90 days after the effective date to implement this section.

Subdivision 5 authorizes the commissioner to make reasonable inspections of registered organizations with reasonable notice given prior to the inspection.

Subdivision 6, paragraph (a), states that registered organizations must be nonprofit entities and are subject to all applicable state laws governing nonprofit entities.

Paragraph (b) states that a registered organization may not be located within 500 feet of a school or structure used primarily for religious services or worship.

Paragraph (c) requires the operating documents of a registered organization to include procedures for the oversight of the organization and to ensure adequate record keeping.

Paragraph (d) requires the registered organization to notify the commissioner within ten days of when an employee or agent stops working at the organization.

Paragraph (e) requires the registered organization to notify the commissioner before a new agent or employee begins working at the organization, in writing, and to submit a $10 fee for the person's identification card.

Paragraph (f) states that the registered organization is not subject to civil penalty or disciplinary action for acting in accordance with these sections and rules, provided that the organization does not possess an amount of marijuana that exceeds 12 marijuana plants and 2.5 ounces of usable marijuana for each registered qualifying patient.

Paragraph (g) states that no employee, agent, or board member of a registered organization shall be subject to arrest, prosecution, search, seizure, or penalty or disciplinary action for working for a registered organization.

Paragraph (h) prohibits the registered organization from:

(1) obtaining marijuana from outside the state in violation of federal law; or

(2) using marijuana for any purpose other than to assist registered qualifying patients with the medical use of marijuana directly or through a qualifying primary caregiver.

Paragraph (i) prohibits a municipality from preventing a registered organization from operating in an area where zoning permits local businesses.

Paragraph (j) states that if these provisions are found to be unconstitutional or enjoined, then enforcing laws against the delivery of marijuana for consideration to registered qualifying patients shall be the lowest priority of law enforcement.

Section 11 provides an effective date.

KC:ph

Senators Kelley, Kierlin and Solon introduced--
S.F. No. 1973: Referred to the Committee on Health and Family Security.

A bill for an act

relating to health; providing for the medical use of marijuana; providing civil and criminal penalties; proposing coding for new law in Minnesota Statutes, chapter 152.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. [152.22] [DEFINITIONS.]

Subdivision 1. [APPLICABILITY.] For purposes of sections 152.22 to 152.31, the terms defined in this section have the meanings given them.

Subd. 2. [COMMISSIONER.] "Commissioner" means the commissioner of health.

Subd. 3. [DEBILITATING MEDICAL CONDITION.] "Debilitating medical condition" means:

(1) cancer, glaucoma, acquired immune deficiency syndrome, hepatitis C, or the treatment of these conditions;

(2) a chronic or debilitating disease or medical condition or its treatment that produces one or more of the following: cachexia or wasting syndrome; severe or chronic pain; severe nausea; seizures, including but not limited to those characteristic of epilepsy; severe and persistent muscle spasms, including but not limited to those characteristic of multiple sclerosis and Crohn's disease; or agitation of Alzheimer's disease;

(3) the condition of an HIV-positive patient when the

patient's condition has worsened and the patient's physician believes the patient could benefit from consumption of marijuana; or

(4) any other medical condition or its treatment approved by the commissioner under section 152.24.

Subd. 4. [MEDICAL USE.] "Medical use" means the acquisition, possession, cultivation, manufacture, use, delivery, transfer, or transportation of marijuana or paraphernalia relating to the consumption of marijuana to alleviate a registered qualifying patient's debilitating medical condition or symptoms associated with the medical condition.

Subd. 5. [PRACTITIONER.] "Practitioner" means a person who is licensed with the authority to prescribe drugs under section 151.01, subdivision 23.

Subd. 6. [PRIMARY CAREGIVER.] "Primary caregiver" means a person who is at least 18 years old and who has agreed to assist with a qualifying patient's medical use of marijuana. A primary caregiver may assist no more than five qualifying patients with their medical use of marijuana.

Subd. 7. [QUALIFYING PATIENT.] "Qualifying patient" means a person who has been diagnosed by a practitioner as having a debilitating medical condition.

Subd. 8. [REGISTRY IDENTIFICATION CARD.] "Registry identification card" means a document issued by the commissioner that identifies a person as a qualifying patient or primary caregiver.

Subd. 9. [USABLE MARIJUANA.] "Usable marijuana" means the dried leaves and flowers of the marijuana plant, and any mixture or preparation thereof, but does not include the seeds, stalks, and roots of the plant.

Subd. 10. [WRITTEN CERTIFICATION.] "Written certification" means the qualifying patient's medical records, or a statement signed by a practitioner, stating that in the practitioner's professional opinion the potential benefits of the medical use of marijuana would likely outweigh the health risks for the qualifying patient. A written certification shall only be made

in the course of a bona fide practitioner-patient relationship after the practitioner has completed a full assessment of the qualifying patient's medical history. The written certification shall specify the qualifying patient's debilitating medical condition or conditions.

Sec. 2. [152.23] [PROTECTIONS FOR THE MEDICAL USE OF MARIJUANA.]

Subdivision 1. [QUALIFYING PATIENT.] A qualifying patient who has a registry identification card in possession shall not be subject to arrest, prosecution, or penalty in any manner or denied any right or privilege, including but not limited to civil penalty or disciplinary action by a business, occupational, or professional licensing board or bureau, for the medical use of marijuana, provided that the qualifying patient possesses an amount of marijuana that does not exceed 12 marijuana plants and 2.5 ounces of usable marijuana.

Subd. 2. [PRIMARY CAREGIVER.] A primary caregiver who has a registry identification card in possession shall not be subject to arrest, prosecution, or penalty in any manner or denied any right or privilege, including but not limited to civil penalty or disciplinary action by a business, occupational, or professional licensing board or bureau, for assisting a qualifying patient to whom the caregiver is connected through the commissioner's registration process with the medical use of marijuana, provided that the primary caregiver possesses an amount of marijuana that does not exceed 12 marijuana plants and 2.5 ounces of usable marijuana for each qualifying patient to whom the caregiver is connected through the commissioner's registration process.

Subd. 3. [DISCRIMINATION PROHIBITED.] No school, employer, or landlord may refuse to enroll, employ, lease to, or otherwise penalize a person solely for the person's status as a registered qualifying patient or a registered primary caregiver.

Subd. 4. [PRESUMPTION.] (a) There is a presumption that a qualifying patient or primary caregiver is engaged in the medical use of marijuana if the qualifying patient or primary

caregiver:

(1) is in possession of a registry identification card; and

(2) is in possession of an amount of marijuana that does not exceed the amount permitted under sections 152.22 to 152.31.

(b) The presumption may be rebutted by evidence that conduct related to marijuana was not for the purpose of alleviating the qualifying patient's debilitating medical condition or symptoms associated with the medical condition.

Subd. 5. [CAREGIVER'S REIMBURSEMENT.] A primary caregiver may receive reimbursement for costs associated with assisting with a registered qualifying patient's medical use of marijuana. Compensation does not constitute sale of controlled substances.

Subd. 6. [PRACTITIONER.] A practitioner shall not be subject to arrest, prosecution, or penalty in any manner or denied any right or privilege, including but not limited to civil penalty or disciplinary action by the Board of Medical Practice or by another business, occupational, or professional licensing board or bureau, solely for providing written certifications or otherwise stating that, in the practitioner's professional opinion, the potential benefits of the medical use of marijuana would likely outweigh the health risks for a patient.

Subd. 7. [PROPERTY RIGHTS.] (a) Any interest in or right to property that is possessed, owned, or used in connection with the medical use of marijuana, or acts incidental to such use, is not forfeited.

(b) A law enforcement agency that seizes and does not return usable marijuana to a registered qualifying patient or a registered primary caregiver is liable to the cardholder for the fair market value of the marijuana.

Subd. 8. [ARREST AND PROSECUTION PROHIBITED.] No person is subject to arrest or prosecution for constructive possession, conspiracy, aiding and abetting, being an accessory, or any other offense for being in the presence or vicinity of the medical use of marijuana as permitted under sections 152.22 to 152.31 or for assisting a registered qualifying patient with

using or administering marijuana.

Subd. 9. [RECIPROCITY.] A registry identification card, or its equivalent, issued under the laws of another state, United States territory, or the District of Columbia to permit the medical use of marijuana by a qualifying patient, or to permit a person to assist with a qualifying patient's medical use of marijuana, shall have the same force and effect as a registry identification card issued by the commissioner.

Sec. 3. [152.24] [RULEMAKING.]

(a) Not later than 90 days after the effective date of this section, the commissioner shall adopt rules governing the manner in which the commissioner shall consider petitions from the public to add debilitating medical conditions to those included under section 152.22, subdivision 3. When considering petitions, the commissioner shall give public notice of and an opportunity to comment at a public hearing upon the petitions. The commissioner shall, after a public hearing, approve or deny petitions within 180 days of submission. The approval or denial of a petition is a final agency action, subject to judicial review. Jurisdiction and venue for judicial review are vested in the district court. The denial of a petition does not disqualify qualifying patients with that condition if they have a debilitating medical condition. The denial of a petition does not prevent a person with the denied condition from raising an affirmative defense.

(b) Not later than 90 days after the effective date of this section, the commissioner shall adopt rules governing the manner in which the commissioner shall consider applications for and renewals of registry identification cards for qualifying patients and primary caregivers. Notwithstanding section 16A.1283, the commissioner shall establish application and renewal fees that generate revenues sufficient to offset all expenses of implementing and administering sections 152.22 to 152.31. The commissioner may vary the application and renewal fees along a sliding scale that accounts for a qualifying patient's income. The commissioner may accept donations from

private sources to reduce the application and renewal fees.

Sec. 4. [152.25] [REGISTRY IDENTIFICATION CARDS; ISSUANCE.]

Subdivision 1. [REQUIREMENTS; ISSUANCE.] (a) The commissioner shall issue registry identification cards to qualifying patients who submit:

(1) a written certification;

(2) the application or renewal fee;

(3) the name, address, and date of birth of the qualifying patient, except that if the applicant is homeless, no address is required;

(4) the name, address, and telephone number of the qualifying patient's practitioner; and

(5) the name, address, and date of birth of each primary caregiver of the qualifying patient, if any.

(b) The commissioner shall not issue a registry identification card to a qualifying patient under the age of 18 unless:

(1) the qualifying patient's practitioner has explained the potential risks and benefits of the medical use of marijuana to the qualifying patient and to a parent, guardian, or person having legal custody of the qualifying patient; and

(2) a parent, guardian, or person having legal custody consents in writing to:

(i) allow the qualifying patient's medical use of marijuana;

(ii) serve as one of the qualifying patient's primary caregivers; and

(iii) control the acquisition of marijuana, the dosage, and the frequency of the medical use of marijuana by the qualifying patient.

(c) The commissioner shall verify the information contained in an application or renewal submitted under this section and shall approve or deny an application or renewal within 15 days of receiving it. The commissioner may deny an application or renewal only if the applicant did not provide the information

required under this section or if the commissioner determines that the information provided was falsified. Rejection of an application or renewal is a final agency action, subject to judicial review. Jurisdiction and venue for judicial review are vested in the district court.

(d) The commissioner shall issue a registry identification card to each primary caregiver, if any, who is named in a qualifying patient's approved application, up to a maximum of two primary caregivers per qualifying patient.

(e) The commissioner shall issue a registry identification card within five days of approving an application or renewal. The card expires one year after the date of issuance. A registry identification card shall contain:

(1) the name, address, and date of birth of the qualifying patient;

(2) the name, address, and date of birth of each primary caregiver of the qualifying patient, if any;

(3) the date of issuance and expiration date of the registry identification card;

(4) a random registry identification number; and

(5) a photograph, if the commissioner adopts rules to require one.

Subd. 2. [NOTIFICATION OF CHANGES; PENALTIES.] (a) A qualifying patient who has been issued a registry identification card shall notify the commissioner within ten days of any change in the qualifying patient's name, address, or primary caregiver or if the qualifying patient ceases to have a debilitating medical condition.

(b) Failure to notify the commissioner of a change as required under paragraph (a) is a civil violation, punishable by a fine of no more than $150. If the person has ceased to have a debilitating medical condition, the card is null and void and the person is liable for any other penalties that may apply to the person's nonmedical use of marijuana.

(c) A registered primary caregiver shall notify the commissioner within ten days of any change in the caregiver's

name or address. Failure to notify the commissioner of the change is a civil violation, punishable by a fine of no more than $150.

(d) When a qualifying patient or primary caregiver notifies the commissioner of any changes under this subdivision, the commissioner shall issue the qualifying patient and each primary caregiver a new registry identification card within ten days of receiving the updated information and a $10 fee.

(e) When a registered qualifying patient ceases to use the assistance of a registered primary caregiver, the commissioner shall notify the primary caregiver within ten days. The primary caregiver's protections as provided under section 152.23 expire ten days after notification by the commissioner.

Subd. 3. [LOST CARDS.] If a registered qualifying patient or a registered primary caregiver loses a registry identification card, the patient or caregiver shall notify the commissioner and submit a $10 fee within ten days of losing the card. Within five days, the commissioner shall issue a new registry identification card with a new random identification number.

Subd. 4. [CARD AS PROBABLE CAUSE.] Possession of, or application for, a registry identification card does not constitute probable cause or reasonable suspicion, nor shall it be used to support search of the person or property of the person possessing or applying for the registry identification card, or otherwise subject the person or property of the person to inspection by any governmental agency.

Subd. 5. [CONFIDENTIALITY.] (a) Registration applications and supporting information submitted by qualifying patients, including information regarding their primary caregivers and practitioners, are confidential.

(b) The commissioner shall maintain a confidential list of the persons to whom the commissioner has issued registry identification cards. Individual names and other identifying information on the list are private data on individuals under chapter 13 and are not subject to disclosure, except to

authorized employees of the Department of Health as necessary to perform official duties of the department.

(c) The commissioner shall verify to law enforcement personnel whether a registry identification card is valid solely by confirming the random registry identification card number.

(d) It is a crime, punishable by up to 180 days in jail and a $1,000 fine, for a person, including an employee or official of the Department of Health or another state agency or local government, to breach the confidentiality of information obtained under sections 152.22 to 152.31. Notwithstanding this paragraph, employees of the Department of Health may notify law enforcement about falsified or fraudulent information submitted to the commissioner.

Subd. 6. [REPORT.] The commissioner shall report annually to the legislature on the number of applications for registry identification cards, the number of qualifying patients and primary caregivers approved, the nature of the debilitating medical conditions of the qualifying patients, the number of registry identification cards revoked, and the number of practitioners providing written certification for qualifying patients. The commissioner shall not provide any identifying information of qualifying patients, primary caregivers, or practitioners.

Subd. 7. [OFFICIAL SANCTIONS.] Any state or local law enforcement official who knowingly cooperates with federal law enforcement agents to arrest, investigate, prosecute, or search a registered qualifying patient or a registered primary caregiver or a patient's or caregiver's property for acting in compliance with sections 152.22 to 152.31 shall have the official's employment suspended or terminated.

Sec. 5. [152.26] [CONSTRUCTION.]

(a) Sections 152.22 to 152.31 do not permit:

(1) a person to undertake a task under the influence of marijuana, when doing so would constitute negligence or professional malpractice;

(2) smoking of marijuana:

(i) in a school bus or other form of public transportation;

(ii) on school grounds;

(iii) in a correctional facility; or

(iv) in any public place; and

(3) a person to operate, navigate, or be in actual physical control of any motor vehicle, aircraft, or motorboat while under the influence of marijuana. However, a registered qualifying patient shall not be considered to be under the influence solely for having marijuana metabolites in the patient's system.

(b) Nothing in sections 152.22 to 152.31 shall be construed to require:

(1) a government medical assistance program or private health insurer to reimburse a person for costs associated with the medical use of marijuana; or

(2) an employer to accommodate the medical use of marijuana in any workplace.

Sec. 6. [152.27] [PENALTIES.]

Fraudulent representation to a law enforcement official of any fact or circumstance relating to the medical use of marijuana to avoid arrest or prosecution is punishable by a fine of $500, which shall be in addition to any other penalties that may apply for making a false statement and for the nonmedical use of marijuana.

Sec. 7. [152.28] [AFFIRMATIVE DEFENSE AND DISMISSAL FOR MEDICAL USE OF MARIJUANA.]

(a) Except as provided in section 152.27, a person and a person's primary caregiver, if any, may assert the medical purpose for using marijuana as a defense to any prosecution involving marijuana, and such defense shall be presumed valid where the evidence shows that:

(1) the person's medical records indicate, or a practitioner has stated that, in the practitioner's professional opinion, after having completed a full assessment of the person's medical history and current medical condition made in the course of a bona fide practitioner-patient relationship, the potential benefits of using marijuana for medical purposes would

likely outweigh the health risks for the person; and

(2) the person and the person's primary caregiver, if any, were collectively in possession of a quantity of marijuana that was not more than was reasonably necessary to ensure the uninterrupted availability of marijuana for the purpose of alleviating the person's medical condition or symptoms associated with the medical condition.

(b) A person may assert the medical purpose for using marijuana in a motion to dismiss and the charges shall be dismissed following an evidentiary hearing when the defendant shows the elements listed in paragraph (a).

(c) Any interest in or right to property that was possessed, owned, or used in connection with a person's use of marijuana for medical purposes is not forfeited if the person or the person's primary caregiver demonstrates the person's medical purpose for using marijuana pursuant to sections 152.22 to 152.31.

Sec. 8. [152.29] [COMMISSIONER'S FAILURE TO ACT.]

(a) If the commissioner fails to adopt rules to implement sections 152.22 to 152.31 within 120 days of the effective date of this section, a qualifying patient may commence an action in a court of competent jurisdiction to compel the commissioner to perform the actions mandated under sections 152.22 to 152.31.

(b) If the commissioner fails to issue a valid registry identification card in response to a valid application submitted according to section 152.25 within 20 days of its submission, the registry identification card shall be deemed granted and a copy of the registry identification application shall be deemed a valid registry identification card.

Sec. 9. [152.30] [SEVERABILITY.]

Any provision of sections 152.22 to 152.31 being held invalid as to any person or circumstances shall not affect the application of any other provision of sections 152.22 to 152.31 that can be given full effect without the invalid section or application.

Sec. 10. [152.31] [REGISTERED ORGANIZATION.]

Subdivision 1. [DEFINITION.] For purposes of this section, "registered organization" means a nonprofit entity registered with the commissioner under this section that acquires, possesses, cultivates, manufactures, delivers, transfers, transports, supplies, or dispenses marijuana, cultivation equipment, related supplies and educational materials, or marijuana seeds to registered qualifying patients and their registered primary caregivers. A registered organization is a primary caregiver, although it may supply marijuana to any number of registered qualifying patients who have designated it as one of their primary caregivers.

Subd. 2. [REGISTRATION REQUIREMENTS.] (a) The commissioner shall issue a registered organization license within 20 days to any person who complies with rules adopted by the commissioner and provides:

(1) a fee in an amount established by the commissioner notwithstanding section 16A.1283, which shall not exceed $1,000;

(2) the name of the registered organization;

(3) the physical addresses of the registered organization and any other real property where marijuana is to be possessed, cultivated, manufactured, supplied, or dispensed relating to the operations of the registered organization; and

(4) the name, address, and date of birth of any person who is an agent of or employed by the registered organization.

(b) The commissioner shall issue each agent and employee of a registered organization a registry identification card for a cost of $10 each within ten days of receipt of the person's identifying information and the fee. Each card shall specify that the cardholder is an employee or agent of a registered organization.

Subd. 3. [EXPIRATION.] A license for a registered organization and each employee or agent registry identification card expires one year after the date of issuance.

Subd. 4. [RULEMAKING.] Not later than 90 days after the effective date of this section, the commissioner shall adopt rules to implement this section, including:

(1) procedures for the oversight of registered organizations, record keeping and reporting requirements for registered organizations, procedures for the transference or sale of seized cultivation equipment and related supplies from law enforcement agencies to registered organizations, and procedures for suspending or terminating the licenses of registered organizations; and

(2) the form and content of the license and renewal applications.

Subd. 5. [INSPECTION.] Registered organizations are subject to reasonable inspection by the commissioner to determine that applicable rules are being followed. Reasonable notice shall be given prior to the inspections.

Subd. 6. [ORGANIZATION REQUIREMENTS.] (a) Registered organizations must be established as nonprofit entities. Registered organizations are subject to all applicable state laws governing nonprofit entities, but need not be recognized as a 501(c)(3) organization by the Internal Revenue Service.

(b) Registered organizations may not be located within 500 feet of the property line of a public school, private school, or structure used primarily for religious services or worship.

(c) The operating documents of a registered organization shall include procedures for the oversight of the registered organization and procedures to ensure adequate record keeping.

(d) A registered organization shall notify the commissioner within ten days of when an employee or agent ceases to work at the registered organization.

(e) The registered organization shall notify the commissioner before a new agent or employee begins working at the registered organization, in writing, and the organization shall submit a $10 fee for the person's registry identification card.

(f) No registered organization shall be subject to prosecution, search, seizure, or penalty in any manner or denied any right or privilege, including but not limited to civil penalty or disciplinary action by a business, occupational, or

professional licensing board or bureau, for acting according to sections 152.22 to 152.31 and rules adopted thereunder to assist registered qualifying patients to whom it is connected through the commissioner's registration process with the medical use of marijuana, provided that the registered organization possesses an amount of marijuana that does not exceed 12 marijuana plants and 2.5 ounces of usable marijuana for each registered qualifying patient.

(g) No employees, agents, or board members of a registered organization shall be subject to arrest, prosecution, search, seizure, or penalty in any manner or denied any right or privilege, including but not limited to civil penalty or disciplinary action by a business, occupational, or professional licensing board or bureau, for working for a registered organization according to sections 152.22 to 152.31.

(h) The registered organization is prohibited from:

(1) obtaining marijuana from outside the state in violation of federal law; or

(2) acquiring, possessing, cultivating, manufacturing, delivering, transferring, transporting, supplying, or dispensing marijuana for any purpose except to assist registered qualifying patients with the medical use of marijuana directly or through the qualifying patients' other primary caregivers.

(i) A municipality may not prevent a registered organization from operating according to sections 152.22 to 152.31 in an area where zoning permits retail businesses.

(j) If provisions of this section are enjoined or declared unconstitutional, then enforcing laws against delivery of marijuana for consideration to registered qualifying patients shall be the lowest priority of law enforcement.

Sec. 11. [EFFECTIVE DATE.]

Sections 1 to 10 are effective the day following final enactment.

My name is Jerome Schaffer, and I am 63 years old. From 1958-1961, I served in the U.S. Air Force. Today I am a retired machinist. In February 2004, I underwent surgery for severe stomach pains. At that time it was discovered that I had stage three colorectal cancer. A grueling eight-hour surgery removed a six-pound tumor and almost half of my intestine.

When I regained my strength in May, I began intense chemotherapy treatments. I received six infusions, once a week -- six weeks on, two weeks off. Beyond the complications generally caused by chemotherapy -- the nausea, the pain, the weight loss, the sleep loss -- I suffered severe intestinal blockages that, because of the earlier surgery, were a cause for great concern.

One evening, a friend of mine who was also undergoing chemotherapy told me that marijuana was effective at treating his pain and nausea. Unfortunately, my friend is no longer with us, having lost his battle. But I thank him to this day for his advice. I tried the marijuana he gave me, and to my shock and relief it actually worked. A small amount of marijuana has the ability to calm my nausea and to ease my pain. Medical marijuana improves my appetite, and helps to ease the pain so that I can sleep at night. Of all the medication I have taken in my long ordeal, I can safely say that medical marijuana worked better than any other.

I didn't come easily to marijuana. I am a man who believes in following the law and doing what is right. And I fought hard without marijuana. I handled the first two rounds of chemo better than most. I was still able to eat and kept most of my weight on. But the third treatment hit me like a ton of bricks. I couldn't eat or sleep, was extremely nauseated, and went from 170 pounds down to 125. It was only then that I gave medical marijuana a try.

In July 2004, roughly two months after beginning chemo, I was readmitted to the hospital because of, again, severe intestinal blockage. I spent roughly a week and a half there. When I was discharged from the hospital, I was prescribed percodan, a high-powered narcotic, because I had been on a morphine pump while in the hospital. After leaving the hospital, I stopped and bought marijuana. Later, on highway 35E around mid-afternoon, I got a flat tire and called a friend for help. Before he could arrive, the police pulled behind me. Forgetting that one of the medications in the truck was illegal, I made no attempt to conceal the medical marijuana.

Handcuffs were put around my hospital bracelet, and the officers ridiculed me for possessing marijuana. I have never felt so humiliated in all my life. Standing there on the highway, as the rush-hour traffic went by, I thought back on my years of proud service to this nation. There I was, a law-abiding, tax paying citizen, being paraded up and down the highway, handcuffed like a common criminal.

Instead of leaving the hospital for the warm comfort of my own bed, I spent that night locked up in a jail cell. To make matters worse, the police confiscated the percodan the hospital gave me. I wouldn't wish a night like that on my worst enemy.

(OVER)

I was charged with possession of marijuana and given a fine as well as 100 hours of community service and 18 months of supervised probation when my case was adjudicated in September. I now check in with a probation officer on a regular basis who makes sure that I am not using the only medication that relieves the pain, nausea, and discomfort associated with my chemotherapy.

Shortly after my arrest, I told one of my oncologists -- whom I would rather not name at this time -- that I was using medical marijuana. He prescribed me marinol, which is a synthetic derivative, and told me to give it a shot. He told me that he had not had much success with it, but I figured it was worth a try. Not wanting to go back to jail, I tried it. It didn't work.

Despite the consequences, I returned -- with my doctor's blessing -- to medical marijuana. It is still the only medication that gives me relief.

Three weeks ago, blood tests showed no signs of cancer in my body. More tests will be run in the near future, but for now there is the possibility that I may come through this nightmare. However, the effect of the chemotherapy treatments is still with me, and so I continue to use medical marijuana to keep food down as I return to my previous body weight. I don't think I belong in jail for doing so.

While nothing can change what I have gone through so far, I am proud to be here so that others might not be treated as I was. I look forward to answering any of your questions.

Thank you for giving me this chance to speak, and thank you for considering this important issue.

WHY YOU SHOULD SUPPORT MEDICAL MARIJUANA

▶ The Minnesota Medical Marijuana Act

The Minnesota Medical Marijuana Act would remove penalties for the sick and dying who use medical marijuana to treat their symptoms with the approval of their physicians.

The bill is modeled after—but learns from—programs currently operating in the 10 states that have passed medical marijuana laws—eight via ballot initiative and two through the legislature.

The bill very strictly controls access to medical marijuana. The designated plant limit is based on National Institute on Drug Abuse (NIDA) patient-use research that has accumulated since NIDA began growing marijuana for federally approved patients. (The federal government currently supplies medical marijuana to seven patients across the nation.)

At root, this bill will allow a very limited number of patients who act on the advice of their doctors to use medical marijuana to alleviate symptoms associated with cancer, HIV/AIDS, MS, or other serious illnesses.

▶ Ultimately, the decision to use medical marijuana should be between a doctor and a patient. But don't take our word for it ...

"Nausea, appetite loss, pain and anxiety are all afflictions of wasting and all can be mitigated by marijuana."

—Institute of Medicine, *Marijuana and Medicine: Assessing the Science Base*, 1999

"[M]arijuana has therapeutic properties not replicated by other currently available medications ... For certain persons the medical use of marijuana can literally mean the difference between life and death."

—Brief filed with the U.S. Supreme Court by the HIV Medicine Association of the Infectious Diseases Society of America and the Lymphoma Foundation of America, October 2004

"Marijuana/cannabis has a wide margin of safety for use under prescribed supervision and it is effective for numerous conditions."

—American Nurses Association, Position Statement on Providing Patients Safe Access to Therapeutic Marijuana/Cannabis, 2003

"[W]e concluded that there are some limited circumstances in which we recommend smoking marijuana for medical uses."

—Principal Investigator Dr. John Benson, opening remarks at the Institute of Medicine's news conference, March 17, 1999

▶ A growing number of prominent medical and professional organizations support access to medical marijuana, including:

- National Association of Attorneys General
- Institute of Medicine (IOM)
- American Nurses Association
- *Lancet Neurology*
- Service Employees International Union
- American Public Health Association
- American Academy of Family Physicians
- American Academy of HIV Medicine
- American Medical Student Association
- AIDS Action Council
- American Bar Association

"Marijuana has an extremely wide margin of acute safety for use under medical supervision and cannot cause lethal reactions."

—American Public Health Association, Resolution 9513, "Access to Therapeutic Marijuana/Cannabis," November 1995

▶ The Public Strongly Supports Medical Marijuana

In February of this year, a statewide Zogby poll showed that Minnesotans support medical marijuana by a 2 - 1 margin—60% to 31%, with the rest undecided.

Voters have never rejected an initiative to protect medical marijuana patients from arrest, approving them in eight states. Most recently, in 2004, voters in Montana approved a medical marijuana initiative by 62% to 38%, and the Vermont Legislature passed a medical marijuana bill through a Republican House and a Democratic Senate. (Vermont's Republican governor allowed it to pass into law without his signature.)

A recent AARP poll showed that 72% of seniors support medical marijuana.

A December 2002 Time/CNN poll showed 80% support nationwide.

Please contact Tom Lehman—(763) 377-9167 or tom@thelehmangroup.com—with any questions.

My name is Sue Wild, and I live in Zimmerman. Being at this hearing tonight is very difficult for me. On Monday, March 21, while I was home, my entire house burned to the ground. While no people were hurt, the fire has temporarily thrown my life upside down, as you can imagine. I also had a chemo treatment yesterday, so please bear with me if I seem to have a hard time getting through this simple statement.

I was raised in a politically active family, and I have always felt so fortunate to live in a country where people can not only express their views, but have a chance to influence the leaders that we depend on, through forums such as this one tonight. I feel when we have strong opinions it is our duty to express them. Even though being here tonight is very hard for me, I am compelled to take the more difficult path, to come to you to speak in person.

I feel strongly that I need to be at this hearing so that I can share with you my experience with medical marijuana. In April 2002, during surgery, I was diagnosed with ovarian cancer. The cancer had spread through most of my body, up near my diaphragm and back down to my liver, bladder, and colon, as well as further throughout. Even with the two surgeons working diligently through a four-hour surgery, they were unable to remove all of the cancer.

Following the surgery, I began an intensive round of extremely strong chemotherapy. Last fall, the cancer was again growing and I began a second round of chemo. In the last two months my bone marrow began wearing out, making me susceptible to infections like the respiratory one I have now. Complicating matters, my immune system has been compromised because of SLE (lupus) for many years, and disabled because of SLE for about six years. Having SLE makes chemotherapy even more difficult. Specifically, SLE amplifies the pain I feel in my joints following chemotherapy. To combat the pain and nausea that comes with chemotherapy, I decided to try medical marijuana, which had originally been recommended to me by a doctor to combat the symptoms associated with SLE.

I was initially skeptical, but I was willing to try almost anything at that point. To my surprise, a small amount of marijuana following a meal allowed me to keep the food down. During my second round of chemotherapy, one of my doctors asked me how the potent anti-nausea pills he had given me were working.

With apprehension and a bit of fear, I told him that those medications had been overwhelmingly powerful, and that I instead was using small amounts of marijuana. He told me that if it was working for me, then he saw no reason I shouldn't continue to benefit from it. He then explained to me why, medically, marijuana was working. I'm afraid I don't have the medical expertise to repeat his technical explanation for you, but I do know one thing: Medical marijuana has a real effect on my pain and nausea.

It's impossible to convey what it is like to live with a diagnosis of cancer that is considered not curable. I can, however, pass along to you my experience of using

marijuana medically, and how it has helped me to be able to eat and hold down food, and to be in less pain.

Since my doctor approves, why shouldn't this matter be between him and me?

Thank you for considering this issue, and please feel free to contact me at (763) 300-8161 with any further questions.

My name is Jason McDonough, but you can call me Jay-Jay. I live in New Richland, Minnesota, and am 36 years old. Seven years ago, the helicopter I was piloting had an in-flight mechanical failure. As a result of the crash, I have lost the use of my legs, and am in constant neurogenic pain. My feet have the sensation of having been recently burned, and they also have a stabbing sensation of pins and needles. This pain never stops.

For some time following the accident, friends and family members told me that they had heard that marijuana is often used to reduce pain and nausea, and to increase appetite in those suffering from chronic pain. Eventually I decided to try medical marijuana, despite my fear of arrest for breaking Minnesota law.

Though medical marijuana is of course no miracle cure, I have found it very effective at reducing my neurogenic pain. By reducing my pain, it has allowed me to rely less heavily on the powerful and addictive pain medications that are legally prescribed to me.

I have never discussed my use of medical marijuana with my doctor because of the stigma attached to the use of an illegal drug. In fact, it is only with great fear and apprehension that I sit before you today, but I consider this matter too important to for me to remain silent.

It is my hope that this legislation will remove the fear that surrounds medical marijuana, so that I can discuss it with my doctor and determine the best way for medical marijuana to fit into my regimen of daily medications.

Thank you for your time. I look forward to answering any of your questions.

Published - Wednesday, March 30, 2005
Winona Daily News

Compassion prompts Kierlin to co-author medical marijuana bill

By Chris Hubbuch / Winona Daily News

State Sen. Robert Kierlin of Winona has co-authored a bill to protect seriously ill people from prosecution for using medicinal marijuana. Although federal law bars all use of the drug, states have passed laws to exempt seriously ill patients from state-level prosecution. Minnesota would become the 11th state to enact such a measure if Kierlin's bill, introduced Tuesday, passes the Legislature.

"It's a question of compassion," the Republican said. "With terminal illnesses, if there's any chance to solve any of the pain problem with any drug we should give it a shot."

Sixty percent of Minnesotans say they would support a law to allow people with cancer, multiple sclerosis and other serious illnesses to use marijuana for medical purposes with physician approval, according to a recent poll conducted by Zogby International. The same poll showed that in greater Minnesota about

29 percent of people said they would be less likely to vote for a representative or senator who voted against a medical marijuana bill.

"There's a feeling that every legislator should be extremely tough on every drug," Kierlin said, acknowledging that such proposals are controversial.

Kierlin said he signed on to the bill, authored by Sen. Steve Kelley, DFL-Hopkins, only after the language was tightened to allow only people with terminal illness or extreme pain to use the drug with their doctors' consent.

"Cancer is not a partisan disease," said Neal Levine, director of state policies at the Marijuana Policy Project, a Washington, D.C., organization that works to decriminalize marijuana. Marijuana can relieve pain, nausea and muscle spasms and can stimulate appetite. It is often used to treat patients with cancer, AIDS, multiple sclerosis, glaucoma and epilepsy.

Levine estimates that hundreds of seriously ill Minnesotans now secretly use marijuana to treat their symptoms.

"It's just a sad situation," Levine said. "People shouldn't be treated like criminals just because they're trying to alleviate their pain."

Similar bills have died in the Legislature in past years. Most of those bills have been authored by urban DFL legislators, said Levine, a former Minnesotan.

This bill is the first with bipartisan and out-state support, Levine said. Levine is hopeful that if the bill does not pass it might get to a committee vote and "build up some steam" for next year.

Zogby Poll Summary

- **Likely voters in Minnesota support medical marijuana two to one**

  By a margin of two to one, Minnesotans support allowing "people with cancer, MS, and other serious illnesses to use and grow their own marijuana for medical purposes, as long as their physician approves."

  60% of voters in Minnesota approve, 31% oppose, and 9.6% are undecided. Not surprisingly, support is greatest in the cities, but even in Greater Minnesota, the legislation has a 15-point lead.

- **Voters will hold it against incumbents who vote against this legislation, especially in Greater Minnesota**

  This issue will not affect the vote of roughly 60% of the electorate. However, the remainder—by a margin of more than two to one—would be far less likely to vote for an incumbent legislator who voted against this bill. They would also be far less likely to vote for Governor Pawlenty if he vetoes the bill, also by a margin of two to one.

  Interestingly, the farther away you get from the cities, the more likely voters are to hold a negative vote against the incumbent. In Greater Minnesota, this would affect the vote of 36% of the electorate, and those people would hold a negative vote on the legislation against their incumbent legislator by a margin of four to one.

  Any attack on a legislator who votes for this legislation will most likely backfire, and at the very worst, fall on deaf ears.

- **Perception is not reality**

  A common—and false—belief among legislators is that voting for this compassionate legislation can be used against them. As we've just shown, the inverse is true. However, this common misperception is shared by most Minnesotans. When voters are asked if the majority of the state favors this legislation—regardless of their own opinion—60% respond that they think the majority of the state opposes—even though 60% of the state actually approves.

- **This legislation does not send the wrong message to children**

  By a two-to-one margin, voters said that enacting medical marijuana legislation "would not send the wrong message to children."

- **Nonprofit dispensaries are the most popular part of the legislation**

  79% of Minnesota voters—and by a margin of five to one—are in favor of allowing patients to purchase their medical marijuana from a strictly regulated, nonprofit dispensary that is similar to a pharmacy.

STATE OF COLORADO

Bill Owens, Governor
Douglas H. Benevento, Executive Director

Dedicated to protecting and improving the health and environment of the people of Colorado

4300 Cherry Creek Dr. S.
Denver, Colorado 80246-1530
Phone (303) 692-2000
TDD Line (303) 691-7700
Located in Glendale, Colorado

http://www.cdphe.state.co.us

Laboratory Services Division
8100 Lowry Blvd.
Denver, Colorado 80230-6928
(303) 692-3090

Colorado Department
of Public Health
and Environment

April 1, 2005

Senate Health and Family Security Committee:

As you may know, in the November 2000 general election Coloradoans passed Amendment 20, and the Colorado Department of Public Health and Environment (CDPHE) was tasked with implementing and administering the Medical Marijuana Registry program. In March of 2001, the State of Colorado Board of Health approved the Rules and Regulations pertaining to the administration of the program, and on June 1st, 2001, the Registry began accepting and processing applications for Registry Identification cards.

To date, 763 people have applied to Colorado's program, and 302 physicians have signed the required paperwork. Ongoing education is provided to state and local law enforcement agencies regarding the registry, and no major issues have occurred with any law enforcement department. There have been several occasions when patients have had contact with their local law enforcement officials, and having a Medical Marijuana Registry ID card has allowed them to be free from the fear of prosecution under Colorado's drug laws. To date, there has been one marijuana-related conviction of a patient on the Registry.

Patients or physicians have not been targeted or charged by federal officials for participating in this program. Also, Colorado has not lost any federal funding or suffered any federal repercussions due to the implementation of this law. It is also important to note that the Registry has spoken with the DEA numerous times here in Colorado, and has been told that recommendations by doctors do not violate federal law, and that our program is not being targeted by any federal law enforcement agency.

No general funds have been designated for this program, and the Amendment allows CDPHE to collect fees to cover the administrative costs of administering the program. Currently the fee is $110, and is evaluated annually by CDPHE.

If you would like to speak with me further about Colorado's program, please feel free to contact me at 303-692-2184 or via email at debra.tuenge@state.co.us.

Sincerely,

Debra Tuenge

Debra Tuenge
Administrator, Medical Marijuana Registry

Editorials

Federal Foolishness and Marijuana

The advanced stages of many illnesses and their treatments are often accompanied by intractable nausea, vomiting, or pain. Thousands of patients with cancer, AIDS, and other diseases report they have obtained striking relief from these devastating symptoms by smoking marijuana.[1] The alleviation of distress can be so striking that some patients and their families have been willing to risk a jail term to obtain or grow the marijuana.

Despite the desperation of these patients, within weeks after voters in Arizona and California approved propositions allowing physicians in their states to prescribe marijuana for medical indications, federal officials, including the President, the secretary of Health and Human Services, and the attorney general sprang into action. At a news conference, Secretary Donna E. Shalala gave an organ recital of the parts of the body that she asserted could be harmed by marijuana and warned of the evils of its spreading use. Attorney General Janet Reno announced that physicians in any state who prescribed the drug could lose the privilege of writing prescriptions, be excluded from Medicare and Medicaid reimbursement, and even be prosecuted for a federal crime. General Barry R. McCaffrey, director of the Office of National Drug Control Policy, reiterated his agency's position that marijuana is a dangerous drug and implied that voters in Arizona and California had been duped into voting for these propositions. He indicated that it is always possible to study the effects of any drug, including marijuana, but that the use of marijuana by seriously ill patients would require, at the least, scientifically valid research.

I believe that a federal policy that prohibits physicians from alleviating suffering by prescribing marijuana for seriously ill patients is misguided, heavy-handed, and inhumane. Marijuana may have long-term adverse effects and its use may presage serious addictions, but neither long-term side effects nor addiction is a relevant issue in such patients. It is also hypocritical to forbid physicians to prescribe marijuana while permitting them to use morphine and meperidine to relieve extreme dyspnea and pain. With both these drugs the difference between the dose that relieves symptoms and the dose that hastens death is very narrow; by contrast, there is no risk of death from smoking marijuana. To demand evidence of therapeutic efficacy is equally hypocritical. The noxious sensations that patients experience are extremely difficult to quantify in controlled experiments. What really counts for a therapy with this kind of safety margin is whether a seriously ill patient feels relief as a result of the intervention, not whether a controlled trial "proves" its efficacy.

Paradoxically, dronabinol, a drug that contains one of the active ingredients in marijuana (tetrahydrocannabinol), has been available by prescription for more than a decade. But it is difficult to titrate the therapeutic dose of this drug, and it is not widely prescribed. By contrast, smoking marijuana produces a rapid increase in the blood level of the active ingredients and is thus more likely to be therapeutic. Needless to say, new drugs such as those that inhibit the nausea associated with chemotherapy may well be more beneficial than smoking marijuana, but their comparative efficacy has never been studied.

Whatever their reasons, federal officials are out of step with the public. Dozens of states have passed laws that ease restrictions on the prescribing of marijuana by physicians, and polls consistently show that the public favors the use of marijuana for such purposes.[1] Federal authorities should rescind their prohibition of the medicinal use of marijuana for seriously ill patients and allow physicians to decide which patients to treat. The government should change marijuana's status from that of a Schedule 1 drug (considered to be potentially addictive and with no current medical use) to that of a Schedule 2 drug (potentially addictive but with some accepted medical use) and regulate it accordingly. To ensure its proper distribution and use, the government could declare itself the only agency sanctioned to provide the marijuana. I believe that such a change in policy would have no adverse effects. The argument that it would be a signal to the young that "marijuana is OK" is, I believe, specious.

This proposal is not new. In 1986, after years of legal wrangling, the Drug Enforcement Administration (DEA) held extensive hearings on the transfer of marijuana to Schedule 2. In 1988, the DEA's own administrative-law judge concluded, "It would be unreasonable, arbitrary, and capricious for DEA to continue to stand between those sufferers and the benefits of this substance in light of the evidence in this record."[1] Nonetheless, the DEA overruled the judge's order to transfer marijuana to Schedule 2, and in 1992 it issued a final rejection of all requests for reclassification.[2]

Some physicians will have the courage to challenge the continued proscription of marijuana for the sick. Eventually, their actions will force the courts to adjudicate between the rights of those at death's door and the absolute power of bureaucrats whose decisions are based more on reflexive ideology and political correctness than on compassion.

Jerome P. Kassirer, M.D.

AMERICAN NURSES ASSOCIATION

Position Statement
on

Providing Patients Safe Access to Therapeutic Marijuana/Cannabis

Summary: The American Nurses Association (ANA) recognizes that patients should have safe access to therapeutic marijuana/cannabis. Cannabis or marijuana has been used medicinally for centuries. It has been shown to be effective in treating a wide range of symptoms and conditions. Therefore, the ANA supports:

1. Research in controlled investigational trials on the therapeutic efficacy of marijuana/cannabis, including alternative methods of administration.

2. The right of patients to have safe access to therapeutic marijuana/cannabis under appropriate prescriber supervision.

3. Legislation to remove criminal penalties including arrest and imprisonment for bona fide patients and prescribers of therapeutic marijuana/cannabis.

4. Federal and state legislation to exclude marijuana/cannabis from classification as a Schedule I drug.

5. Research in controlled investigational trials on the therapeutic efficacy of marijuana/cannabis, including alternative methods of administration.

6. The education of registered nurses regarding current, evidence based therapeutic use of marijuana/cannabis.

Background:

Until 1937, cannabis was widely prescribed in the United States. The Marihuana Tax Act of 1937 began the prohibition of its use, and the Controlled Substances Act of 1970 completely prohibited all therapeutic medicinal use of marijuana/cannabis by making it a Schedule I drug. In 1992, access to legal marijuana through the FDA's Investigational New Drug Program was terminated by the Secretary of Health and Human Services.

There is a growing body of evidence that marijuana has a significant margin of safety when used under a practitioner's supervision when all of the patient's medications can be considered in the therapeutic regimen. (IOM, 1999) and (Steinborn, 2001). The American Public Health Association (1995) noted that marijuana's therapeutic properties seem to work differently from conventional medication, making it a viable option for patients who are resistant to this conventional therapy. Marijuana/cannabis was noted in the APHA statement to be effective in:

- Reducing nausea and vomiting associated with chemotherapy
- Stimulating the appetite of patients coping with the wasting syndrome associated with HIV/AIDS and cancer
- Controlling spasticity associated with spinal cord injury and multiple sclerosis
- Decreasing suffering from chronic pain
- Controlling seizures

- Somewhat relieving intraocular pressure associated with glaucoma

Yet, it should also be acknowledged that there continues to be controversy and conflicting opinions on the efficacy and safety of using marijuana/cannabis for medicinal therapeutic purposes (Schwartz, 2002 and Fintor, 2001). Therefore, more study is required before definitive conclusions about the effectiveness of marijuana, differences between pharmacological marijuana equivalents and the side effects of marijuana can be made.

In spite of ongoing controversy, nine states (California, Washington, Oregon, Alaska, Hawaii, Arizona, Colorado, Nevada, Maine) and the District of Columbia have passed medical marijuana laws, some more restrictive than others (Schwartz, 2002). While voters have approved the use of marijuana in these states, there are several where the administration and legislative bodies have refused to accept regulations or codify provider behaviors. Further, the FDA, the DEA and the federal government have issued warnings to the providers in those states, identifying the federal consequences of distributing or prescribing medical marijuana. Therefore, families and patients who gain access to or use marijuana/cannabis as adjunct therapy for symptom relief are still at risk for breaking the law (Wall, 2001).

Nurses have an ethical obligation to advocate for patients' access to healthcare. In 2000 Mary Lynn Mathre, MSN, RN, CARN (Virginia Nurses Association) and Melanie Dreher, PhD, RN, FAAN (Iowa Nurses Association) co-directed an historic national conference on the medical use of marijuana/cannabis, the First National Clinical Conference on Cannabis Therapeutics. Over 250 nurses, physicians, patients and attorneys attended the conference at the University of Iowa. Mathre also has founded an advocacy group, Patients Out of Time, to promote the therapeutic use of marijuana/cannabis (Trossman, 2000).

Eleven of ANA's CMAs have positions that address the therapeutic use of marijuana. They are Alaska, Colorado, Hawaii, Minnesota, Mississippi, New Mexico, New York, North Carolina, Virginia, Wisconsin, and New Jersey. In 1996, ANA's Congress on Nursing Practice advocated support for:

- The education of registered professional nurses regarding current, evidence based therapeutic use of marijuana/cannabis, and
- The investigation in controlled trials of the therapeutic efficacy of marijuana/cannabis.

There is significant research that demonstrates a connection between therapeutic use of marijuana/cannabis and symptom relief. The American Nurses Association actively supports patients' rights to legally and safely access marijuana/cannabis for symptom management and to promote quality of life for patients needing such an alternative to conventional therapy.

References

American Public Health Association. (1995). Access to therapeutic marijuana/cannabis. Washington, DC: Author.

Bergen, J. Mother's homemade marijuana: A plan to aid her son leads to arrest and push for change. (1993, October 11). The New York Times, p.B-1.

Fintor, L. (2001). Canada's Marijuana regulations raise efficacy, safety issues. Journal of the National Cancer Institute, 93: 740-742.

Grinspon, L. & Bakalar, J.B. (1995). Marijuana as medicine: A plea for reconsideration. JAMA, 273(23), 1875-1876.

Institute of Medicine (1999). Marijuana and medicine: Assessing the science base. Washington, DC: National Academy Press.

In the Matter of Marijuana Rescheduling Petition, Docket 86-22, Opinion Recommended Ruling, Findings of Tort, Conclusions of Law, and Decision of Administrative Law Judge, September 6, 1988. Washington, DC: Drug Enforcement Agency.

Mathre, M.L. (Eds.). (1997). Cannabis in Medical Practice: A Legal, Historical and Pharmacological Overview of Therapeutic Marijuana. Jefferson, NC: McFarland & Co.

Russo, E. Dreher, M., and Mathre, M.L. (2002). Women and cannabis: Medicine, science and sociology. Haworth Press.

Schwartz, R. (2002). Marijuana: A decade and a half later, still a crude drug with underappreciated toxicity. Pediatrics, 109: 284-289.

Steinborn, J. et.al. (2001). The latest buzz on medicinal marijuana: A legal and medical perspective. American Journal of Hospice and Palliative Care, 18 (5), 295-298.

Trossman, S. (2000). A Virginia nurse takes on a tough issue: Medical Marijuana. The American Nurse, 32(6), 20, 22.

Wall, J. et.al. (2001). Cannabis: it's therapeutic use. Nursing Standard, 16 (10), 39-44.

Wren, C. Votes on medical marijuana are stirring debate. (1996, November 17). The New York Times, p. A-16.

Effective Date: March 19, 2004
Status: Position Statement
Originated by: Congress on Nursing Practice & Economics
Adopted by: ANA Board of Directors

Related Past Action: 1. 2003 HOD Action Report: Providing Patients Safe Access to Therapeutic Marijuana/Cannabis

My name is Darrell Paulsen.

I am 34 years old and live with cerebral palsy. I was diagnosed with this disability about eight months after my birth, and I have lived with intense muscle spasticity ever since. I have little or no use of my legs, and my left arm might as well be nonexistent, because I am unable to do much of anything with it. I live my life from a power wheelchair.

I live with disability. I deal with it every day. I know that I am different from most other people and I have slowly learned to accept and even celebrate this part of me.

I first realized that medical marijuana helped to alleviate my symptoms by reducing my spasticity and increasing my appetite. I have used marijuana successfully to treat my spasticity for 16 years now. It has always been effective medicine for me, and I use it in consultation with my doctor.

I am inspired to join these patients speaking before you tonight. It takes a lot of courage for us to risk our health care, housing, education, transportation, and most importantly, our liberty, to testify before you today. These are all things that people who aren't disabled take for granted on a daily basis, but medical marijuana patients are forced to consider.

I would like to leave this committee with one fundamental question: Is Minnesota a better place with me and my fellow patients locked behind bars,
or receiving the treatment our doctors recommend?

I look forward to answering your questions. Thank you.

IVAN W. SLETTEN MD
Orchard Park
6381C Osgood Ave. N.
Stillwater, MN 55082-1179

DISTINGUISHED LIFE FELLOW
AMERICAN PSYCHIATRIC ASSOCIATION

Phones:
Office: 651-351-9358
Fax: 651-351-1405
E-Mail: isletten@aol.com

To: Health and Family Security Committee

From: Dr. Ivan W. Sletten, MD

Re: Support for S.F. 1973, the Medical Marijuana Bill

I regret that I cannot be before you today, but I am away on business in Rochester for several days. Please feel free to contact me at the number above if you would like to speak further about medical marijuana.

Briefly, I support S.F. 1973 for the following reasons:

1) Many prestigious and respected medical organizations have endorsed medical marijuana, including the National Academy of Sciences Institute of Medicine (IOM), the *Lancet Neurology*, the American Public Health Association, and the American Nurses Association, just to name a few. A March 17, 1999 report by the IOM recommended:

> "Compassionate" use of marijuana for "those patients most likely to benefit -- such as people with debilitating symptoms that do not respond to approved medications and the terminally ill."

2) In my 50 years of psychiatric practice, I have seen hundreds of patients actively using medical marijuana without obvious harm. Generally, I've found medical marijuana helps patients to ease nausea, eat, sleep, reduce pain, and control the symptoms associated with multiple sclerosis, AIDS, and cancer.

3) Allowing doctors and patients to confer about the use of marijuana as medicine will increase the efficacy of the treatment, and also allow for the conduct of more rigorous trials to evaluate its usefulness and possible harms.

4) Patients who can benefit from medical marijuana should be able to do so. We are no better off as a society with them behind bars.

Ivan W. Sletten

The Minnesota Conference United Church of Christ
122 West Franklin, Suite 323, Minneapolis, MN 55404 Phone:(612) 871-0359 Fax: (612) 870-4885
MN Phone: 1-800-684-1718 Web Site: http://www.uccmn.org

Come Listen, Go Serve: God Is Still Speaking!
Theme of 2005 MN Conference UCC Annual Meeting and UCC General Synod

DAVID R. MCMAHILL
Acting Conference Minister
DavidM@uccmn.org

DICK SCHEERER
Interim Associate Conference Minister
222 NW 3rd Avenue, Suite B
Faribault, MN 55021-5119
Phone: (507) 331-7292
Fax: (507) 331-4531
Mnuccsa@hickorytech.net

MARY KAY SAUTER
Interim Associate Conference Minister
P.O. Box 305
Alexandria, MN 56308
(901 Hwy. 29 North)
MN Phone: (800) 958-1970
Office: (320) 763-6549
Fax: (320) 763-9883
mnucona@rea-alp.com

AMY WICK-MOORE
Director of Outdoor Ministries
Pilgrim Point Administrator
P.O. Box 305
Alexandria, MN 56308
Camp Phone: (320) 846-2852
Office: (320) 763-6549

GARTH SCHUMACHER
Youth Ministry Coordinator
122 W. Franklin, Suite 323
Minneapolis, MN 55404
Phone: (612) 522-9499
garths@uccmn.org

April 5, 2005

Dear Minnesota state legislators,

I am writing to encourage you to support medical marijuana legislation currently being considered by the legislature. (S.F. 1973, H.F. 2151)

Many people who suffer from cancer, AIDS, multiple sclerosis and other serious chronic illnesses find physician-approved medical marijuana to be helpful. These patients face a terrible choice: either continue to suffer needlessly or risk arrest and jail. They need mercy, not handcuffs.

My denomination, the United Church of Christ, signed a statement in 2002 that says, "We believe that seriously ill people should not be subject to arrest and imprisonment for using medical marijuana with their doctors' approval."

The United Church of Christ has joined other religious denominations such as the United Methodist Church, Union for Reform Judaism, Progressive National Baptist Convention, Episcopal Church, and the Unitarian Universalist Association in calling for this sensible policy change.

May I speak personally for a moment. I have lived with a debilitating medical condition all my adult life. This condition—Crohn's Disease—has destroyed most of my intestinal tract. For the past five years, the only thing that has made it possible for me to continue to work and enjoy a reasonably normal life has been large daily doses of a controlled substance. I take this medication under close medical supervision and regulation. If I did not have access to this medication, I would have had no choice but to go on long-term disability and face possible bankruptcy from excessive medical costs that are not covered by insurance.

I share this example by way of pointing out that close medical supervision of a controlled substance is possible, and for some of us,

God is still speaking.

using such a substance makes the difference between a productive life and a life of serious disability.

Please, dear friends, don't restrict the treatment options a physician may use for seriously ill patients.

Thank you for your leadership.

Sincerely,

Rev David McMahill / for

Rev. David McMahill
Acting Conference Minister
Minnesota Conference of the United Church of Christ

We have convened here to examine the merits of medical marijuana. I believe I can help you with that. While living in California, I was a legally registered medical marijuana patient. Under my doctor's care and advisement, I used marijuana to treat the symptoms associated with my advanced liver disease and to mitigate the symptoms associated with cirrhosis and myofascial pain syndrome. What I don't understand is why, when I moved to Minnesota, I suddenly had to risk arrest and prison just for following my doctor's recommendation. Why should a certain medication be legally available to me in 10 other states, but available only illegally here in Minnesota, my adopted home?

The simple fact is that medical marijuana works for me. Its ability to control the symptoms I suffer from allows me to reduce my intake of other prescription drugs. My doctor should have every tool available at his disposal when treating me. Medical treatment decisions should be between my doctor and me.

The reality is that whenever my nausea has become so debilitating that I use a small amount of marijuana to remain functional, my liver and metabolism do not know — or care — whether my actions were okay under state law. What is clear is that the drug helped relieve my symptoms and caused no harm. That's all that matters to a doctor and a patient, and that's all that matters to me.

By moving this legislation forward, each of you would be helping to enable the safe and humane treatment of severe medical conditions like mine. I look forward to answering your questions. Thank you.

DONALD HAUMANT

Senate Counsel, Research, and Fiscal Analysis

G-17 STATE CAPITOL
75 REV. DR. MARTIN LUTHER KING, JR. BLVD.
ST. PAUL, MN 55155-1606
(651) 296-4791
FAX: (651) 296-7747
JO ANNE ZOFF SELLNER
DIRECTOR

Senate
State of Minnesota

S.F. No. 1955 - MFIP Work Participation Rate Enhancement Program (The Delete-Everything Amendment)

Author: Senator Linda Berglin

Prepared by: Joan White, Senate Counsel (651/296-3814)

Date: April 5, 2005

Sections 1 and 2 (119B.011, subdivision 23; 119B.05, subdivision 1) amend child care statutes, inserting the definition of the new program, Work Participation Rate Enhancement Program, and making families who are participating in this program eligible for child care assistance.

Section 3 (256J.021) creates the separate state program for the work participation rate enhancement program, established under section 6.

Section 4 (256J.08, subdivision 65) expands the MFIP definition of "participant" to include a person who receives cash payments under the work participation rate enhancement program.

Section 5 (256J.521, subdivision 1) amends the assessment of the MFIP participant by requiring the job counselor to determine if the participant should be referred to the new program under section 6.

Section 6 (267J.575) establishes the work participation rate enhancement program (WORK PREP).

Subdivision 1 states the purpose of the program, which is to serve families who are not making significant progress within MFIP due to barriers to employment. The program's goal is to stabilize and improve the lives of families at risk of long-term welfare dependency.

Subdivision 2 defines the program terms, which are "work participation rate enhancement program," "case management," "family stabilization plan," and "family stabilization services."

Subdivision 3 specifies the eligibility criteria for the program. Eligible participants include:

(1) participants who are age 60 or older, have been diagnosed as suffering from an illness or incapacity that is expected to last 30 days or more, or participants who are needed in the home to care for an ill or incapacitated family member, provided the individual is eligible for or has an employment plan that is adjusted due to personal and family circumstances under the MFIP assessment statute;

(2) participants who are unlikely to benefit from DWP, which includes individuals who are unable to obtain or retain employment due to illness, injury, or incapacity, individuals who are required in the home as a caregiver, individuals who are pregnant and unable to work, and individuals who have applied for SSI or SSDI.

(3) participants who meets the requirements for or have been granted a hardship extension under either the ill or incapacitated or hard-to-employ category; or

(4) a person applying for SSI or SSDI.

Families must meet all other MFIP eligibility requirements, and they are eligible for the same financial assistance as MFIP participants.

Subdivision 4 requires all participants to participate in the family stabilization services.

Subdivision 5 requires the county to provide family stabilization services through a case management model. This section specifies what must be included in the family stabilization plan, when the case manager and the family must meet to develop the plan, and under what circumstances the case manager may modify the plan.

Subdivision 6 requires compliance with the plan, and specifies the number of hours the family must be participating in activities. When the participant's participation in work activities meets the federal participation requirements, the participant is referred to the MFIP program and assigned a job counselor.

Subdivision 7 specifies the sanction policy for participants in this program.

Section 7 (256J.621) establishes the work participation bonus, which provides $75 per month to a participant who is employed and working at least 24 hours per week when the participant's case is closed. The participant will receive the bonus in any month that the participant is employed an average of 24 hours per week, for a maximum of 12 months.

Sections 8 to 11 (256J.626, subdivision 1; 256J.626, subdivision 2; 256J.626, subdivision 3; 256J.626, subdivision 4) incorporate expenditures for the work participation rate enhancement program into the MFIP consolidated fund.

Section 12(256J.626, subdivision 7) amends the MFIP consolidated fund performance base funds statute by requiring that each county and tribe be allocated 100 percent of their calendar year allocation, instead of 95 percent. This section also states that counties and tribes will be allocated additional funds from federal TANF bonus funds the state receives. The additional funds will be determined by the commissioner based on available funds, instead of capped at 2.5 or five percent of the initial allocation.

JW:rdr

Senators Berglin and Lourey introduced--

S.F. No. 1955: Referred to the Committee on Health and Family Security.

A bill for an act

relating to human services; establishing the work participation rate enhancement program; amending Minnesota Statutes 2004, sections 256J.021; 256J.08, subdivision 65; 256J.521, subdivision 1; 256J.53, subdivision 2; 256J.626, subdivisions 1, 2, 3, 4, 7; proposing coding for new law in Minnesota Statutes, chapter 256J.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2004, section 256J.021, is amended to read:

256J.021 [SEPARATE STATE ~~PROGRAM~~ PROGRAMS FOR USE OF STATE MONEY.]

(a) Beginning October 1, 2001, and each year thereafter, the commissioner of human services must treat MFIP expenditures made to or on behalf of any minor child under section 256J.02, subdivision 2, clause (1), who is a resident of this state under section 256J.12, and who is part of a two-parent eligible household as expenditures under a separately funded state program and report those expenditures to the federal Department of Health and Human Services as separate state program expenditures under Code of Federal Regulations, title 45, section 263.5.

(b) Beginning October 1, 2005, and each year thereafter, the commissioner of human services must treat MFIP expenditures made to or on behalf of any minor child under section 256J.02, subdivision 2, clause (1), who is a resident of this state under

section 256J.12, and who is part of a household participating in the work participation rate enhancement program under section 256J.575 as expenditures under a separately funded state program and report those expenditures to the federal Department of Health and Human Services as separate state program expenditures under Code of Federal Regulations, title 45, section 263.5.

Sec. 2. Minnesota Statutes 2004, section 256J.08, subdivision 65, is amended to read:

Subd. 65. [PARTICIPANT.] "Participant" means a person who is currently receiving cash assistance or the food portion available through MFIP. A person who fails to withdraw or access electronically any portion of the person's cash and food assistance payment by the end of the payment month, who makes a written request for closure before the first of a payment month and repays cash and food assistance electronically issued for that payment month within that payment month, or who returns any uncashed assistance check and food coupons and withdraws from the program is not a participant. A person who withdraws a cash or food assistance payment by electronic transfer or receives and cashes an MFIP assistance check or food coupons and is subsequently determined to be ineligible for assistance for that period of time is a participant, regardless whether that assistance is repaid. The term "participant" includes the caregiver relative and the minor child whose needs are included in the assistance payment. A person in an assistance unit who does not receive a cash and food assistance payment because the case has been suspended from MFIP is a participant. A person who receives cash payments under the diversionary work program under section 256J.95 is a participant. A person who receives cash payments under the work participation rate enhancement program under section 256J.575 is a participant.

Sec. 3. Minnesota Statutes 2004, section 256J.521, subdivision 1, is amended to read:

Subdivision 1. [ASSESSMENTS.] (a) For purposes of MFIP employment services, assessment is a continuing process of gathering information related to employability for the purpose

of identifying both participant's strengths and strategies for coping with issues that interfere with employment. The job counselor must use information from the assessment process to develop and update the employment plan under subdivision 2 or 3, as appropriate, ~~and~~ to determine whether the participant qualifies for a family violence waiver including an employment plan under subdivision 3, and to determine whether the participant should be referred to the work participation rate enhancement program under section 256J.575.

(b) The scope of assessment must cover at least the following areas:

(1) basic information about the participant's ability to obtain and retain employment, including: a review of the participant's education level; interests, skills, and abilities; prior employment or work experience; transferable work skills; child care and transportation needs;

(2) identification of personal and family circumstances that impact the participant's ability to obtain and retain employment, including: any special needs of the children, the level of English proficiency, family violence issues, and any involvement with social services or the legal system;

(3) the results of a mental and chemical health screening tool designed by the commissioner and results of the brief screening tool for special learning needs. Screening tools for mental and chemical health and special learning needs must be approved by the commissioner and may only be administered by job counselors or county staff trained in using such screening tools. The commissioner shall work with county agencies to develop protocols for referrals and follow-up actions after screens are administered to participants, including guidance on how employment plans may be modified based upon outcomes of certain screens. Participants must be told of the purpose of the screens and how the information will be used to assist the participant in identifying and overcoming barriers to employment. Screening for mental and chemical health and special learning needs must be completed by participants who are

unable to find suitable employment after six weeks of job search under subdivision 2, paragraph (b), and participants who are determined to have barriers to employment under subdivision 2, paragraph (d). Failure to complete the screens will result in sanction under section 256J.46; and

(4) a comprehensive review of participation and progress for participants who have received MFIP assistance and have not worked in unsubsidized employment during the past 12 months. The purpose of the review is to determine the need for additional services and supports, including placement in subsidized employment or unpaid work experience under section 256J.49, subdivision 13.

(c) Information gathered during a caregiver's participation in the diversionary work program under section 256J.95 must be incorporated into the assessment process.

(d) The job counselor may require the participant to complete a professional chemical use assessment to be performed according to the rules adopted under section 254A.03, subdivision 3, including provisions in the administrative rules which recognize the cultural background of the participant, or a professional psychological assessment as a component of the assessment process, when the job counselor has a reasonable belief, based on objective evidence, that a participant's ability to obtain and retain suitable employment is impaired by a medical condition. The job counselor may assist the participant with arranging services, including child care assistance and transportation, necessary to meet needs identified by the assessment. Data gathered as part of a professional assessment must be classified and disclosed according to the provisions in section 13.46.

Sec. 4. Minnesota Statutes 2004, section 256J.53, subdivision 2, is amended to read:

Subd. 2. [APPROVAL OF POSTSECONDARY EDUCATION OR TRAINING.] (a) In order for a postsecondary education or training program to be an approved activity in an employment plan, the participant must be working in unsubsidized employment

at least ~~20~~ ten hours per week.

(b) Participants seeking approval of a postsecondary education or training plan must provide documentation that:

(1) the employment goal can only be met with the additional education or training;

(2) there are suitable employment opportunities that require the specific education or training in the area in which the participant resides or is willing to reside;

(3) the education or training will result in significantly higher wages for the participant than the participant could earn without the education or training;

(4) the participant can meet the requirements for admission into the program; and

(5) there is a reasonable expectation that the participant will complete the training program based on such factors as the participant's MFIP assessment, previous education, training, and work history; current motivation; and changes in previous circumstances.

(c) The hourly unsubsidized employment requirement does not apply for intensive education or training programs lasting ~~12~~ 20 weeks or less when full-time attendance is required.

(d) Participants with an approved employment plan in place on July 1, 2003, which includes more than 12 months of postsecondary education or training shall be allowed to complete that plan provided that hourly requirements in section 256J.55, subdivision 1, and conditions specified in paragraph (b), and subdivisions 3 and 5 are met. A participant whose case is subsequently closed for three months or less for reasons other than noncompliance with program requirements and who returns to MFIP shall be allowed to complete that plan provided that hourly requirements in section 256J.55, subdivision 1, and conditions specified in paragraph (b) and subdivisions 3 and 5 are met.

Sec. 5. [256J.575] [WORK PARTICIPATION RATE ENHANCEMENT PROGRAM.]

Subdivision 1. [PURPOSE.] (a) The work participation rate enhancement program (WORK PREP) is Minnesota's TANF program to

serve families who are not making significant progress within MFIP due to a variety of barriers to employment.

(b) The goal of this program is to stabilize and improve the lives of families at risk of long-term welfare dependency or family instability due to employment barriers such as physical disability, mental disability, age, and caring for a disabled household member. WORK PREP provides services to promote and support families to achieve the greatest possible degree of self-sufficiency.

Subd. 2. [DEFINITIONS.] The terms used in this section have the meanings given them in paragraphs (a) to (e).

(a) The "work participation rate enhancement program" means the program established under this section.

(b) "Barrier" means:

(1) any physical, emotional, or mental condition;

(2) any lack of educational, vocational, or other skill or ability;

(3) limited English proficiency;

(4) criminal records;

(5) alcohol or chemical dependency;

(6) a lack of transportation, child care, housing, medical assistance, or other services or resources;

(7) domestic violence circumstances;

(8) caregiver responsibilities; or

(9) other conditions or circumstances impacting the participant or participant's household members that prevent the participant from engaging in employment or other work activity.

(c) "Case management" means the services provided by or through the county agency to participating families, including assessment, information, referrals, and assistance in the preparation and implementation of a family stabilization plan under subdivision 5.

(d) "Family stabilization plan" means a plan developed by a case manager and the participant, which identifies the participant's most appropriate path to unsubsidized employment, family stability, and barrier reduction, taking into account the

family's circumstances.

(e) "Family stabilization services" means programs, activities, and services in this section that provide participants and their family members with assistance regarding, but not limited to:

(1) obtaining and retaining employment;

(2) job-seeking skills;

(3) job coach;

(4) family budgeting;

(5) nutrition;

(6) self-esteem;

(7) substance abuse;

(8) health and hygiene;

(9) child rearing;

(10) child education preparation; and

(11) goal setting with the goal of achieving the greatest degree of economic self-sufficiency and family well-being possible for the family under the circumstances.

Subd. 3. [ELIGIBILITY.] (a) The following MFIP or DWP participants are eligible for the program under this section:

(1) a participant who is 60 years of age or older;

(2) a caregiver under the age of 20;

(3) a participant with an employment plan developed under section 256J.521, subdivision 2, paragraph (c) or (d); or 3;

(4) a participant who has been diagnosed by a qualified professional as suffering from an illness or incapacity that is expected to last for 30 days or more, including a pregnant participant who is determined to be unable to obtain or retain employment due to the pregnancy;

(5) a participant who is determined by a qualified professional as being needed in the home to care for an ill or incapacitated family member;

(6) a participant who meets the requirements for or has been granted a hardship extension under section 256J.425, subdivision 2 or 3;

(7) a participant who is unable to work more than 24 hours

a week due to, but not limited to, any of the following:

(i) medical, family, or other personal circumstances, including mental or physical health problems;

(ii) domestic violence;

(iii) substance abuse;

(iv) severe vocational barriers, including, but not limited to, lack of proficiency in English, lack of a high school diploma, lack of past work experience, long-term unemployment, or a felony record;

(v) learning disabilities;

(vi) a lack of education;

(vii) homelessness; or

(viii) children's health or behavioral problems;

(8) a participant who is applying for supplemental security income or Social Security disability insurance; and

(9) a participant who is not making progress in MFIP or DWP as determined by the county agency or job counselor as part of the assessment or comprehensive review under section 256J.521, subdivision 1.

(b) Families must meet all other eligibility requirements for MFIP established in this chapter. Families are eligible for financial assistance to the same extent as if they were participating in MFIP.

(c) Section 256J.24, subdivision 6, does not apply to participants in this program.

Subd. 4. [UNIVERSAL PARTICIPATION.] All caregivers must participate in family stabilization services as defined in subdivision 2.

Subd. 5. [CASE MANAGEMENT; FAMILY STABILIZATION PLANS; COORDINATED SERVICES.] (a) The county agency shall provide all required and appropriate services to families through a case management model. A case manager shall be assigned to each participating family as soon as the family begins to receive financial assistance. The case manager, with the full involvement of the family, shall recommend, and the county agency shall establish and modify as necessary, a family

stabilization plan for each participating family.

(b) The family stabilization plan shall include:

(1) each participant's plan for long-term self-sufficiency, including an employment goal where applicable;

(2) an assessment of each participant's strengths and barriers, and any special circumstances of the participant's family that impact, or are likely to impact, the participant's progress towards the goals in the plan; and

(3) an identification of the services, supports, education, training, and accommodations needed to overcome any barriers to enable the family to achieve self-sufficiency and to fulfill each caregiver's personal and family responsibilities.

(c) The case manager and the participant must meet within 30 days of the family's referral to WORK PREP. The initial family stabilization plan shall be completed within 30 days of the first meeting with the case manager. The case manager shall establish a schedule for periodic review of the family stabilization plan that includes personal contact with the participant at least once per month. In addition, the case manager shall review and modify if necessary the plan under the following circumstances:

(1) there is a lack of satisfactory progress in achieving the goals of the plan;

(2) the participant has lost unsubsidized or subsidized employment;

(3) a family member has failed to comply with a family stabilization plan requirement or a work requirement;

(4) services required by the plan are unavailable;

(5) within 15 days of the date the participant started an unsubsidized or subsidized job; or

(6) changes to the plan are needed to promote the well-being of the children.

(d) The county agency shall establish, consistent with research on best practices, maximum caseloads for case managers.

(e) Family stabilization plans under this section shall be written for a period of time not to exceed six months.

Subd. 6. [COOPERATION WITH PROGRAM REQUIREMENTS.] (a) To be eligible, a participant must comply with paragraphs (b) to (h).

(b) Each participating adult shall begin to comply with family stabilization plan requirements as soon as possible, and no later than ten days following identification of initial requirements at the initial family stabilization plan meeting. Each participating adult shall continue to comply with the family stabilization plan requirements until the participant is able to comply with the employment plan requirements provided for MFIP participants under section 256J.521, subdivision 2 or 3, or until the participant is determined to be ineligible for or is no longer receiving financial assistance.

(c) Participants shall engage in family stabilization plan activities for the number of hours per week that the activities are scheduled and available, unless good cause exists for not doing so, as defined in section 256J.57, subdivision 1.

(d) The case manager shall review the participant's progress toward the goals in the family stabilization plan every three months to determine whether conditions have changed, including whether revisions to the plan are needed.

(e) When the participant has increased participation in work-related activities sufficient to meet the federal participation requirements of TANF, the county agency shall refer the participant to the MFIP program and assign the participant to a job counselor. The participant and the job counselor must meet within 15 days of referral to MFIP to develop an employment plan under section 256J.521. No reapplication is necessary and financial assistance shall continue without interruption.

(f) Participants who have not increased their participation in work activities sufficient to meet the federal participation requirements of TANF may request a referral to the MFIP program and assignment to a job counselor after 12 months in the program.

(g) Participants who are referred to MFIP under paragraph (e) or (f) may not be sanctioned for noncompliance with the MFIP

program requirements until they have first been offered the opportunity to be referred back to the program.

(h) A participant's requirement to comply with any or all family stabilization plan requirements under this subdivision shall be excused when the case management services, training and educational services, and family support services identified in the participant's family stabilization plan are unavailable for reasons beyond the control of the participant, including when money appropriated is not sufficient to provide the services.

Subd. 7. [SANCTIONS.] (a) The financial assistance grant of a participating family shall be reduced, according to section 256J.46, if a participating adult fails without good cause to comply or continue to comply with the family stabilization plan requirements in this subdivision, unless compliance has been excused under subdivision 6, paragraph (h).

(b) Given the purpose of the work participation rate enhancement program in this section, the nature of the underlying family circumstances that act as barriers to both employment and full compliance with program requirements, and the serious nature of sanctions and their negative effect on families, especially children, sanctions must be used only as a last resort. Sanctions are appropriate only when it is clear that there is both ability to comply and willful noncompliance on the part of the participant and after the case manager specifically determines that good cause does not exist that would excuse the noncompliance.

(c) Section 256J.57 applies to this section except to the extent that it is modified by this subdivision.

(d) Prior to the reduction in a family's financial assistance resulting from a sanction imposed under this subdivision, the county agency shall provide an independent review of the participant's circumstances and the basis for the participant's noncompliance.

Sec. 6. [256J.621] [WORK PARTICIPATION BONUS.]

Upon exiting the diversionary work program (DWP) or upon terminating MFIP cash assistance with earnings, a participant

may be eligible for a work participation bonus of $75 per month to assist the household in meeting work-related and household expenses as the family continues to move to economic self-sufficiency. A participant is eligible for the work participation bonus if:

(1) the participant is employed and working at least 24 hours a week when the MFIP case is closed;

(2) the participant sustains this level of employment for nine of the next 12 months; and

(3) the participant does not apply for assistance from DWP or MFIP during this period.

The work participation bonus is available for a maximum of 12 months upon exiting DWP or MFIP. The commissioner shall establish policies and forms for verifying the level of employment necessary to qualify for the work participation bonus.

Sec. 7. Minnesota Statutes 2004, section 256J.626, subdivision 1, is amended to read:

Subdivision 1. [CONSOLIDATED FUND.] The consolidated fund is established to support counties and tribes in meeting their duties under this chapter. Counties and tribes must use funds from the consolidated fund to develop programs and services that are designed to improve participant outcomes as measured in section 256J.751, subdivision 2, and to provide case management services to participants of the work participation rate enhancement program. Counties may use the funds for any allowable expenditures under subdivision 2. Tribes may use the funds for any allowable expenditures under subdivision 2, except those in clauses (1) and (6).

Sec. 8. Minnesota Statutes 2004, section 256J.626, subdivision 2, is amended to read:

Subd. 2. [ALLOWABLE EXPENDITURES.] (a) The commissioner must restrict expenditures under the consolidated fund to benefits and services allowed under title IV-A of the federal Social Security Act. Allowable expenditures under the consolidated fund may include, but are not limited to:

(1) short-term, nonrecurring shelter and utility needs that

are excluded from the definition of assistance under Code of Federal Regulations, title 45, section 260.31, for families who meet the residency requirement in section 256J.12, subdivisions 1 and 1a. Payments under this subdivision are not considered TANF cash assistance and are not counted towards the 60-month time limit;

(2) transportation needed to obtain or retain employment or to participate in other approved work activities or activities under a family stabilization plan;

(3) direct and administrative costs of staff to deliver employment services for MFIP ~~or~~, the diversionary work program, or the work participation rate enhancement program; to administer financial assistance~~,~~; and to provide specialized services intended to assist hard-to-employ participants to transition to work or transition from the work participation rate enhancement program to MFIP;

(4) costs of education and training including functional work literacy and English as a second language;

(5) cost of work supports including tools, clothing, boots, and other work-related expenses;

(6) county administrative expenses as defined in Code of Federal Regulations, title 45, section 260(b);

(7) services to parenting and pregnant teens;

(8) supported work;

(9) wage subsidies;

(10) child care needed for MFIP ~~or~~, the diversionary work program, or the work participation rate enhancement program participants to participate in social services;

(11) child care to ensure that families leaving MFIP or diversionary work program will continue to receive child care assistance from the time the family no longer qualifies for transition year child care until an opening occurs under the basic sliding fee child care program; ~~and~~

(12) services to help noncustodial parents who live in Minnesota and have minor children receiving MFIP or DWP assistance, but do not live in the same household as the child,

obtain or retain employment; and

(13) services to help families participating in the work participation rate enhancement program achieve the greatest possible degree of economic and emotional self-sufficiency.

(b) Administrative costs that are not matched with county funds as provided in subdivision 8 may not exceed 7.5 percent of a county's or 15 percent of a tribe's allocation under this section. The commissioner shall define administrative costs for purposes of this subdivision.

Sec. 9. Minnesota Statutes 2004, section 256J.626, subdivision 3, is amended to read:

Subd. 3. [ELIGIBILITY FOR SERVICES.] Families with a minor child, a pregnant woman, or a noncustodial parent of a minor child receiving assistance, with incomes below 200 percent of the federal poverty guideline for a family of the applicable size, are eligible for services funded under the consolidated fund. Counties and tribes must give priority to families currently receiving MFIP ~~or~~, the diversionary work program, or the work participation rate enhancement program, and families at risk of receiving MFIP or diversionary work program.

Sec. 10. Minnesota Statutes 2004, section 256J.626, subdivision 4, is amended to read:

Subd. 4. [COUNTY AND TRIBAL BIENNIAL SERVICE AGREEMENTS.] (a) Effective January 1, 2004, and each two-year period thereafter, each county and tribe must have in place an approved biennial service agreement related to the services and programs in this chapter. In counties with a city of the first class with a population over 300,000, the county must consider a service agreement that includes a jointly developed plan for the delivery of employment services with the city. Counties may collaborate to develop multicounty, multitribal, or regional service agreements.

(b) The service agreements will be completed in a form prescribed by the commissioner. The agreement must include:

(1) a statement of the needs of the service population and strengths and resources in the community;

(2) numerical goals for participant outcomes measures to be accomplished during the biennial period. The commissioner may identify outcomes from section 256J.751, subdivision 2, as core outcomes for all counties and tribes;

(3) strategies the county or tribe will pursue to achieve the outcome targets. Strategies must include specification of how funds under this section will be used and may include community partnerships that will be established or strengthened; ~~and~~

(4) strategies the county or tribe will pursue under the work participation rate enhancement program; and

(5) other items prescribed by the commissioner in consultation with counties and tribes.

(c) The commissioner shall provide each county and tribe with information needed to complete an agreement, including: (1) information on MFIP cases in the county or tribe; (2) comparisons with the rest of the state; (3) baseline performance on outcome measures; and (4) promising program practices.

(d) The service agreement must be submitted to the commissioner by October 15, 2003, and October 15 of each second year thereafter. The county or tribe must allow a period of not less than 30 days prior to the submission of the agreement to solicit comments from the public on the contents of the agreement.

(e) The commissioner must, within 60 days of receiving each county or tribal service agreement, inform the county or tribe if the service agreement is approved. If the service agreement is not approved, the commissioner must inform the county or tribe of any revisions needed prior to approval.

(f) The service agreement in this subdivision supersedes the plan requirements of section 116L.88.

Sec. 11. Minnesota Statutes 2004, section 256J.626, subdivision 7, is amended to read:

Subd. 7. [PERFORMANCE BASE FUNDS.] (a) Beginning calendar year 2005, each county and tribe will be allocated ~~95~~ 100 percent of their initial calendar year allocation. Counties and

tribe that performs within its range of expected performance on the three-year self-support index under section 256J.751, subdivision 2, clause (7), in both measurements in the preceding year, or above the top of its range of expected performance in one measurement and within its expected range of performance in the other measurement, will receive an additional allocation equal to 2.5 percent of its initial allocation.

(b) Funds remaining unallocated after the performance-based allocations in paragraph (a) are available to the commissioner for innovation projects under subdivision 5.

(c)(1) If available funds are insufficient to meet county and tribal allocations under paragraph (a), the commissioner may make available for allocation funds that are unobligated and available from the innovation projects through the end of the current biennium.

(2) If after the application of clause (1) funds remain insufficient to meet county and tribal allocations under paragraph (a), the commissioner must proportionally reduce the allocation of each county and tribe with respect to their maximum allocation available under paragraph (a).

Senator ..... moves to amend S.F. No. .... as follows:

Delete everything after the enacting clause and insert:

"Section 1. Minnesota Statutes 2004, section 119B.011, is amended by adding a subdivision to read:

Subd. 23. [WORK PARTICIPATION RATE ENHANCEMENT PROGRAM.] "Work participation rate enhancement program" means the program established under section 256J.575.

Sec. 2. Minnesota Statutes 2004, section 119B.05, subdivision 1, is amended to read:

Subdivision 1. [ELIGIBLE PARTICIPANTS.] Families eligible for child care assistance under the MFIP child care program are:

(1) MFIP participants who are employed or in job search and meet the requirements of section 119B.10;

(2) persons who are members of transition year families under section 119B.011, subdivision 20, and meet the requirements of section 119B.10;

(3) families who are participating in employment orientation or job search, or other employment or training activities that are included in an approved employability development plan under section 256J.95;

(4) MFIP families who are participating in work job search, job support, employment, or training activities as required in their employment plan, or in appeals, hearings, assessments, or orientations according to chapter 256J;

(5) MFIP families who are participating in social services activities under chapter 256J as required in their employment plan approved according to chapter 256J;

(6) families who are participating in services or activities that are included in an approved family stabilization plan under section 256J.575;

(7) families who are participating in programs as required in tribal contracts under section 119B.02, subdivision 2, or 256.01, subdivision 2; and

~~(7)~~ (8) families who are participating in the transition year extension under section 119B.011, subdivision 20a.

Sec. 3. Minnesota Statutes 2004, section 256J.021, is

amended to read:

256J.021 [SEPARATE STATE ~~PROGRAM~~ PROGRAMS FOR USE OF STATE MONEY.]

(a) Beginning October 1, 2001, and each year thereafter, the commissioner of human services must treat MFIP expenditures made to or on behalf of any minor child under section 256J.02, subdivision 2, clause (1), who is a resident of this state under section 256J.12, and who is part of a two-parent eligible household as expenditures under a separately funded state program and report those expenditures to the federal Department of Health and Human Services as separate state program expenditures under Code of Federal Regulations, title 45, section 263.5.

(b) Beginning October 1, 2005, and each year thereafter, the commissioner of human services must treat MFIP expenditures made to or on behalf of any minor child under section 256J.02, subdivision 2, clause (1), who is a resident of this state under section 256J.12, and who is part of a household participating in the work participation rate enhancement program under section 256J.575 as expenditures under a separately funded state program and report those expenditures to the federal Department of Health and Human Services as separate state program expenditures under Code of Federal Regulations, title 45, section 263.5.

Sec. 4. Minnesota Statutes 2004, section 256J.08, subdivision 65, is amended to read:

Subd. 65. [PARTICIPANT.] "Participant" means a person who is currently receiving cash assistance or the food portion available through MFIP. A person who fails to withdraw or access electronically any portion of the person's cash and food assistance payment by the end of the payment month, who makes a written request for closure before the first of a payment month and repays cash and food assistance electronically issued for that payment month within that payment month, or who returns any uncashed assistance check and food coupons and withdraws from the program is not a participant. A person who withdraws a cash or food assistance payment by electronic transfer or receives

and cashes an MFIP assistance check or food coupons and is subsequently determined to be ineligible for assistance for that period of time is a participant, regardless whether that assistance is repaid. The term "participant" includes the caregiver relative and the minor child whose needs are included in the assistance payment. A person in an assistance unit who does not receive a cash and food assistance payment because the case has been suspended from MFIP is a participant. A person who receives cash payments under the diversionary work program under section 256J.95 is a participant. A person who receives cash payments under the work participation rate enhancement program under section 256J.575 is a participant.

Sec. 5. Minnesota Statutes 2004, section 256J.521, subdivision 1, is amended to read:

Subdivision 1. [ASSESSMENTS.] (a) For purposes of MFIP employment services, assessment is a continuing process of gathering information related to employability for the purpose of identifying both participant's strengths and strategies for coping with issues that interfere with employment. The job counselor must use information from the assessment process to develop and update the employment plan under subdivision 2 or 3, as appropriate, ~~and~~ to determine whether the participant qualifies for a family violence waiver including an employment plan under subdivision 3, and to determine whether the participant should be referred to the work participation rate enhancement program under section 256J.575.

(b) The scope of assessment must cover at least the following areas:

(1) basic information about the participant's ability to obtain and retain employment, including: a review of the participant's education level; interests, skills, and abilities; prior employment or work experience; transferable work skills; child care and transportation needs;

(2) identification of personal and family circumstances that impact the participant's ability to obtain and retain employment, including: any special needs of the children, the

level of English proficiency, family violence issues, and any involvement with social services or the legal system;

(3) the results of a mental and chemical health screening tool designed by the commissioner and results of the brief screening tool for special learning needs. Screening tools for mental and chemical health and special learning needs must be approved by the commissioner and may only be administered by job counselors or county staff trained in using such screening tools. The commissioner shall work with county agencies to develop protocols for referrals and follow-up actions after screens are administered to participants, including guidance on how employment plans may be modified based upon outcomes of certain screens. Participants must be told of the purpose of the screens and how the information will be used to assist the participant in identifying and overcoming barriers to employment. Screening for mental and chemical health and special learning needs must be completed by participants who are unable to find suitable employment after six weeks of job search under subdivision 2, paragraph (b), and participants who are determined to have barriers to employment under subdivision 2, paragraph (d). Failure to complete the screens will result in sanction under section 256J.46; and

(4) a comprehensive review of participation and progress for participants who have received MFIP assistance and have not worked in unsubsidized employment during the past 12 months. The purpose of the review is to determine the need for additional services and supports, including placement in subsidized employment or unpaid work experience under section 256J.49, subdivision 13, or referral to the work participation rate enhancement program under section 256J.575.

(c) Information gathered during a caregiver's participation in the diversionary work program under section 256J.95 must be incorporated into the assessment process.

(d) The job counselor may require the participant to complete a professional chemical use assessment to be performed according to the rules adopted under section 254A.03,

subdivision 3, including provisions in the administrative rules which recognize the cultural background of the participant, or a professional psychological assessment as a component of the assessment process, when the job counselor has a reasonable belief, based on objective evidence, that a participant's ability to obtain and retain suitable employment is impaired by a medical condition. The job counselor may assist the participant with arranging services, including child care assistance and transportation, necessary to meet needs identified by the assessment. Data gathered as part of a professional assessment must be classified and disclosed according to the provisions in section 13.46.

Sec. 6. [256J.575] [WORK PARTICIPATION RATE ENHANCEMENT PROGRAM.]

Subdivision 1. [PURPOSE.] (a) The work participation rate enhancement program (WORK PREP) is Minnesota's TANF program to serve families who are not making significant progress within MFIP due to a variety of barriers to employment.

(b) The goal of this program is to stabilize and improve the lives of families at risk of long-term welfare dependency or family instability due to employment barriers such as physical disability, mental disability, age, and caring for a disabled household member. WORK PREP provides services to promote and support families to achieve the greatest possible degree of self-sufficiency. Counties may provide supportive and other allowable services funded by the MFIP consolidated fund under section 256J.626 to eligible participants.

Subd. 2. [DEFINITIONS.] The terms used in this section have the meanings given them in paragraphs (a) to (e).

(a) The "work participation rate enhancement program" means the program established under this section.

(b) "Case management" means the services provided by or through the county agency to participating families, including assessment, information, referrals, and assistance in the preparation and implementation of a family stabilization plan under subdivision 5.

(c) "Family stabilization plan" means a plan developed by a case manager and the participant, which identifies the participant's most appropriate path to unsubsidized employment, family stability, and barrier reduction, taking into account the family's circumstances.

(d) "Family stabilization services" means programs, activities, and services in this section that provide participants and their family members with assistance regarding, but not limited to:

(1) obtaining and retaining unsubsidized employment;

(2) family stability;

(3) economic stability; and

(4) barrier reduction.

The goal of the program is to achieve the greatest degree of economic self-sufficiency and family well-being possible for the family under the circumstances.

Subd. 3. [ELIGIBILITY.] (a) The following MFIP or DWP participants are eligible for the program under this section:

(1) a participant identified under section 256J.561, subdivision 2, paragraph (d), who has or is eligible for an employment plan developed under section 256J.521, subdivision 2, paragraph (c);

(2) a participant identified under section 256J.95, subdivision 12, paragraph (b), as unlikely to benefit from the diversionary work program;

(3) a participant who meets the requirements for or has been granted a hardship extension under section 256J.425, subdivision 2 or 3; and

(4) a participant who is applying for supplemental security income or Social Security disability insurance.

(b) Families must meet all other eligibility requirements for MFIP established in this chapter. Families are eligible for financial assistance to the same extent as if they were participating in MFIP.

Subd. 4. [UNIVERSAL PARTICIPATION.] All caregivers must participate in family stabilization services as defined in

subdivision 2.

Subd. 5. [CASE MANAGEMENT; FAMILY STABILIZATION PLANS; COORDINATED SERVICES.] (a) The county agency shall provide family stabilization services to families through a case management model. A case manager shall be assigned to each participating family within 30 days after the family begins to receive financial assistance as a participant of the work participation rate enhancement program. The case manager, with the full involvement of the family, shall recommend, and the county agency shall establish and modify as necessary, a family stabilization plan for each participating family.

(b) The family stabilization plan shall include:

(1) each participant's plan for long-term self-sufficiency, including an employment goal where applicable;

(2) an assessment of each participant's strengths and barriers, and any special circumstances of the participant's family that impact, or are likely to impact, the participant's progress towards the goals in the plan; and

(3) an identification of the services, supports, education, training, and accommodations needed to overcome any barriers to enable the family to achieve self-sufficiency and to fulfill each caregiver's personal and family responsibilities.

(c) The case manager and the participant must meet within 30 days of the family's referral to the case manager. The initial family stabilization plan shall be completed within 30 days of the first meeting with the case manager. The case manager shall establish a schedule for periodic review of the family stabilization plan that includes personal contact with the participant at least once per month. In addition, the case manager shall review and modify if necessary the plan under the following circumstances:

(1) there is a lack of satisfactory progress in achieving the goals of the plan;

(2) the participant has lost unsubsidized or subsidized employment;

(3) a family member has failed to comply with a family

stabilization plan requirement;

(4) services required by the plan are unavailable; or

(5) changes to the plan are needed to promote the well-being of the children.

(d) Family stabilization plans under this section shall be written for a period of time not to exceed six months.

Subd. 6. [COOPERATION WITH PROGRAM REQUIREMENTS.] (a) To be eligible, a participant must comply with paragraphs (b) to (f).

(b) Participants shall engage in family stabilization plan activities listed in clause (1) or (2) for the number of hours per week that the activities are scheduled and available, unless good cause exists for not doing so, as defined in section 256J.57, subdivision 1:

(1) in single-parent families with no children under six years of age, the case manager and the participant must develop a family stabilization plan that includes 30 to 35 hours per week of activities; and

(2) in single-parent families with a child under six years of age, the case manager and the participant must develop a family stabilization plan that includes 20 to 35 hours per week of activities.

(c) The case manager shall review the participant's progress toward the goals in the family stabilization plan every six months to determine whether conditions have changed, including whether revisions to the plan are needed.

(d) When the participant has increased participation in work-related activities sufficient to meet the federal participation requirements of TANF, the county agency shall refer the participant to the MFIP program and assign the participant to a job counselor. The participant and the job counselor must meet within 15 days of referral to MFIP to develop an employment plan under section 256J.521. No reapplication is necessary and financial assistance shall continue without interruption.

(e) Participants who have not increased their participation

in work activities sufficient to meet the federal participation requirements of TANF may request a referral to the MFIP program and assignment to a job counselor after 12 months in the program.

(f) A participant's requirement to comply with any or all family stabilization plan requirements under this subdivision shall be excused when the case management services, training and educational services, and family support services identified in the participant's family stabilization plan are unavailable for reasons beyond the control of the participant, including when money appropriated is not sufficient to provide the services.

Subd. 7. [SANCTIONS.] (a) The financial assistance grant of a participating family shall be reduced, according to section 256J.46, if a participating adult fails without good cause to comply or continue to comply with the family stabilization plan requirements in this subdivision, unless compliance has been excused under subdivision 6, paragraph (h).

(b) Given the purpose of the work participation rate enhancement program in this section and the nature of the underlying family circumstances that act as barriers to both employment full compliance with program requirements. Sanctions are appropriate only when it is clear that there is both ability to comply and willful noncompliance on the part of the participant.

(c) Prior to the imposition of a sanction, the county agency must review the participant's case to determine if the family stabilization plan is still appropriate and meet with the participants face-to-face. The participant may bring an advocate to the face-to-face meeting. If a face-to-face meeting is not conducted, the county agency must send the participant a written notice that includes the information required under clause (1):

(1) during the face-to-face meeting, the county agency must:

(i) determine whether the continued noncompliance can be explained and mitigated by providing a needed family stabilization service, as defined in section 256J.575, subdivision 2, paragraph (e);

(ii) determine whether the participant qualifies for a good cause exception under section 256J.57, or if the sanction is for noncooperation with child support requirements, determine if the participant qualifies for a good cause exemption under section 256.741, subdivision 10;

(iii) determine whether activities in the family stabilization plan are appropriate based on the family's circumstances;

(iv) explain the consequences of continuing noncompliance;

(v) identify other resources that may be available to the participant to meet the needs of the family; and

(vi) inform the participant of the right to appeal under section 256J.40; and

(2) if the lack of an identified activity or service can explain the noncompliance, the county must work with the participant to provide the identified activity.

(d) After the requirements of paragraph (c) are met and prior to imposition of a sanction, the county agency shall provide a notice of intent to sanction under section 256J.57, subdivision 2, and, when applicable, a notice of adverse action as provided in section 256J.31.

(e) Section 256J.57 applies to this section except to the extent that it is modified by this subdivision.

Sec. 7. [256J.621] [WORK PARTICIPATION BONUS.]

Upon exiting the diversionary work program (DWP) or upon terminating MFIP cash assistance with earnings, a participant shall be eligible for a work participation bonus of $75 per month to assist the household in meeting work-related expenses, including child care, transportation, and clothing, as the participant continues to move toward self-sufficiency. A participant is eligible for the work participation bonus if the participant is employed and working at least 24 hours a week when the MFIP case is closed. The participant will receive the work participation bonus in any month that the participant is employed an average of 24 hours per week, for a maximum of 12 months upon exiting DWP or MFIP. The commissioner shall

establish policies and forms for verifying the level of employment necessary to qualify for the work participation bonus.

Sec. 8. Minnesota Statutes 2004, section 256J.626, subdivision 1, is amended to read:

Subdivision 1. [CONSOLIDATED FUND.] The consolidated fund is established to support counties and tribes in meeting their duties under this chapter. Counties and tribes must use funds from the consolidated fund to develop programs and services that are designed to improve participant outcomes as measured in section 256J.751, subdivision 2, and to provide case management services to participants of the work participation rate enhancement program. Counties may use the funds for any allowable expenditures under subdivision 2. Tribes may use the funds for any allowable expenditures under subdivision 2, except those in clauses (1) and (6).

Sec. 9. Minnesota Statutes 2004, section 256J.626, subdivision 2, is amended to read:

Subd. 2. [ALLOWABLE EXPENDITURES.] (a) The commissioner must restrict expenditures under the consolidated fund to benefits and services allowed under title IV-A of the federal Social Security Act. Allowable expenditures under the consolidated fund may include, but are not limited to:

(1) short-term, nonrecurring shelter and utility needs that are excluded from the definition of assistance under Code of Federal Regulations, title 45, section 260.31, for families who meet the residency requirement in section 256J.12, subdivisions 1 and 1a. Payments under this subdivision are not considered TANF cash assistance and are not counted towards the 60-month time limit;

(2) transportation needed to obtain or retain employment or to participate in other approved work activities or activities under a family stabilization plan;

(3) direct and administrative costs of staff to deliver employment services for MFIP ~~or~~, the diversionary work program, or the work participation rate enhancement program; to administer financial assistance~~,~~; and to provide specialized

services intended to assist hard-to-employ participants to transition to work or transition from the work participation rate enhancement program to MFIP;

(4) costs of education and training including functional work literacy and English as a second language;

(5) cost of work supports including tools, clothing, boots, and other work-related expenses;

(6) county administrative expenses as defined in Code of Federal Regulations, title 45, section 260(b);

(7) services to parenting and pregnant teens;

(8) supported work;

(9) wage subsidies;

(10) child care needed for MFIP ~~or~~, the diversionary work program, or the work participation rate enhancement program participants to participate in social services;

(11) child care to ensure that families leaving MFIP or diversionary work program will continue to receive child care assistance from the time the family no longer qualifies for transition year child care until an opening occurs under the basic sliding fee child care program; ~~and~~

(12) services to help noncustodial parents who live in Minnesota and have minor children receiving MFIP or DWP assistance, but do not live in the same household as the child, obtain or retain employment; and

(13) services to help families participating in the work participation rate enhancement program achieve the greatest possible degree of self-sufficiency.

(b) Administrative costs that are not matched with county funds as provided in subdivision 8 may not exceed 7.5 percent of a county's or 15 percent of a tribe's allocation under this section. The commissioner shall define administrative costs for purposes of this subdivision.

Sec. 10. Minnesota Statutes 2004, section 256J.626, subdivision 3, is amended to read:

Subd. 3. [ELIGIBILITY FOR SERVICES.] Families with a minor child, a pregnant woman, or a noncustodial parent of a minor

child receiving assistance, with incomes below 200 percent of the federal poverty guideline for a family of the applicable size, are eligible for services funded under the consolidated fund. Counties and tribes must give priority to families currently receiving MFIP ~~or~~, the diversionary work program, or the work participation rate enhancement program, and families at risk of receiving MFIP or diversionary work program.

Sec. 11. Minnesota Statutes 2004, section 256J.626, subdivision 4, is amended to read:

Subd. 4. [COUNTY AND TRIBAL BIENNIAL SERVICE AGREEMENTS.] (a) Effective January 1, 2004, and each two-year period thereafter, each county and tribe must have in place an approved biennial service agreement related to the services and programs in this chapter. In counties with a city of the first class with a population over 300,000, the county must consider a service agreement that includes a jointly developed plan for the delivery of employment services with the city. Counties may collaborate to develop multicounty, multitribal, or regional service agreements.

(b) The service agreements will be completed in a form prescribed by the commissioner. The agreement must include:

(1) a statement of the needs of the service population and strengths and resources in the community;

(2) numerical goals for participant outcomes measures to be accomplished during the biennial period. The commissioner may identify outcomes from section 256J.751, subdivision 2, as core outcomes for all counties and tribes;

(3) strategies the county or tribe will pursue to achieve the outcome targets. Strategies must include specification of how funds under this section will be used and may include community partnerships that will be established or strengthened; ~~and~~

(4) strategies the county or tribe will pursue under the work participation rate enhancement program; and

(5) other items prescribed by the commissioner in consultation with counties and tribes.

(c) The commissioner shall provide each county and tribe with information needed to complete an agreement, including: (1) information on MFIP cases in the county or tribe; (2) comparisons with the rest of the state; (3) baseline performance on outcome measures; and (4) promising program practices.

(d) The service agreement must be submitted to the commissioner by October 15, 2003, and October 15 of each second year thereafter. The county or tribe must allow a period of not less than 30 days prior to the submission of the agreement to solicit comments from the public on the contents of the agreement.

(e) The commissioner must, within 60 days of receiving each county or tribal service agreement, inform the county or tribe if the service agreement is approved. If the service agreement is not approved, the commissioner must inform the county or tribe of any revisions needed prior to approval.

(f) The service agreement in this subdivision supersedes the plan requirements of section 116L.88.

Sec. 12. Minnesota Statutes 2004, section 256J.626, subdivision 7, is amended to read:

Subd. 7. [PERFORMANCE BASE FUNDS.] (a) Beginning calendar year 2005, each county and tribe will be allocated ~~95~~ 100 percent of their initial calendar year allocation. Counties and tribes will be allocated additional funds from federal TANF bonus funds the state receives based on performance as follows:

(1) for calendar year 2005, a county or tribe that achieves a 30 percent rate or higher on the MFIP participation rate under section 256J.751, subdivision 2, clause (8), as averaged across the four quarterly measurements for the most recent year for which the measurements are available, will receive an additional allocation ~~equal to 2.5 percent of its initial allocation~~ to be determined by the commissioner based upon available funds; and

(2) for calendar year 2006, a county or tribe that achieves a 40 percent rate or a five percentage point improvement over the previous year's MFIP participation rate under section 256J.751, subdivision 2, clause (8), as averaged across the four

quarterly measurements for the most recent year for which the measurements are available, will receive an additional allocation ~~equal to 2.5 percent of its initial allocation~~ to be determined by the commissioner based upon available funds; and

(3) for calendar year 2007, a county or tribe that achieves a 50 percent rate or a five percentage point improvement over the previous year's MFIP participation rate under section 256J.751, subdivision 2, clause (8), as averaged across the four quarterly measurements for the most recent year for which the measurements are available, will receive an additional allocation ~~equal to 2.5 percent of its initial allocation~~ to be determined by the commissioner based upon available funds; and

(4) for calendar year 2008 and yearly thereafter, a county or tribe that achieves a 50 percent MFIP participation rate under section 256J.751, subdivision 2, clause (8), as averaged across the four quarterly measurements for the most recent year for which the measurements are available, will receive an additional allocation ~~equal to 2.5 percent of its initial allocation~~ to be determined by the commissioner based upon available funds; and

(5) for calendar years 2005 and thereafter, a county or tribe that performs above the top of its range of expected performance on the three-year self-support index under section 256J.751, subdivision 2, clause (7), in both measurements in the preceding year will receive an additional allocation ~~equal to five percent of its initial allocation~~ to be determined by the commissioner based upon available funds; or

(6) for calendar years 2005 and thereafter, a county or tribe that performs within its range of expected performance on the three-year self-support index under section 256J.751, subdivision 2, clause (7), in both measurements in the preceding year, or above the top of its range of expected performance in one measurement and within its expected range of performance in the other measurement, will receive an additional allocation ~~equal to 2.5 percent of its initial allocation~~ to be determined by the commissioner based upon available funds.

(b) Funds remaining unallocated after the performance-based allocations in paragraph (a) are available to the commissioner for innovation projects under subdivision 5.

~~(c) (1) If available funds are insufficient to meet county and tribal allocations under paragraph (a), the commissioner may make available for allocation funds that are unobligated and available from the innovation projects through the end of the current biennium.~~

~~(2) If after the application of clause (1) funds remain insufficient to meet county and tribal allocations under paragraph (a), the commissioner must proportionally reduce the allocation of each county and tribe with respect to their maximum allocation available under paragraph (a).~~"

Delete the title and insert:

"A bill for an act relating to human services; establishing the work participation rate enhancement program; amending Minnesota Statutes 2004, sections 119B.011, by adding a subdivision; 119B.05, subdivision 1; 256J.021; 256J.08, subdivision 65; 256J.521, subdivision 1; 256J.626, subdivisions 1, 2, 3, 4, 7; proposing coding for new law in Minnesota Statutes, chapter 256J."