TITLE 77: PUBLIC HEALTH
CHAPTER X: DEPARTMENT OF HUMAN SERVICES
SUBCHAPTER d: LICENSURE

PART 2060
ALCOHOLISM AND SUBSTANCE ABUSE TREATMENT AND INTERVENTION LICENSES

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AUTHORITY: Implementing and authorized by the Illinois Vehicle Code [625 ILCS 5] and the

Alcoholism and Other Drug Dependency Act [20 ILCS 301].

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SUBPART A: GENERAL REQUIREMENTS

Section 2060.101 Applicability

This Part shall apply to all persons engaged in substance abuse treatment and intervention as defined in Section 301/15-5 of the Illinois Alcoholism and Other Drug Abuse and Dependency Act [20 ILCS 301/15-5] and further defined in this Part.

Section 2060.103 Incorporation by Reference and Definitions

"Act" means the Alcoholism and Other Drug Abuse and Dependency Act [20 ILCS 301].

"Admission" means what occurs after a patient has completed an assessment, received placement into a level of care, and been accepted for and begins such treatment.

"Adolescent" means a person who is at least 12 years of age and under 18 years of age.

"Adult" means a person who is 18 years of age or older.

"Alcohol and Drug Evaluation Report Summary" means the form, developed by the Office of the Secretary of State and required for use by the Illinois courts when granting judicial driving privileges, as defined in Section 6-201 of the Illinois Driver Licensing Law [625 ILCS 5/6-201].

"Alcohol and Drug Evaluation Uniform Report" means the form, mandated by the Department and produced from the DUI Services Reporting System (DSRS), that is required to report a summary of the DUI evaluation to the circuit court or the Office of the Secretary of State.

"Americans with Disabilities Act of 1990 (ADA)", 42 USC 12101, is the federal law requiring that public accommodations offer their services equally to persons

without discrimination based on disabilities. An organization may not deny its services, offer unequal services or separate services, or have policies and procedures that have a discriminatory effect based on a disability, and shall remove barriers where possible and provide alternatives where not possible.

"ASAM Patient Placement Criteria" means the American Society of Addiction Medicine's Patient Placement Criteria for the Treatment of Substance-Related Disorders, Fourth Edition (ASAMPPC-2R), 4601 North Park Avenue, Upper Arcade Suite 101, Chevy Chase MD 20815 (2001, no later amendments or editions included).

"Assessment" means the process of collecting and professionally interpreting data and information from an individual and/or collateral sources, with the individual's permission, about alcohol and other drug use and its consequences as a basis for establishing a diagnosis of a substance use disorder, determining the severity of the disorder and comorbid conditions and identifying the appropriate level and intensity of substance abuse treatment, as well as needs for other services.

"Associate Director" means the Associate Director of the Department of Human Services Office of Alcoholism and Substance Abuse (OASA).

"Authorized Prescriber" means a physician licensed to practice medicine in all its branches pursuant to the Medical Practice Act of 1987 [225 ILCS 60] or a physician under federal authority who issues prescriptions pursuant to 21 CFR 1301.25 (2000).

"Authorized Organization Representative" means the individual in whom authority is vested for the management, control and operation of all services at a facility and for communication with the Department regarding the status of the organization's licenses at that facility.

"CDC Tuberculosis Guidelines" means "Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health Care Facilities", MMWR 1994 (no. RR13).

"Case Management" means the provision, coordination, or arrangement of ancillary services designed to support a specific patient's substance abuse treatment with the goal of improving clinical outcomes.

"Chemical Test" means, in the context of intervention services, a breath, blood or urine test that measures the blood alcohol concentration (BAC) and/or drug concentration.

"Client" means a person who receives intervention services as defined in this Part.

"Clinical Services" means substance abuse assessment, individual or group counseling, and discharge planning. The organization may also determine that other specified activities require the services of a professional staff member.

"Continuing Recovery Plan" means a plan developed with the patient prior to discharge that identifies recommended activities, support groups, referrals and any other necessary follow-up activities that will support and enhance patient progress, to date.

"Continuum of Care" means a structure of interlinked treatment services (either offered by one organization or through linkage agreements with other organizations) that is designed so a patient's changing needs will be met as that individual moves through the treatment and recovery process.

"Controlled Substance" means a drug or substance, or immediate precursor, that is enumerated in the Schedules of Article II of the Illinois Controlled Substances Act [720 ILCS 570] and in the Cannabis Control Act [720 ILCS 550]

"Department" means the Department of Human Services.

"Detoxification" means the process of withdrawing a person from a specific psychoactive substance in a safe and effective manner.

"Discharge" means the point at which the patient's treatment is terminated either by successful completion or by some other action initiated by the patient and/or the organization.

"Drunk and Drugged Driving Prevention Fund" means a special fund in the State Treasury created by Section 50-20 of the Alcoholism and Other Drug Abuse and Dependency Act out of which the Department may provide reimbursement for DUI evaluation and risk education services to indigent DUI offenders pursuant to this Part, and that it may also use to enhance and support its regulatory inspections and investigations.

"DUI" means driving while under the influence of alcohol, other drugs or combination thereof as defined in the Illinois Vehicle Title and Registration Law [625 ILCS 5/Ch. 2-5] or a similar provision of a local ordinance.

"DUI Evaluation" means the services provided to a person relative to a DUI offense in order to determine the nature and extent of the use of alcohol or other drugs as required by the Unified Code of Corrections [730 ILCS 5] and Section 6-

206.1 of the Illinois Driver Licensing Law [625 ILCS 5/6-206.1].

"DUI Service Reporting System (DSRS)" means the computer software that shall be utilized to summarize all evaluation and risk education services statistics semi-annually and to produce the "Alcohol and Drug Evaluation Uniform Report" and other associated forms.

"Early Intervention" means services that are sub-clinical or pre-treatment and are designed to explore and address problems or risk factors that appear to be related to substance use and/or to assist individuals in recognizing the harmful consequences of inappropriate substance abuse.

"Facility" means the building or premises that are used for treatment and intervention services as specified in this Part.

"Good Cause" means conditions that would prevent a reasonable licensee from meeting one or more of the requirements of this Part.

"HIPAA" means the Health Insurance Portability and Accountability Act, 42 USC 1320(d) et seq. and the regulations promulgated thereunder at 45 CFR 160, 162 and 164 (Privacy and Security).

"Incident" means any action by staff or patients that led, or is likely to lead, to adverse effects on patient services.

"Indigent DUI Offender" means anyone who has proven inability to pay the full cost of the DUI evaluation or risk education service as determined through criteria established by the U.S. Department of Health and Human Services and published in the Federal Register and whose costs for such DUI services may be reimbursed from the Drunk and Drugged Driving Prevention Fund, subject to availability of such funds.

"Individual Counseling" means a therapeutic interaction between a patient and professional staff that includes but is not limited to the following: assessment of the patient's needs; development of a treatment plan to meet those identified needs; continual assessment of patient progress toward identified treatment plan goals and objectives; referral, if necessary; and discharge planning.

"Informed Consent" means a legally valid written consent by an individual or legal guardian that authorizes treatment, intervention or other services or the release of information about the individual, and that gives appropriate information to the individual so that he or she can authorize the service or disclosure with understanding of the consequences.

"Intervention" means activities or services that assist persons and their significant others in coping with the immediate problems of substance abuse or dependence and in reducing their substance use. Such services facilitate emotional and social stability and involve referring persons for treatment, as needed.

"Investigational New Drugs" means those substances that require approval by the U.S. Food and Drug Administration for trials with human subjects pursuant to 21 CFR 312 (2002).

"LAAM" means levo-alpha-acetyl-methadol that is a synthetic opioid agonist whose opioid effect is slower in onset and longer in duration (72 hours) than methadone and that is used in opioid maintenance therapy.

"Life Safety Code of 2000" means the National Fire Protection Association's Life Safety Code of 2000, National Fire Protection Association, 1 N. Batterymarch Park, Quincy MA 02269 (2000, no later amendments or editions included).

"Linkage Agreement" means a written agreement with an external organization to supplement existing levels of care and to arrange for other specialty services not directly provided by the organization.

"Methadone" means a synthetic narcotic analgesic drug (4,4-diphenyl-6-dimethylamino-heptanone-3-hydrochloride) that is used in opioid maintenance therapy.

"Mission Statement" means the reason for existence for the organization and/or specific setting or service.

"Opioid Maintenance Therapy (OMT)" means the medical prescription, medical monitoring and dispensing of opioid compounds (such as Methadone and LAAM) as a medical adjunct to substance abuse treatment.

"Off-Site Delivery of Services" means licensable services that are delivered at a location separate from the licensed facility.

"Organization" means any public or private agency, corporation, unit of State or local government or other legal entity acting individually or as a group that seeks licensure or is licensed to operate one or more substance abuse treatment or intervention services.

"Patient" means a person who receives substance abuse treatment services as defined in this Part from an organization licensed under this Part.

"Person" means any individual, firm, group, association, partnership, corporation, trust, government or governmental subdivision or agency.

"Physician" means a person who is licensed to practice medicine in all its branches pursuant to the Medical Practice Act of 1987 [225 ILCS 60].

"Practitioner" means a physician, dentist, podiatrist, veterinarian, scientific investigator, pharmacist, licensed practical nurse, registered nurse, hospital, laboratory, or pharmacy, or other person licensed, registered, or otherwise permitted by the United States pursuant to 21 CFR 1301.21 and this State to distribute or dispense in accordance with Section 312 of the Illinois Controlled Substances Act [720 ILCS 510], conduct research with respect to, administer or use in teaching or chemical analysis, a controlled substance in the course of professional practice or research.

"Professional Staff" means any person who provides clinical services or who delivers intervention services as defined in this Part.

"Protected Health Information" means the health information governed by HIPAA privacy and security requirements set forth in 45 CFR 164.501.

"Psychiatrist" means a physician licensed to practice medicine in all its branches pursuant to the Medical Practice Act of 1987 [225 ILCS 60] and who meets the requirements of the Mental Health and Developmental Disabilities Code [405 ILCS 5].

"Recovery Home" means alcohol and drug free housing authorized by an intervention license issued by the Department, whose rules, peer-led groups, staff activities and/or other structured operations are directed toward maintenance of sobriety for persons in early recovery from substance abuse or who recently have completed substance abuse treatment services or who may still be receiving such treatment services at another licensed facility.

"Relapse" means a process manifested by a progressive pattern of behavior that reactivates the symptoms of a disease or creates debilitating conditions in an individual who has experienced remission from addiction.

"Residential Extended Care" (formerly halfway house) means residential clinical services for adults (17 year olds may be admitted provided that their assessment includes justification based on their behavior and life experience) or adolescents provided by professional staff in a 24 hour structured and supervised treatment environment. This type of service is primarily designed to provide residents with

a safe and stable living environment in order to develop sufficient recovery skills.

"Revocation" means the termination of a treatment or intervention license, or any portion thereof, by the Department.

"Risk" means, in the context of intervention services, the designation (minimal, moderate, significant, or high) assigned to a person who has completed a substance abuse evaluation as a result of a charge for DUI that describes the person's probability of continuing to operate a motor vehicle in an unsafe manner. This assignment is based upon the following factors: the nature and extent of the person's substance use; chemical testing results; prior dispositions for DUI, statutory summary suspensions or reckless driving convictions reduced from a DUI; and any other significant dysfunction resulting from substance abuse or dependence.

"Secretary" means the Secretary of the Department of Human Services or his or her designee.

"Significant Incident" means any occurrence at a licensed facility that requires the services of the coroner and/or that renders the facility inoperable.

"Significant Other" means the spouse, immediate family member, other relative or individual who interacts most frequently with the patient in a variety of settings and who may also receive substance abuse services.

"Substance Abuse or Dependence" means maladaptive patterns of substance use leading to a clinically significant impairment or distress as defined in the American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV), 1400 K Street NW, Washington, DC 20005 (1994, no later amendments or editions included).

"Support Staff" means any staff who do not deliver clinical or intervention services.

"Transfer" means the process that occurs when a patient can no longer receive services at an organization because the appropriate level of care is not available, or the movement of the patient from one level of care to another within an organization's continuum of care.

"Treatment" means a continuum of care provided to persons addicted to or abusing alcohol or other drugs that is designed to identify and change patterns of behavior that are maladaptive, destructive and/or injurious to health; or to restore appropriate levels of physical, psychological, and/or social functioning.

"Treatment Plan" means an individually written plan for a patient that identifies the treatment goals and objectives based upon a clinical assessment of the patient's individual problems, needs, strengths and weaknesses.

"Tuberculosis Services" means counseling the person regarding tuberculosis; testing to determine whether the person has been infected with mycobacteria tuberculosis to determine the appropriate form of treatment; and providing for or referring the infected person for appropriate medical evaluation and treatment.

"U.S. Drug Enforcement Administration rules and regulations pertaining to medical dispensary services" means 21 CFR 1301.71-1301.76, 1304, and 1307.2 (2000).

"Universal Precautions" means the following guidelines published by the U.S. Centers for Disease Control and Prevention:

"Recommendations for Prevention of HIV Transmission in Health Care Settings", MMWR 1987; 36 (2s); and

"Update: Universal Precautions for Prevention of Transmission of Human Immunodeficiency Virus, Hepatitis B Virus, and other Bloodborne Pathogens in Health Care Settings, MMWR 1988; 37 (no. 24).

"Utilization Review" means a quality protective function that attempts to ensure that the patient is receiving an appropriate level of services, in accordance with assessed clinical conditions. Utilization review activities focus primarily in four major areas:

the appropriateness and clinical necessity of admitting a patient to a level of care;

the appropriateness and clinical necessity of continuation of the initiated level of care;

the initiation and completion of timely discharge planning; and

the appropriateness and clinical necessity and timelines of support services.

(Source: Amended at 27 Ill. Reg. 13997, effective August 8, 2003)

SUBPART B: LICENSURE REQUIREMENTS

Section 2060.201 Types of Licenses

Substance abuse treatment and intervention services as specified in Section 2060.101 of this Part shall be licensed by the Department. An organization may apply for an intervention and a treatment license at the same facility and all services authorized by both an intervention and a treatment license shall be authorized by a single license issued to that facility. Consistent with rules herein, services may be provided to adults as well as adolescents. The license certificate for the facility shall specify all levels of care and a designation of adult and or adolescent services. Individuals who are 16 and 17 may be admitted as adults and individuals who are 18, 19 and 20 may be admitted as adolescents provided that the assessment of such individuals includes justification based on the person's behavior and life experience.

a) Treatment

A treatment license issued by the Department may authorize substance abuse services as established in the ASAM Patient Placement Criteria. The level of care and category (adolescent/adult) shall be specified on the license application or, after licensure, on any application to add an additional level of care and/or category (adolescent/adult).

b) Intervention

An intervention license issued by the Department may authorize the following services:

1) DUI Evaluation

Substance abuse evaluation services for persons who are charged with driving under the influence (DUI) offenses pursuant to the Illinois Vehicle Code [625 ILCS 5/11-501] or similar local ordinances that determine the offender's risk to public safety and make a subsequent corresponding recommendation for intervention to the Illinois courts or the Office of the Secretary of State.

2) DUI Risk Education

Substance abuse risk education services for persons who are charged with driving under the influence (DUI) offenses pursuant to the Illinois Vehicle Code [625 ILCS 5/11-501] or similar local ordinances.

3) Designated Program

A program designated by the Department to provide screening, assessment, referral and tracking services pursuant to Article 40 of the Act.

4) Recovery Homes

Alcohol and drug free housing with rules, peer-led groups, staff activities and/or other structured operations which are directed toward maintenance of sobriety for persons in early recovery from substance abuse or persons who have completed substance abuse treatment services or who may still be receiving such treatment at another licensed facility.

Section 2060.203 Off-Site Delivery of Services

a) Licensure shall be facility specific; however, treatment or intervention services may be offered off-site when good cause is established by the organization for an exception to be granted by the Department in accordance with Section 2060.303 of this Part and the criteria outlined in subsection (d) of this Section.

b) The exception process for off-site delivery of services shall not be required for:
   1) patient or client emergency situations;
   2) services delivered in schools, hospitals or facilities or offices owned or operated by the State of Illinois or any local governmental entity, with the exception of Illinois Department of Corrections facilities and city or county operated jails and detention centers;
   3) court ordered service to an individual in jail;
   4) early intervention services; or
   5) case management services.

   However, in such cases, the rationale and location for the provision of the off-site service shall be documented in the patient record and any patient record utilized or stored at the off-site location shall be done so in accordance with the provisions specified in Section 2060.319 of this Part.

c) In order to receive an exception for off-site services the licensed organization shall submit a request to the Department at least 30 calendar days prior to the anticipated provision of such services. The request shall include the following:
   1) the legal name, address and telephone number of the off-site location;
   2) the services that will be provided at the off-site location;
   3) the days of the week and hours when each service will be provided;
   4) the legal name, address, telephone number and license number of the organization that will operate and provide supervision for the services;
   5) the names of professional staff who will provide the services;
   6) the reason for the provision of services at the off-site location; and
   7) the numbers of individuals to be served.

d) In determining whether the provision of off-site service shall be allowed, the Department shall consider, but not be limited to, appropriate factors such as:
   1) the ability to provide the environment required for the level of care;
   2) the gravity of the reason that service at the licensed location is not acceptable (transportation requirements, sickness, etc.);
   3) availability of necessary support functions at the off-site location;
   4) ability to provide professional environment at the off-site location;
   5) physical safety of the patient; and
   6) compliance with applicable State and federal regulations.

e) The Department shall also be notified of any change in the provision of off-site services at least 10 calendar days prior to any change in such services.

f) Failure to report such information to the Department shall result in the unlicensed practice of services at such locations.

(Source: Amended at 25 Ill. Reg. 11063, effective August 14, 2001)

Section 2060.205 Unlicensed Practice

a) Whenever the Department determines that an unlicensed organization or person is engaging in activities that require licensure, pursuant to the specifications in Section 2060.101 of this Part, it shall issue an order to that organization or person to cease and desist from engaging in the activity. The order shall specify the particular services that require licensure, and shall include citation of relevant Sections of the Act and this Part.

b) The Department's order shall be accompanied by a notice that instructs the recipient that written documentation may be submitted to the Department within 10 calendar days to support a claim that licensure is not required, or that the recipient is properly authorized to conduct the services.

c) After the expiration of the 10 day period, if the Department believes that the organization or unlicensed person is continuing to provide services that require licensure, the matter shall be referred to the appropriate State's Attorney or to the Office of the Attorney General for prosecution.

(Source: Amended at 25 Ill. Reg. 11063, effective August 14, 2001)

Section 2060.207 Organization Representative

a) At each facility, one individual shall be designated by the organization as the authority for the management, control, and operation of all services relative to that facility and for communication with the Department regarding the status of the license for that facility. This person shall be known as the organization representative.

b) The Department shall be notified, in writing, within ten calendar days, when there is a new designation of an organization representative.

Section 2060.209 Ownership Disclosure

a) At the time of application for licensure, the names and addresses of all owners or controlling parties of the organization (whether they are individuals, partnerships, corporate bodies, or subdivisions of other bodies, such as public agencies or religious, fraternal, or other charitable organizations) shall be fully disclosed.

b) In the case of corporations, the names and addresses of all officers, directors, and stockholders owning five percent or more of the stock of the corporation, either beneficial or of record, shall be disclosed.

Section 2060.211 License Application Forms

a) An application for a license, an application to renew a license, an application to relocate a facility or an application to add an additional level of care or category (adolescent/adult) shall be made on forms specified by the Department. The organization shall provide any and all information requested on the application forms.

b) Such forms may be obtained in person or by writing to:

Illinois Department of Human Services
Office of Alcoholism and Substance Abuse
100 W. Randolph St., Suite 5-600
Chicago, Illinois 60601
Attention: Division of Licensing and Certification

c) An application for a license shall be signed and dated by the organization representative, and at least two of the corporate officers in the case of a corporate applicant, or by all partners or associates in the case of a partnership or association.

(Source: Amended at 25 Ill. Reg. 11063, effective August 14, 2001)

Section 2060.213 License Application Fees

a) Application fees are due upon application for each facility license. Application fees are not refundable. Payment shall be made by check or money order made payable to the Department of Human Services. Payment shall not be in the form of U.S. currency, foreign currency, or stamps. A separate check or money order shall be submitted with each application.

b) The application fee is $200.00 for each facility license.

c) Relocation of a facility requires submission of a relocation application and payment of the application fee.

d) No application fee shall be required of any unit of local, State, or federal government.

Section 2060.215 Period of Licensure

a) Each license issued by the Department shall be effective for a period of three years.

b) At any time during this licensure cycle, an additional treatment or intervention service may be added at a facility at no extra cost.

Section 2060.217 License Processing/Review Requirements

a) All licensure applications are deemed received by the Department on the postmarked date.

b) The Department shall notify the organization regarding any error or omission found after review of the application. The organization shall submit all requested information within 90 calendar days after the date of the Department's notification. If the organization fails to submit all required information within this 90 day period, the entire application will be returned and the process will be terminated. To re-initiate the process after this 90 day period, the organization shall re-submit the corrected application and another application fee.

c) The Department may verify the data furnished in any application for licensure. Submission of an application carries implied consent to permit inquiry into the data furnished when an examination of submitted information discloses an anomaly or disparity in the information in comparison to that on file with the Department or other data submitted by other organizations, or information about the organization, facility, staff and/or board of directors received by the Department.

d) The Department may, either before or after the issuance of a license, request the cooperation of the State Fire Marshal, county health departments, or local boards of health to make investigations if the Department is unable through its own resources to ascertain compliance with this Part.

e) Prior to issuance or renewal of a license and upon receipt by the Department of evidence to the contrary, the Department may seek to verify that the physical, mental and professional capability and integrity of management, control and/or ownership personnel is sufficient to assure that the applicant can perform anticipated services with reasonable judgement, skill and safety. In determining such capability and integrity the Department may consider, but is not limited to, the following:

1) the accuracy of materials and information maintained and/or submitted in the course of the establishment or operation of the services;

2) prior criminal conduct by personnel;

3) prior violations of this Part or any other Department Rule by the organization or by personnel either as current employees of the organization applying for licensure or as employees of any other organization that has held or holds a license from the Department;

4) competent evidence of emotional, psychological and/or physical impairment which may substantially interfere with the provision of services as licensed; or

5) the timeliness of responses to the Department's reasonable requests for information from such personnel.

f) The Department may investigate the background of staff members, if deemed necessary, to assure that these individuals satisfy applicable professional requirements and/or standards referenced in Sections 2060.309 and 2060.313 of this Part.

Section 2060.219 Renewal Of Licensure

a) The Department shall send a license renewal application to each organization at least 60 calendar days prior to expiration of the license. The organization shall notify the Department if the license renewal application is not received.

b) The Department shall receive the license renewal application at least 30 calendar days prior to expiration of the license in order to guarantee that the renewal process is complete prior to expiration.

Section 2060.221 Change of Ownership/Management

a) Each license issued by the Department shall be valid only for the premises and persons named in the application. Licensure is not transferrable. A license shall become null and void when:
   1) a change in ownership involving more than 25% of the aggregate ownership interest within a one year period or a significant change in management; or
   2) a change of 50% or more in the board of directors of a not-for-profit corporation within a one year period.

b) In order to obtain a new license reflective of the change in ownership the licensee shall submit to the Department:
   1) written notification at least ten calendar days prior to any of the above referenced changes in ownership; and
   2) an application for initial licensure and the license application fee of $200 per license.

c) Failure to notify the Department within ten calendar days relative to the above referenced changes in ownership will result in the imposition of a license fee of $1000 for each affected license.

Section 2060.223 Dissolution of the Corporation

a) A license shall become null, void and of no further effect when there is any dissolution of the corporation. Written notification shall be given to the Department within ten calendar days after such dissolution.

b) A license issued to a corporation which is subsequently dissolved shall not be reactivated upon reinstatement of the corporation and the license is also subject to sanctions provided herein. Such corporation shall reapply for licensure.

c) In order to obtain a new license relative to reinstatement of a corporation, an application for initial licensure and the license application fee of $200 per license shall be submitted to the Department. If the Department was not notified within ten calendar days relative to the dissolution of the corporation the license fee will be $1000 for each affected license.

Section 2060.225 Relocation of Facility

a) Notification shall be given to the Department at least 30 calendar days prior to the relocation of any facility.
b) An application shall be completed by the organization relative to each relocation.
c) A relocation fee of $200 per application is required unless proper notification, as referenced in subsection (a), was not given, in which case the relocation fee will be $1000 per application.

Section 2060.227 License Certificate Requirements

a) A license certificate shall be issued by the Department for each facility that reflects the type of license and the levels of care and category (adolescent/adult) authorized for that facility.
b) The license certificate shall remain the property of the Department and shall be returned to the Department if there is a change in ownership, management, or location, or if the license is suspended, revoked or modified.
c) The license certificate issued by the Department shall contain the name and address of the facility, license number, all levels of care and the category (adolescent/adult) authorized by that license and expiration date.
d) The most current license certificate issued by the Department shall be displayed in the facility at all times in a location that is visible to all patients.

Section 2060.229 Deemed Status (Repealed)

(Source: Repealed at 26 Ill. Reg. 16913, effective November 08, 2002)

SUBPART C: REQUIREMENTS – ALL LICENSES

Section 2060.301 Federal, State and Local Regulations and Court Rules

All organizations shall attest to compliance, on the license application, and shall comply with all applicable provisions of State and federal constitutions, laws, regulations, court rules or judicial orders, including but not limited to:

a) The Illinois Human Rights Act [775 ILCS 5]. The licensee shall also take affirmative action to ensure that no unlawful discrimination is committed;
b) The Americans with Disabilities Act of 1990 (42 USC 12101) and the regulations and guidelines;
c) The Environmental Barriers Act [410 ILCS 25] and The Illinois Accessibility Code (71 Ill Adm Code 400);
d) The Age Discrimination Act of 1975 [42 USC 3001]; and

e) The 1991 Civil Rights Act [42 USC 1981].

Section 2060.303 Rule Exception Request Process

a) Requests for exceptions to any Section in this Part that is not statutorily mandated may be submitted to the Department. Requests shall be made by the Authorized Organization Representative to the Associate Director in writing, indicating the specific basis, rationale and need for the exception. Requests for exceptions may be made by any Department staff or provider.

b) In order to maintain uniformity to the greatest extent feasible, the Department will endeavor to keep exceptions to a minimum. Prior to granting any exception, the Department shall consider, but not be limited to, the following factors: the organization's patient or client population and size; type of services; geographic location; client or patient well-being if the exception is granted; the specific geographic location of the organization; and the accreditation status of the organization, as applicable.

c) Exceptions are at the sole discretion of the Department and the decision of the Associate Director is final.

d) The Department may revoke any exception granted when the circumstances that gave rise to the exception no longer exist or when any conditions imposed by the granting of the exception are not implemented by the provider or are subsequently prohibited by State or federal statute. The provider shall notify the Department in writing within 10 calendar days when the circumstances that gave rise to the exception no longer exist.

e) An exception to any Sections shall be valid only for the term of the license under which it was granted unless a different time period or permanent variance is specified by the Department. At the point of license renewal, reapplication for the exception shall be made.

f) Any licensed organization may be granted deemed status, in accordance with the provisions specified in Section 2060.229 of this Part.

(Source: Amended at 25 Ill. Reg. 11063, effective August 14, 2001)

Section 2060.305 Facility Requirements

a) At the time of application for initial or renewal licensure, all organizations, with the exception of Recovery Homes that are subject to the provisions specified in Section 2060.509 of this Part, shall, on a form supplied by the Department, document full compliance with all applicable provisions specified in this Section and, specifically, with the following:

1) all local and State health, safety, sanitation, building and zoning codes;

2) all applicable sections, as specified in this Section, of the National Fire Protection Association's (NFPA) Life Safety Code of 2000;

3) the facility requirements specified in the Environmental Barriers Act [410 ILCS 25] and the Illinois Accessibility Code (71 Ill. Adm. Code 400); and
4) the facility requirements specified in Section 12181 of the Americans with Disabilities Act of 1990 (42 USC 12181).

b) The days and hours of operation shall be posted at each facility where treatment or intervention services are provided. This information shall be displayed in a location that is visible to all persons.

c) Each facility shall also:
1) have a written emergency preparedness plan that ensures appropriate disaster preparedness and continuation of services, if possible, after a disaster. This plan shall contain provisions for a tornado and fire drill at least annually, identify the role of the facility in a community-wide disaster and have an emergency evacuation plan, including provisions for disabled persons; and
2) have areas for confidential interviewing, counseling, and administration and public reception and waiting areas.

d) Residential extended care facilities shall comply with the provisions specified in Chapter 26 (Lodging or Rooming Houses) of the National Fire Protection Association's (NFPA) Life Safety Code of 2000 for any building housing 16 or fewer residents and with the provisions specified in Chapter 29 (Existing Hotels and Dormitories) of the NFPA Life Safety Code of 2000 for any building housing 17 residents or more.

e) Inpatient treatment facilities shall comply with the provisions specified in Chapter 28 (New Hotels and Dormitories) of the NFPA Life Safety Code of 2000.

f) All existing outpatient treatment facilities shall comply with Chapter 39 (Existing Business Occupancies) of the NFPA Life Safety Code of 2000. Any outpatient treatment facility constructed after promulgation of this Part shall comply with Chapter 38 (New Business Occupancies) of the NFPA Life Safety Code of 2000.

g) Organizations shall also ensure, as applicable:
1) that each bedroom is kept clean and organized;
2) that each bedroom is occupied only by those of the same sex, except in situations where children are in residence with a parent in treatment;
3) a separate bedroom is provided for any 16 or 17 year old patient admitted to an adult inpatient service or any patient 17 years old or younger admitted to medically monitored detoxification services;
4) a minimum of 80 square feet is provided in a single bedroom and 60 square feet per bed in a multi-bed room with no more than four beds per room;
5) at least three feet of space is provided at the foot or head and one side of each bed and at least three feet between each bed;
6) that bunk beds will not be used for any detoxification patient and all other beds shall be non-folding, at least 36 inches wide and have flame retardant mattresses;

7) that each inpatient bedroom is an outside room with not less than the equivalent of ten percent of its floor area devoted to windows, which shall be covered with curtains, blinds, or shades;

8) that no inpatient bedroom opens into the kitchen or necessitates passing through the kitchen to reach any other part of the facility;

9) that no bedroom is in an attic or in an area with a floor more than three feet below the adjacent ground level;

10) that each inpatient has a wardrobe, locker, or closet;

11) that each bedroom has a swinging door no less than 32 inches in width that opens directly into a corridor or to the outside;

12) that doors in inpatient facilities that lead to corridors shall not be lockable from the inside;

13) that each bathroom contains a toilet and sink and that each tub or shower is enclosed with space for drying and dressing (the sink may be omitted from a bathroom that serves two adjacent bedrooms if each of these rooms contains a sink);

14) that a bathroom is accessible to each central bathing area and that a minimum of one toilet, one sink and one bathtub or shower for each sex shall be provided on each inpatient floor occupied by both sexes;

15) that one sink, one toilet and one bathtub or shower is provided for each eight beds on each floor where bathrooms are not adjacent to bedrooms;

16) that all bathrooms are well lighted and vented to the outside, either by means of a window that can be opened or by an exhaust fan; that no bathroom, other than for employees, shall open directly into a kitchen, pantry, food preparation area or food storage room;

17) that, in inpatient facilities with a capacity to serve more than 20 patients, a separate enclosed room is available for group counseling, other than the one used for recreation or dining;

18) that any facility that provides 24 hour care or that provides any meals shall do so under the direction, as an employee or through a contractual agreement, of a licensed dietician (LD) or a licensed nutrition counselor (LNC);

19) that the dietitian or licensed nutrition counselor shall develop a written plan for the provision of food services that describes either the organization of the food service and the delivery of food services or the arrangements for the provision of such services to patients;

20) that all nutritional aspects of patient care, including any specific dietary patient needs, shall be under the direction of the licensed dietitian, the licensed nutrition counselor or other persons who are supervised by the licensed dietitian or the licensed nutrition counselor;

21) that the dining area is supervised and staffed to provide assistance to the patients when needed, shall be sized and equipped to accommodate the age and number of patients served and shall be separate from the kitchen

area;

22) that the preparation or cooking of regularly scheduled hot meals is restricted to kitchen areas that shall be designed and equipped to meet the requirements of the services provided, including provisions for food receiving, storage, and preparation, dish and pot washing, and waste disposal;

23) that there is access to a handwashing sink and toilet and that all equipment and appliances are installed to permit thorough cleaning of all equipment, walls, baseboards, and non-absorbent floor material and that each kitchen has an Underwriters Laboratories (U.L.) approved five pound class B:C dry chemical fire extinguisher; and

24) that if laundry is done at the facility, space for soiled linen sorting, laundry equipment, including washers and dryers, and clean linen storage space is provided. If laundry is done outside the facility, a soiled linen storage room or area shall be provided.

(Source: Amended at 26 Ill. Reg. 16913, effective November 08, 2002)

Section 2060.307 Service Termination/Record Retention

a) The Department shall be notified at least 30 calendar days prior to the date on which cessation of any service is scheduled to occur. If involuntary termination occurs due to inability to operate (from damage to the facility, loss of staff, change in management, corporate dissolution or any other cause) the licensee shall notify the Department upon termination even though the 30 day notice has not occurred.

b) All patients receiving such services shall be apprised of the pending cessation and the needs of such patients shall be met by alternative means. The Department shall be notified within ten calendar days prior to closure of any case in which it is anticipated that a patient's needs cannot be met by existing systems of treatment.

c) When notified by an organization of its intention to cease operations at a location, the Department, if necessary, will schedule an inspection to ensure that the controlled substances inventory is transferred or destroyed in accordance with the Drug Enforcement Administration (DEA) requirements set forth at 21 CFR 1307.14 and 1301.21 (1987), respectively.

d) When an organization ceases operation of any service, all records (patient, personnel, financial) relative to that service shall be maintained as follows:

1) If the organization has a current license issued by the Department for any other treatment or intervention service, the organization may maintain the records from the service that has ceased operation.

2) If the organization has no other current license issued by the Department for any other treatment or intervention service, all records shall be transferred for maintenance and storage to a treatment or intervention

service currently licensed by the Department or to a person specifically exempted from such licensure in Section 15-5 of the Act.

e) The Department shall be notified regarding the location where records will be maintained and stored within ten calendar days after cessation of service.

f) Such records shall be stored and maintained for a period of five years from the date of cessation of service, if the organization is required to document disclosures of the record pursuant to the provisions of 45 CFR 164.528, for such documentation shall be maintained six years from the date of its creation or the date when it last was in effect, whichever is later.

g) Upon cessation of operations, the license shall automatically become null and void, and all documentation of licensure shall be immediately surrendered to the Department.

(Source: Amended at 27 Ill. Reg. 13997, effective August 8, 2003)

Section 2060.309 Professional Staff Qualifications

a) All professional staff providing clinical services (except as set forth in subsection (b)(2)), as defined in this Part, shall:
   1) hold clinical certification as a Certified Alcohol and Drug Counselor from the Illinois Alcoholism and Other Drug Abuse Professional Certification Association (IAODAPCA), 1305 Wabash Avenue, Suite L, Springfield, Illinois 62704; or
   2) be a licensed professional counselor or licensed clinical professional counselor pursuant to the Professional Counselor and Clinical Professional Counselor Licensing Act [225 ILCS 107]; or
   3) be a physician licensed to practice medicine in all its branches pursuant to the Medical Practice Act of 1987; or
   4) be licensed as a psychologist pursuant to the Clinical Psychology Practice Act [225 ILCS 15]; or
   5) be licensed as a social worker or licensed clinical social worker pursuant to the Clinical Social Work and Social Work Practice Act [225 ILCS 20].

b) All professional staff providing only clinical assessments, DUI evaluations or designated program intervention services, as defined in this Part, shall:
   1) meet one of the qualifications specified in subsection (a) above; or
   2) hold assessor certification as a Certified Assessment and Referral Specialist (CARS) from IAODAPCA.

c) In any medically managed or monitored detoxification service at least one staff, 24 hours a day, shall:
   1) be a registered nurse pursuant to Section 3(k) of the Illinois Nursing and Advanced Practice Nursing Act of 1987 [225 ILCS 65/3(k)];
   2) be a licensed practical nurse pursuant to Section 3(i) of the Illinois Nursing and Advanced Practice Nursing Act of 1987 [225 ILCS 65/3(i)]

who has completed at least 40 clock hours of formal training in the field of alcoholism or other substance abuse; or

3) be a certified emergency medical technician pursuant to Section 4.12 of the Emergency Medical Services (EMS) Systems Act [210 ILCS 50/4.12] who has completed at least 40 clock hours of formal training in the field of alcoholism or other substance abuse.

d) Any other staff who provide direct patient care that is not defined as a clinical service shall be supervised by an individual who meets the requirements for professional staff as defined in subsection (a), (b) or (c)(1) and (2) as applicable to detoxification.

e) Any new professional staff, including interns, who will provide clinical services in a treatment or designated program service and who do not meet the requirements of subsection (a) or (b) when hired shall:

1) meet the requirements specified in subsection (a) or (b) within two years after the date of employment; and

2) not work in any supervisory capacity until such requirements are met; and

3) work under the direct, verifiable supervision of an individual who has staff supervisory responsibility at the facility and who meets the requirements for professional staff specified in subsection (a); and

4) sign, and adhere to, a professional code of ethics developed by the organization.

f) The above referenced supervision shall last until the employee meets at least one of the requirements for professional staff designation specified in subsection (a) or (b) or until the two year period has elapsed. Such supervision is verifiable, at a minimum, by:

1) signature of the supervisor and the affected employee on the treatment plan and all reviews of or any change to the patient's treatment plan; and

2) documentation of face-to-face supervision meetings, at least once monthly. This supervision can occur in a group or individual setting and shall be a distinct activity separate from regularly scheduled patient staffings.

g) Any employee providing clinical services under supervision at one or more organizations who does not meet at least one of the requirements specified in subsection (a) or (b) within the relevant two year period shall not provide any direct clinical services at the end of the two years until such requirement is met.

h) All staff providing DUI risk education services shall:

1) meet one of the qualifications specified in subsection (a); or

2) hold Alcohol and Other Drug Abuse (AODA) certification from IAODAPCA.

i) It is the responsibility of each organization to ensure that all professional staff meet the requirements outlined in this Section.

j) The Department will consider granting an exception to the requirements specified in subsection (e) of this Section based upon timing of certification or licensure

examinations and part-time employment. In such cases, the exception will be time limited and based upon the minimum extension of time necessary to achieve full compliance. All exceptions shall be granted in accordance with Section 2060.303 of this Part.

(Source: Amended at 25 Ill. Reg. 11063, effective August 14, 2001)

Section 2060.311 Staff Training Requirements

a) All organizations shall provide an initial employee orientation to all staff within the first seven days after employment that shall include, at a minimum, the following information:
   1) An overview of all organization operations, including the specific duties assigned to the employee; emergencies and disaster drills; familiarization with existing staff backup and support; and all required training.
   2) An overview of this Part for all staff.
   3) Information on bloodborne pathogens and universal precautions (as those terms are defined in the regulations set forth in Section 2060.413 of this Part) and the importance of tuberculosis control and personal hygiene, the responsibilities of all staff with regard to infection control and an overview of the fundamentals of HIV, AIDS and tuberculosis control.
   4) Information on HIV and AIDS relative to the etiology and transmission of HIV infection and associated risk behaviors, the symptomatology and clinical progression of HIV infection and AIDS and their relationship to substance abuse behavior, the purposes, uses and meaning of available testing and test results, relapse prevention and sensitivity to the issues of an HIV infected patient.
   5) An overview of the principles of patient confidentiality, all related federal and State statutes and all record keeping requirements regarding confidential information.

b) Within the first six months after employment, any and all staff providing a DUI evaluation service shall attend one complete DUI Orientation training session offered or approved by the Department.

c) Within the first 12 months after employment, any and all staff providing a DUI risk education intervention service shall attend the first day of a DUI Orientation training session offered or approved by the Department.

d) In addition to mandatory training specified in subsections (b) and (c) of this Section, each DUI evaluator or Risk Education instructor shall obtain additional hours of substance abuse training annually consistent with the requirements of their professional staff credential.

(Source: Amended at 25 Ill. Reg. 11063, effective August 14, 2001)

Section 2060.313 Personnel Requirements and Procedures

a) All professional staff:
   1) shall be at least 18 years of age; and
   2) cannot have been convicted of any felony or had any subsequent incarceration for at least two years prior to the date of employment.

b) Verification of the requirements specified in subsection (a) above shall be documented on the Department's Schedule L at the time of employment and this form shall be maintained in the employee's personnel file. Prior to employment a copy of the Schedule L, along with a letter requesting an exception for employment, shall be sent to the Department relative to any person that indicates a felony conviction within the time period specified above.

c) In addition, any staff providing DUI evaluation or risk education services shall not have a suspension or revocation of driving privileges for an alcohol or drug related driving offense for at least two years prior to the date of employment.

d) Any staff providing clinical services to or any other supportive services for a child or adolescent who is receiving treatment at a facility, or is receiving child care at a facility, or is residing at a facility with a parent who is in treatment shall consent to a background check to determine whether they have been indicated as a perpetrator of child abuse or neglect in the Child Abuse and Neglect Tracking System (CANTS), maintained by the Department of Children and Family Services as authorized by the Abused and Neglected Child Reporting Act [325 ILCS 5/11.1(15)]. The organization shall have a procedure that precludes hiring of indicated perpetrators based on the reasons set forth in 89 Ill. Adm. Code 385.30(a) and procedures wherein exceptions will be made consistent with 89 Ill. Adm. Code 385.30(e) and procedures for record keeping consistent with 89 Ill. Adm. Code 385.60.

e) The organization shall ensure that treatment services for special populations (gender, youth, criminal justice, HIV, etc.) are delivered by appropriate professional staff as clinical needs indicate.

f) The organization shall have written personnel procedures approved by the management or, if applicable, the board of directors. Such procedures shall apply to all full and part-time employees and shall include the process for:
   1) recruiting, selecting, promoting and terminating staff;
   2) verifying applicant or employee information;
   3) protecting the privacy of personnel records;
   4) performance appraisals, and review and update of job descriptions, for all positions in the organization;
   5) disciplinary action, including suspension and termination;
   6) employee grievances;
   7) employment related accident or injury;
   8) handling instances of suspected or confirmed patient/client abuse and/or neglect by staff, whether paid or volunteer;

9) handling instances of suspected or confirmed alcohol and other drug abuse by staff; and

10) documentation that the personnel procedures, and any changes in procedures, have been distributed to employees and are available on request.

g) The organization shall provide documentation that all personnel procedures have been reviewed and approved at least annually by the Authorized Organization Representative or, if applicable, the board of directors.

h) A personnel file shall be maintained for each employee that contains:

1) the employee's name, address, telephone number, social security number, emergency contact and telephone number;

2) resume and evidence of qualifications;

3) documentation of the Schedule L and any relevant background checks and/or exception request;

4) unless otherwise kept in a training file, documentation of required training and continuing education received while employed by the organization (as indicated by a certificate of completion or the title, date and location of the training and the signature of the staff member who attended the training);

5) a copy of any professional certification, current license and/or registration, and date of employment and/or termination from the organization;

6) a copy of the signed applicable professional code of ethics as referenced in Part 2060.309(e)(4) of this Part; and

7) documentation of annual review of the organization's policy and procedures manual by all staff during their first year of employment and, annually thereafter, any updated sections that pertain to each staff member.

i) Each personnel file shall be maintained for a period of five years from the date of employee termination.

(Source: Amended at 25 Ill. Reg. 11063, effective August 14, 2001)

Section 2060.315 Quality Improvement

a) The licensee shall design and utilize a quality improvement plan. Such plan shall be written and shall contain, at a minimum, a method of evaluation to assess achievement of the organization's mission and the functioning of the organization and its service delivery systems and utilization review process.

b) The quality improvement plan shall be approved by management or, if applicable, the board of directors of the organization and annually reviewed and revised as necessary.

c) The evaluation shall contain, at a minimum:

1) a mission statement for the organization;

2) specific and measurable goals, objectives, activities and outcome

standards that are utilized by the organization to achieve its missions and projected results;

3) a description of how the organization will review and implement needed changes based on the results of the evaluation;

4) a method to review use of medication in any level of care;

5) a method of risk management that, at a minimum, includes:

A) review and analysis of any incident or significant incident reports as referenced in Section 2060.331 of this Part; and

B) design and implementation of necessary procedures to address both proactively and reactively any identified risks; and

6) a method of utilization review to measure appropriate patient placement.

d) The method of organization evaluation shall be submitted with the application for licensure. The results of the evaluation shall also be available for inspection by the Department and submitted at the time of application for renewal of licensure.

e) Utilization Review

1) For treatment licensees, utilization review shall be conducted at least quarterly and shall be conducted on a minimum 15% sample. If random sampling at 15% indicates problems, the organization will develop a specific remediation plan to correct the identified problems. Utilization review shall be conducted in accordance with continued stay and discharge criteria as established in the ASAM Patient Placement Criteria.

2) For DUI evaluation or designated program intervention licensees, utilization review shall:

A) be conducted at least quarterly on randomly selected cases consisting of at least 15% (but no less than five and no more than 20) of persons receiving each service; and

B) be based on the established criteria specified in this Part for the applicable category of intervention license relative to the substance abuse assessment or evaluation and subsequent intervention or referral.

f) All organizations required to conduct utilization review shall also:

1) specify all staff participating in utilization review;

2) specify how conflict of interest shall be addressed in any small organization where professional staff cannot always avoid reviewing their own cases; and

3) issue a report of finding from utilization review at least quarterly and make such report available to all professional staff.

g) Treatment licensees who are not otherwise required to report data electronically to the Department shall maintain statistics that, at a minimum, determine the total number of assessments, admissions, and discharges per patient by type of discharge and the average length of stay in each level of care.

h) DUI risk education services shall not be subject to utilization review as specified in subsection (e).

i) All treatment and intervention licensees shall develop and maintain a written policy and procedures manual that describes the operation of the organization. At a minimum, the manual shall explain how the organization will comply with all federal and State regulatory and contractual requirements, any additional requirements from independent accrediting bodies, and any other organizational policies and procedures. The manual shall be approved by the board of directors of the organization or, if not applicable, the organization representative and annually reviewed and revised as necessary. The manual shall be submitted to the Department at the time of licensure and upon request from Department staff. The manual shall also be reviewed during the first year of employment by all staff. Annually thereafter, the organization shall ensure that all staff shall review updated sections pertinent to such staff.

(Source: Amended at 25 Ill. Reg. 11063, effective August 14, 2001)

Section 2060.317 Service Fees

a) A fee schedule shall be established that specifies the fee charged for all treatment and intervention services and any other related services and that also specifies or estimates the amount for which the individual might be responsible based upon the anticipated length of stay in treatment or the type of intervention service.

b) Each person shall be given a fee schedule prior to the beginning of any treatment or intervention service for which the organization intends to seek reimbursement from the individual, indicating the amount that he or she will be responsible to pay along with any relevant payment schedule for each service.

(Source: Amended at 25 Ill. Reg. 11063, effective August 14, 2001)

Section 2060.319 Confidentiality – Patient Information

a) The organization shall have written policies and procedures controlling access to and use of records and information that are governed by the Confidentiality of Alcohol and Drug Abuse Patient Records regulations (42 CFR 2 (1987)) of the Alcohol, Drug Abuse, and Mental Health Administration of the Public Health Service of the United States Department of Health and Human Services effective August 10, 1987 and Article 30 of the Act [20 ILCS 301/Art. 30], and access to and use of protected health information governed by the Health Insurance Portability and Accountability Act (HIPAA), 42 USC 1320 et seq., and the regulations promulgated thereunder at 45 CFR 160, 162 and 164. The policies and procedures shall be consistent with said regulations and statutes. The organization shall comply with said regulations and statutes. However, nothing in this Part shall be construed as having the effect of imposing HIPAA requirements on a provider to whom HIPAA does not apply.

b) This Section shall not prohibit:
   1) disclosure of information about a crime committed by a patient at the organization, or a threat to commit such crime;
   2) disclosure of information about suspected child abuse or neglect, as allowed by, required by and consistent with State law;
   3) disclosure of a patient's own records to the patient, or as consented to in writing by the patient;
   4) communications of information between or among personnel having a need for the information in connection with their duties either within the organization or with an entity having direct administrative control over the services;
   5) disclosure of information to medical personnel if necessary in a medical emergency;
   6) disclosure of information as authorized by an appropriate court order upon showing of good cause, after appropriate procedure and notice, and with appropriate safeguards against unauthorized disclosure contained in the order as set forth in 42 CFR 2.61-2.67 (1987);
   7) disclosure of information to qualified personnel for the purpose of conducting scientific research as set forth in 42 CFR 2.52 (1987) (if such disclosure is in compliance with HIPAA regulations, 45 CFR 160, 162 and 164);
   8) disclosure of information to qualified personnel who are authorized by law or who provide financial assistance for the purpose of conducting audit or evaluation activity (services review or evaluation, quality review, financial or management audits, etc., as set forth in 42 CFR 2.53 (1987)).

   This Section shall also not prohibit any other disclosure not precluded by the regulations and statute cited in subsection (a), nor by any other applicable law, provided that any and all of the above disclosure is done consistent with the regulations and laws in subsection (a), is made only to the extent allowed, for the purposes allowed and that appropriate safeguards as required therein are provided.

c) Patient records and any other information which is subject to any laws and rules cited in this Section shall be maintained in a secure room, locked file cabinet, safe or other similar container when not in use. If patient information is stored in electronic or other types of automated information systems, security measures shall be in place to prevent inadvertent or unauthorized access to such information.

d) Except as authorized by an appropriate court order granted pursuant to the regulations and statutes cited in this Section, no record referred to by said laws may be used to initiate or substantiate any charges against a patient or to conduct any investigation of a patient.

e) The prohibitions cited in this Section apply to records concerning any individual who has been a patient, regardless of whether or when he or she ceases to be a patient.

f) When the Department requests a record or information which is subject to the regulations and statutes cited in this Section for audit, evaluation, research or other authorized purposes, it shall, in writing:
   1) indicate the purpose for obtaining the information;
   2) agree to maintain the information in accordance with security requirements of said laws;
   3) agree to comply with limitations on disclosures in said laws;
   4) agree to destroy all the information upon completion of its use; and
   5) indicate the authorized personnel to whom such information is to be submitted.

g) Organizations providing a DUI evaluation or risk education intervention service shall disclose offender information as allowed by law. The informed consent form and procedures as referenced in Section 2060.503(d) and (e) of this Part shall be utilized to allow for the disclosure of evaluation and risk education information to Illinois court officials, the Illinois Office of the Secretary of State and the Department for the purpose of adjudicating and court monitoring of DUI cases, drivers license issues and for monitoring licensed services.

h) Organizations shall have policies and procedures to comply with HIPAA and its regulations as set forth more specifically in Sections 2060.323(e) and 2060.325(u) of this Part, if the organization is required to comply with HIPAA.

(Source: Amended at 27 Ill. Reg. 13997, effective August 8, 2003)

Section 2060.321 Confidentiality - HIV Antibody/AIDS Status

a) The organization shall have written policies and procedures controlling access to records and information governed by the AIDS Confidentiality Act [410 ILCS 305] (AIDS Act), and the AIDS Confidentiality and Testing Code (77 Ill Adm Code 697) (AIDS Code).

b) The confidentiality of the following information is protected by the AIDS Act and AIDS Code:
   1) the identity of a person upon whom a test for HIV is performed; and
   2) the results of a test for HIV for an individual.

c) This Section shall not apply to HIV and/or AIDS risk reduction education and/or counseling, or other HIV and/or AIDS education which is provided to all persons but shall apply to information regarding individual requests for or participation in HIV pre-test and/or post-test counseling.

d) When dealing with information governed by the AIDS Confidentiality Act and AIDS Code, this Section shall control, notwithstanding any other provisions of this Part to the contrary.

e) An HIV antibody or AIDS test cannot be required as a condition of treatment, and an individual cannot be required to disclose or to sign an authorization for release of information concerning his or her HIV antibody test or HIV or AIDS status as

a condition of treatment.

f) An individual who wishes to be tested for HIV antibodies shall be informed that he or she may undergo testing on an anonymous basis.

g) Unless disclosure is otherwise authorized by statute and rule, no information governed by the AIDS Confidentiality Act and the AIDS Code shall be released by an organization, or by any member of its staff, to other staff members, including but not limited to the executive director, and/or to the medical director, and/or to any other person or entity, unless there is a legally effective consent or another exception in accordance with the statute and rule. Release of information which is allowed by consent or by statute and rule shall be done only to the extent provided therein.

h) Records which document the above confidential information shall be maintained in a separate portion of the file and be accessible only in accordance with the AIDS Confidentiality Act and Section 697.140(c) of the AIDS Code.

i) The organization shall have a policy regarding how and what shall be recorded if a person self-discloses HIV status during the course of treatment or if the person requires the administration of medications or other services by staff related to AIDS treatment. The policy shall protect the confidentiality of the person and protect his or her right to give consent prior to disclosure of HIV status, and shall limit disclosure to only what is necessary to accomplish the purpose of the disclosure.

j) Any HIV and/or AIDS counseling or testing service which is operated within the facility is considered a separate service and shall maintain separate records. Organization staff shall not have access to such counseling and testing records unless otherwise authorized in writing by the patient's informed consent.

Section 2060.323 Patient Rights

a) A written statement shall be provided to any patient at the time of acceptance for an intervention service or admission to a treatment service which describes the rights of all patients as specified in Article 30 of the Act as follows:

1) access to services will not be denied on the basis of race, religion, ethnicity, disability, sexual orientation or HIV status;

2) services will be provided in the least restrictive environment available;

3) confidentiality of HIV/AIDS status and testing and anonymous testing as specified in Section 2060.321 of this Part;

4) the right to nondiscriminatory access to services as specified in the American's With Disabilities Act of 1990 (42 USC 12101);

5) the right to give or withhold informed consent regarding treatment and regarding confidential information about the patient;

6) a description of the route of appeal available when a person disagrees with an organization's decision or policies;

7) confidentiality of patient records as specified in Section 2060.319 of this

Part;

8) the right to refuse treatment or any specific treatment procedure and a right to be informed of the consequences resulting from such refusal.

b) The patient will attest by signature that he or she has received a copy of the written statement of patient rights and this signatory document shall be maintained in the patient record.

c) The statement of patient rights shall be posted in an area accessible to patients at all times.

d) Each patient shall be given the statement of patient rights. If a patient is unable to read such written statement, it shall be read to the patient in a language the patient understands.

e) If the organization is required to comply with HIPAA, the patient shall also be given written notice of the uses and disclosures of protected health information that will be collected and maintained, and the rights provided by HIPAA with respect to such information as set forth in 45 CFR 164.520 and referenced in part in Sections 2060.319 and 2060.325(u) of this Part.

(Source: Amended at 27 Ill. Reg. 13997, effective August 8, 2003)

Section 2060.325 Patient/Client Records

a) Licensees shall maintain a written record for each patient or client. Such record may also be maintained electronically on a computer but shall be made available in hard copy upon request for review by the Department.

b) Any written entry on the record shall be in ink and shall be dated and shall meet all other signatory requirements for professional staff as specified in Sections 2060.421 and 2060.423 of this Part.

c) Written signatures or initials and electronic signature or computer-generated signature codes and corresponding dates are acceptable as authentication to identify the author of the record entry by that author and to confirm that the contents are what the author intended. Signature or initial stamps shall not be utilized.

d) All signatures or initials, whether written, electronic, or computer-generated, shall include the initials of the signer's credentials.

e) In order to utilize electronic signature or computer-generated signature codes and dates, the organization shall adopt a policy that permits use and authentication by electronic or computer-generated signature and dates and shall, at a minimum:

1) identify which staff are authorized to authenticate records using electronic or computer-generated signatures and dates;

2) ensure that each user is assigned a unique identifier that is generated through a confidential access code;

3) certify in writing that each identifier is kept confidential; and

4) have each user certify in writing that he or she is the only person with user

access to the identifier and the only person authorized to use the signature code.

f) Records maintained on computer shall have a back-up system to safeguard the records in the event of operator or equipment failure.

g) Any document or entry made on a document in the record that is in any other language than English shall have an accompanying English language translation.

h) All records shall be protected in a locked room, locked file, safe or similar container or in computer records with secure, limited access.

i) The record shall document any service provided by the organization at any facility. Additionally, if the organization provides multiple services that are licensed by the Department at any facility, one record can document all of such services.

j) The record shall contain the signatory document that indicates the patient/client has been informed of his or her rights.

k) The record shall contain documentation indicating the consent of the patient, and any other family members or guardians, for any service.

l) The record shall contain, on a standardized format, the following information:

1) name;
2) home address;
3) home and work telephone number;
4) date of birth;
5) sex;
6) race or ethnic origin and/or language preference;
7) emergency contact;
8) education;
9) religion;
10) marital status;
11) type and place of employment;
12) physical or mental disability, if any;
13) social security number, if requested;
14) drivers license number, county of residence and county of arrest (required only for DUI evaluation or risk education services);
15) annual household income, if applicable to any subsidized or reduced fee for service, unless this information is kept in a separate financial record; and
16) documentation of any disclosures of protected health information to the extent required by HIPAA (see Section 2060.325(u)(3) of this Part).

m) The record shall contain dates of any admission, change in level of care or discharge.

n) The record shall contain a dated service fee statement and proof, if applicable, of any qualifying documents relative to fee subsidization, including the "Qualification for DUI Services as an Indigent" form, unless this information is kept in a separate financial record.

o) The record shall be kept for a period of five years from the date of discharge, except that required accounting of disclosures of HIPAA protected health information must be kept for six years. While organizations may elect to keep records past this five year period, if the option to delete records is exercised, it shall be done by one of the following methods:
   1) burning or shredding; or
   2) erasure from all computer files.

p) The record shall contain the following information or documents for any treatment service:
   1) documentation of the treatment assessment and patient placement process;
   2) documentation of the diagnostic impression and physician confirmed diagnosis;
   3) documentation of laboratory and/or other diagnostic procedures/results and reports that the organization directly provided (except for HIV testing unless the patient has given written informed consent) and documentation of the tuberculin skin test results, the date given and date read, if applicable;
   4) the treatment plan and documentation of all required signatures and dates;
   5) progress notes that document all treatment services, any subsequent treatment plan reviews and on-going assessment and documentation of all required signatures and dates;
   6) documentation of completion of patient education specified in Section 2060.409 of this Part;
   7) documentation of any correspondence or telephone calls received or made relevant to treatment services; and
   8) a copy of the discharge summary unless the patient left prior to receiving any of these services.

q) The record shall contain copies of all referenced forms in Subpart E for any offender receiving a DUI evaluation or risk education service.

r) A staff member shall be designated who will have responsibility to ensure that all records are in compliance with this Part. This staff member shall review, at least annually, the record system to ensure that the system meets all requirements specified in this Part.

s) Records shall be kept in the facility where the patient/client is receiving services (or in accordance with Section 2060.203(b) of this Part, in specific relation to off-site services) and shall be directly accessible to the professional staff providing those services.

t) Information in the record may be used for training, research and quality improvement provided that the information is collected in accordance with any relevant confidentiality requirements.

u) Licensees who are covered by HIPAA shall have procedures to comply with HIPAA Privacy and Security provisions (45 CFR 160 and 164), including the following:

1) procedure to access the patient's record as set forth in 45 CFR 164.524;
2) procedure to request amendment to his or her record as set forth in 45 CFR 164.526;
3) procedure to request an accounting of disclosures of his or her medical records or portions thereof for the previous six years as set forth in 45 CFR 164.528; and
4) procedure to file a complaint with the licensee and with the U.S. Department of Health and Human Services, Office of Civil Rights in connection with an alleged violation of the HIPAA Privacy provisions set forth in 45 CFR 160.306.

(Source: Amended at 27 Ill. Reg. 13997, effective August 8, 2003)

Section 2060.327 Emergency Patient Care

a) A written plan shall be submitted at the time of application for licensure which specifies the manner in which emergency patient care is provided, either by the organization or through a linkage agreement with another facility or both, in the event of unforeseen interruption of services to current patients.
b) The plan should specify staff who are authorized to provide emergency care, the method for exchange of patient records when necessary, the name, location and contact person who is part of the emergency patient care plan, the method of transfer of any patients, if applicable, to another facility and the method of notification of patient families concerning the emergency and any subsequent transfer of the patients.

Section 2060.329 Referral Procedure

a) Written procedures shall be established for the referral of patients to other providers for services that are not available within the organization and/or that are requested by the patient. These procedures shall include the following:
   1) the method of obtaining any necessary written consent from the patient for transfer of any relevant portion of the patient record and for communication regarding patient services with that provider;
   2) the method for ensuring continuity of patient care which shall include a written referral document that indicates the reason for the referral, provides information about any service received to date and any additional services needed or requested, specifies any necessary continued coordination between the providers and the time frame for any necessary follow-up reports; and
   3) the method by which a patient may request a referral.
b) Each organization shall have a written linkage agreement, specifying the above provisions, with any other provider that it routinely utilizes for referrals unless

otherwise required by the Department.

c) All referrals made for treatment or intervention services as defined in this Part shall only be made to organizations licensed under this Part, to those individuals or organizations that are specifically exempted from licensure as specified in Section 15-5 of the Act or to similarly licensed and regulated organizations in other states.

Section 2060.331 Incident and Significant Incident Reporting

a) An incident is any action by staff or patients that led to, or is likely to lead to, an adverse effect on patient services because of a deviation from established patient care procedures.

b) Such incidents shall be documented immediately, in writing, by staff and such report shall be maintained at the facility for review by Department staff as necessary or during inspection.

c) A significant incident is any occurrence at the facility which requires the services of the coroner and/or which renders the facility inoperable.

d) A verbal report of any significant incident shall be given to the Department's Division of Licensing and Monitoring within 24 hours after its occurrence.

e) A written report of any significant incident shall be submitted within ten calendar days after the occurrence and, if applicable, a copy of any coroner's report shall be submitted within five calendar days after receipt of the written report.

Section 2060.333 Complaints

a) A complaint shall be filed with this Department whenever evidence is discovered that indicates non-compliance with this Part by any other organization providing services licensed under this Part or about any person suspected of providing unlicensed services. An individual may also file a complaint with the Department relative to any service. In all cases, complaints shall be directed to the Department as follows:

1) complaints may be received verbally but shall be documented in writing by the complainant before any official Department action is undertaken;

2) any supporting documentation relative to the complaint shall also be submitted to the Department; and

3) the Department shall notify the organization of any complaints that it receives relative to any service provided within the organization.

b) The complaint procedure poster furnished by the Department shall be posted in an area accessible to persons at all times.

Section 2060.335 Inspections

a) The Department shall conduct inspections of services licensed under this Part to

enforce compliance with this Part.

b) Such inspections shall be routinely scheduled but may also occur at any reasonable time. Employees of the Department shall be authorized to enter the facility and shall be permitted access to all areas and records.

c) If consent to inspect is not given, the Department will seek access pursuant to Section 45-5 of the Act.

Section 2060.337 Investigations

a) The Department may on its own motion, and shall upon the sworn complaint in writing of any person setting forth charges which, if proved, indicate criminal activity and/or would constitute grounds for sanction pursuant to the Act, conduct its own investigation and/or refer the matter for investigation.

b) The Department may also refer such matters for investigation to the appropriate legal authority.

Section 2060.339 License Sanctions

a) Prior to initiating a formal action to sanction a license, the Department will allow an organization an opportunity to take corrective action to eliminate or ameliorate a violation of the Act or this Part, except in cases in which the Department determines that emergency action is necessary to protect the public interest, safety or welfare.

b) The Department shall issue written notice to an organization determined to be in non-compliance. The Department's notice shall specify the particular activities deemed to violate the Act and/or this Part. The Department's notice shall require such corrective action as it deems necessary for compliance and shall establish a time period within which the corrective action is to be completed.

c) In determining whether to initiate formal action the Department shall consider whether the organization made an effort to comply with the Department's notice of corrective action, whether compliance with the Act and this Part was achieved within the designated time frame and the potential for harm to a patient as a result of the failure to comply.

d) Nothing contained herein shall preclude the Department from initiating formal action against an organization who has complied with the Department's notice of corrective action. In such case, the factors enumerated above shall be considered by the Department in determining whether and to what extent the following sanctions should be imposed:

1) Administrative Warning - A written warning issued by the Department which specifies rule violations and a corrective time period and that also warns that any additional violation of this Part may result in a more severe sanction.

2) Probation - Probation of the license for a specified period of time during

which action shall be taken, as necessary, to achieve compliance with all licensure standards. When the probationary period has expired, the Department shall terminate the probationary status. If the Department determines that the organization still does not meet licensure standards or has continued violations, the Department may suspend the license or extend the probationary period, if such extension would likely result in correction.

3) Restricted License - A restriction placed on a license which limits operation to specified services after a Department finding that one or more services has not met licensure standards.

4) Financial Penalty - A financial penalty imposed upon a finding of violation of any one or combination of the provisions of Section 15-25 of the Act. A financial penalty may not be paid with public funds. In determining an appropriate financial penalty the Department may consider the deterrent effect of the penalty on the organization and on other providers, the nature of the violation, the degree to which the violation resulted in a benefit to the organization and/or harm to the public and any other relevant factor to be examined in mitigation or aggravation of the organization's conduct. The financial penalty may be imposed in conjunction with other sanctions or separately.

5) Summary Suspension - An immediate suspension of the license ordered if the Department finds that the public interest, safety, or welfare imperatively requires emergency action.

A) A petition for summary suspension shall state the statutory basis for the action petitioned, alleged facts, supported by evidence or affidavit, sufficient to demonstrate a need for emergency action, be signed by the Department's chief legal counsel and be presented to the Secretary either in person or by telephone and in the presence of a court reporter.

B) An order for summary suspension shall contain findings of fact sufficient to support imposition of a summary suspension, recite the statutory basis for the action, appoint a hearing officer, demand immediate surrender of the license and be signed by the Secretary.

C) A notice of summary suspension shall accompany the order and shall set a date for commencement of a hearing within 14 calendar days after the date on which the order takes effect. The notice of summary suspension shall also identify the hearing officer who will conduct the hearing and include a copy of the Department's rule pertaining to hearings.

D) If the parties agree to a prehearing conference, such conference shall constitute the commencement of the hearing. The hearing shall determine whether the summary suspension shall remain in effect until conclusion of a formal hearing on the merits.

6) Suspension - Suspension of the license is a temporary withdrawal, by formal action, of a license for a period of time specified by the Department during which corrective action is taken to rectify problem areas that led to the suspension. When the corrective action has been taken, the Department will determine if such action meets Department standards and either reinstate or revoke the license.

7) Revocation - Revocation of the license is withdrawal by formal action of a license to provide treatment or intervention services. The termination shall be in effect until such time as the license is reinstated or an application for a new license has been made and approved by the Department.

e) The Department may reinstate a license, after a period of suspension or revocation, providing the organization proves full compliance with licensure standards.

f) The Department shall deny a license application for failure to comply with the Act and this Part.

Section 2060.341 License Hearings

a) Hearings conducted pursuant to Sections 45-20 and 45-25 [20 ILCS 301/45-20 and 45-25] of the Act shall follow the procedures set forth in 89 Ill. Adm. Code 508 and this Section.

b) Any organization receiving a "Notice of an Opportunity for Hearing" shall file a request for such hearing within 30 calendar days after the date of notice or the hearing rights afforded under this Act shall be deemed waived.

c) Both the burden of going forward with evidence and the burden of proof rest with the party requesting a hearing. The burden of proof is to show by preponderance of the evidence that the Department's decision is contrary to the evidence on the record when taken as a whole.

d) Hearing Officer Report

1) Within 30 calendar days after the conclusion of the hearing, the hearing officer shall deliver a report of the hearing to the Secretary.

2) All exhibits, pleadings, documents, or other material made a part of the record will accompany the report.

3) The report will summarize the testimony presented at the hearing and the hearing officer's opinion about the reliability of the witnesses.

(Source: Amended at 23 Ill. Reg. 10803, effective August 23, 1999)

SUBPART D: REQUIREMENTS – TREATMENT LICENSES

Section 2060.401 Levels of Care

Substance abuse treatment shall be offered in varying degrees of intensity based on the level of care in which the patient is placed and the subsequent treatment plan developed for that patient. The level of care provided shall be in accordance with that specified in the ASAM Patient Placement Criteria and with the following:

a) Level 0.5: Early Intervention
An organized service, delivered in a wide variety of settings, for individuals (adult or adolescent) who, for a known reason, are at risk of developing substance-related problems. Early intervention services are considered sub-clinical or pre-treatment and are designed to explore and address problems or risk factors that appear to be related to substance use and to assist the individual in recognizing the harmful consequences of inappropriate substance use. The length of such service varies according to the individual's ability to comprehend the information provided and to use that information to make behavior changes to avoid problems related to substance use or the appearance of new problems that require treatment at another level of care. Early intervention services are for individuals whose problems and risk factors appear to be related to substance use but do not appear to meet any diagnostic criteria for substance related disorders. Examples of individuals who might receive early intervention are at-risk individuals (i.e., family members of an individual who is in treatment or in need of treatment) or DUI offenders classified at a moderate risk level.

b) Level I: Outpatient
Non-residential substance abuse treatment consisting of face-to-face clinical services for adults or adolescents. The frequency and intensity of such treatment shall depend on patient need but shall be a planned regimen of regularly scheduled sessions that average less than nine hours per week.

c) Level II: Intensive Outpatient/Partial Hospitalization
Non-residential substance abuse treatment consisting of face-to-face clinical services for adults or adolescents. The frequency and intensity of such treatment shall depend on patient need but shall be a planned regimen of scheduled sessions for a minimum of nine hours per week.

d) Level III: Inpatient Subacute/Residential
Residential substance abuse treatment consisting of clinical services for adults or adolescents. The frequency and intensity of such treatment shall depend on patient need but shall, except in residential extended care as defined in this Part, include a planned regimen of clinical services for a minimum of 25 hours per week. Inpatient care, with the exception of residential extended care as defined in this Part, shall require staff that are on duty and awake, 24 hours a day, seven days per week. During any work period, if professional staff as defined in Section 2060.309(a) of this Part are not on duty, such staff shall be available on call for consultation relative to any aspect of patient care. Residential extended care shall require staff on duty 24 hours a day, seven days per week and that low intensity treatment services be offered at least five hours per week. Any staff providing clinical services shall meet the requirements for professional staff as defined in

Section 2060.309(a) of this Part. Individuals who have been in residence for at least three months without relapse may be used to fulfill any remaining staff requirements.

e) Level IV: Medically Managed Intensive Inpatient
Inpatient subacute residential substance abuse treatment for patients whose acute bio/medical/emotional/behavioral problems are severe enough to require primary medical and nursing care services. Such services are for adults or adolescents and require 24 hours medically directed evaluation, care and treatment and that a physician see the patient daily.

(Source: Amended at 25 Ill. Reg. 11063, effective August 14, 2001)

Section 2060.403 Court Mandated Treatment

Any organization providing treatment to any individual under a specific court order that mandates such treatment shall:

a) Have the organization's medical director develop admission criteria and any necessary associated clinical protocol that will allow physician confirmation for admission and initial placement in a level of care without a diagnosis of substance abuse or dependence for an individual under a court order for treatment. Such criteria and protocol shall be in accordance with all other provisions specified in Section 2060.417 of this Part; and

b) Deliver such treatment in accordance with the provisions specified in the court order as long as there is clinical justification (as specified in Section 2060.419 and 2060.423) for the intensity and duration of such treatment; and

c) Upon admission to treatment, require all necessary patient signatures authorizing the release of information, in accordance with Section 2060.319, in order to ensure effective communication with the court relative to progress in treatment, any recommended change in duration and intensity of treatment, unsuccessful or successful discharge from treatment and information about the individual's continuing care plan.

Section 2060.405 Detoxification

The medical director, as referenced in Section 2060.413 of this Part, shall develop protocols and authorize procedures for the medical supervision of and the staffing pattern for any patient receiving ambulatory or clinically managed residential detoxification as specified in the ASAM Patient Placement Criteria. All other detoxification shall be medically monitored or managed by a physician according the specifications contained in the ASAM Patient Placement Criteria and as follows:

a) Medically Monitored (Level III.7-D)
Medically monitored detoxification is for adults and adolescents. At least two staff persons shall provide 24 hour observation, monitoring and treatment, one of

whom shall meet the staff qualifications specified in Section 2060.309(c) of this Part.

b) Medically Managed (Level IV-D)
Medically managed detoxification is for adults and adolescents. However, medically managed opioid maintenance therapy shall only be used for adolescents age 16 and 17. At least two staff persons shall provide 24 hour observation, monitoring and treatment, one of whom shall meet the staff qualifications specified in Section 2060.309(c) of this Part. Medically managed detoxification also requires that a physician see the patient daily.

(Source: Amended at 25 Ill. Reg. 11063, effective August 14, 2001)

Section 2060.407 Group Treatment

Group treatment shall consist of didactic and counseling groups as follows:

a) Didactic groups are, but are not limited to, a therapeutic activity the primary purpose of which is to educate patients and their significant others on a specific treatment related topic in a group setting. All didactic groups shall be led or supervised by professional staff or by other professionals with credentials specific to the subject matter of the didactic group following a lesson plan or outline approved by the organization. Justification for all patients who attend any didactic group needs to be documented. Didactic groups should not exceed an average of 24 people.

b) Counseling groups are, but are not limited to, a therapeutic activity the primary purpose of which is to allow patients or their significant others an opportunity to process issues related to their treatment in a group setting. Counseling groups can have a specific focus (i.e., women, relapse, cocaine, etc.) but are generally less educational and more process oriented than didactic groups. All counseling groups shall be facilitated by professional staff. Justification for all patients who attend any counseling group needs to be documented as an assessed need. Counseling groups at no time shall exceed 16 patients per group.

(Source: Amended at 25 Ill. Reg. 11063, effective August 14, 2001)

Section 2060.409 Patient Education

All organizations shall develop a patient education plan that specifies all patient education that is available at the facility and ensures that all patients are informed about this plan and the mandatory elements of it (as specified in this Section) prior to or during the development of the treatment plan. Patient education may be provided individually or in a group in accordance with the group size specifications contained in Section 2060.407 of this Part. Such education shall be provided to each patient at least once and documented as such in the patient record. Upon subsequent admissions, the need for such education may be determined by the organization. At a

minimum, the patient education plan shall include the following:

a) Information about the benefits and risks of all medications prescribed by the organization's medical director or physician working under his/her supervision/direction, laboratory tests performed by the organization's medical director or physician working under their supervision/direction, treatment protocol, all rules relative to patient conduct and patient rights, and all organization rules relative to confidential patient information as referenced in Section 2060.319 of this Part.

b) Initial AIDS risk reduction counseling and education services and tuberculosis information consisting of the following components:

1) Education relative to infectious disease control and HIV/AIDS that shall provide information about the etiology and transmission of HIV infection and associated risk behaviors, symptomatology and clinical progression of HIV infection and AIDS and their relationship to substance abuse behavior, prevention of transmission and risk reduction (including information about needle sharing, sexual transmission, transmission to infants, etc.), the availability of counseling and testing services, the confidentiality rights of the patient regarding counseling, testing and HIV status and relapse prevention.

2) Education relative to infectious disease control and tuberculosis that shall include information about its transmission and prevention, the importance of diagnosis, the requirement for skin testing and the interpretation of skin test results, the importance of x-rays for positive test results and HIV infected persons, the importance of treatment regimens and the basic symptoms associated with tuberculosis.

c) Upon completion of any mandatory education specified in this Section, documentation shall be placed in the patient record. That documentation shall specify the type of education received and the date received, and shall be signed by the patient if the documentation is maintained separately from the treatment plan.

(Source: Amended at 25 Ill. Reg. 11063, effective August 14, 2001)

Section 2060.411 Recreational Activities

Recreational activities may be provided to patients if they:

a) are identified in the treatment plan as an assessed need; and

b) are conducted under the supervision of staff. Recreational activities shall not average more than one-fourth of the treatment services received for any patient in any ASAM level of care.

Section 2060.413 Medical Services

a) Medical Director
   1) Any organization providing treatment services shall designate a medical director, who is licensed and in good standing to practice medicine in all its branches in Illinois, who shall oversee all medical procedures.
   2) The medical director may be part-time or serve on a consulting basis and the name and professional license number of the medical director shall be designated on the application for licensure.
   3) The medical director as well as all medical and nursing staff shall read and comply with this Part.
   4) The Department shall be notified in writing, within 10 calendar days, of any change in medical directors.

b) Medical Screening
   1) The medical director shall develop and authorize a medical screening form that shall be completed for each patient prior to admission to Levels I-IV care that shall be used, at a minimum, to assess acute intoxication and/or withdrawal potential, biomedical conditions or complications, and emotional/behavioral conditions and complications. The medical screening shall include, but not be limited to, inquiry in the following areas:
      A) primary complaint per patient;
      B) date of last physical exam and the name of the patient's primary care physician;
      C) history of substance use;
      D) history of past withdrawal symptoms;
      E) history of concurrent medical symptoms, complications or conditions, including sexual activity and risk for pregnancy;
      F) history of concurrent psychiatric symptoms, complications or conditions, including suicide/homicide potential;
      G) history of recent trauma (including physical/sexual abuse);
      H) hospitalizations;
      I) medications currently prescribed and any allergies to medications; and
      J) infectious or communicable diseases.
   2) The medical director shall designate the factors in a medical screening, including a determination of the patient's risk for HIV and tuberculosis infection, and the specific medications prescribed or used by a patient that would require physician review if such medical screening is not conducted by a physician.
   3) The purpose of physician review is to determine the immediate need for a medical referral for a physical or psychiatric examination. If determined necessary, physician review may be by phone, facsimile transmission, or in person, and shall occur no later than 24 hours after admission to Level IV care, within 48 hours after admission to Level III care, and within 72

hours after admission to Levels I and II care.

4) A patient shall be referred for medical, surgical, obstetric, prenatal or psychiatric treatment or laboratory services as determined necessary by the medical director or other physician.

5) All pregnant women admitted for any type of detoxification shall be subject to physician review as defined in subsection (b)(3) of this Section.

6) Any patient under the age of 12 admitted to adolescent treatment shall be subject to physician review as defined in subsection (b)(3) of this Section.

c) Physical Examinations

1) The medical director shall develop protocol and authorize procedures for any physical examination of a patient that shall, at a minimum, specify the professional requirements for any individual who shall conduct the physical examinations under the supervision of the medical director.

2) Physical examinations are not required for any patient in Level I or II care unless otherwise indicated by the specifications in subsection (b)(3) of this Section.

3) All inpatients (Levels III and IV care), with the exception of those individuals in residential extended care as defined in this Part, shall undergo a physical examination within 72 hours after admission if on prescription medication or pregnant. All other patients in such care shall undergo a physical examination within 7 days after admission.

4) Patients may provide documentation of a physical examination completed within 7 calendar days prior to admission to Level III and IV care and 30 calendar days prior to admission to residential extended care that may be accepted by the medical director in lieu of an additional physical examination.

d) All organizations shall have first aid kits and, when such services are not directly provided, a written agreement with a licensed hospital or medical center for the provision of physical examinations, laboratory tests and emergency medical services and, if applicable, for high risk prenatal care and transportation during emergencies.

e) When nursing services are provided, a registered nurse shall plan, assign, supervise and evaluate all nursing care.

f) Medication dispensary services shall be in accordance with the Medical Practice Act of 1987 [225 ILCS 60]; the Pharmacy Practice Act [225 ILCS 85]; the Illinois Controlled Substances Act [720 ILCS 570]; the Poison Prevention Packaging Act (15 USC 1471); substances requiring special packaging (16 CFR 1700.14); and rules and regulations of the U.S. Drug Enforcement Administration (see Section 2060.103).

g) The administration or dispensing of patient-owned medications shall comply with the following:

1) patients shall surrender all medications on admission;

2) medications brought by patients shall not be administered unless they can

be absolutely identified and unless written orders to administer these specific drugs are given by the authorized prescriber and are confirmed in writing in the patient record;

3) self-administration of medication shall be permitted only when specifically ordered by the authorized prescriber;

4) self-administration of medication shall be documented, including the date, time, and dosage of all medications issued;

5) in those cases where patients are unable to self-medicate, medication shall be dispensed or administered only by a practitioner. An exemption from these requirements may be requested provided that an alternate protocol for handling patient-owned medications is submitted and that the protocol is approved by the medical director;

6) any drugs that the patient brings that are not used shall be packaged, sealed, and stored, and, if approved by the authorized prescriber, returned to the patient, family, or significant others at the time of discharge; and

7) medications for minors who are in residence with patients shall be reviewed by the authorized prescriber. Permission to keep medication at bedside in their possession and self administer to one's dependent minors shall be given by the authorized prescriber.

h) Opioid Maintenance Therapy

1) Any treatment service that uses methadone or LAAM for the treatment of opioid addiction shall comply with the provisions of 21 CFR 291.505 (2001, no later amendments or editions included).

2) The social security number for each patient shall be obtained and used in all circumstances requiring patient identification; i.e., medication logs, take-home bottles, exception requests, and general correspondence.

3) Organizations shall obtain prior written approval from the Department for exceptions as referenced in 21 CFR 505 (2001) relative to more than a three day supply of take-home medication and shall utilize the Department's Schedule H when requesting such exceptions. Documentation of each such exception granted or any other exception granted by organization staff shall be maintained in the patient record. Such documentation shall include, but need not be limited to:

A) the circumstances that made the exception necessary;

B) the dates and locations involved and the methadone or LAAM dosage; and

C) the name, title and signature of the staff person who granted the exception.

4) On the first day of each month a log listing all exceptions granted during the previous month shall be forwarded to the Department. Organizations shall also utilize medication accounting forms supplied by the Department. These forms shall be completed weekly and maintained for inspection by State and federal inspectors or investigators either on-site or via mail.

5) Triplicate medication logs for dispensing methadone or LAAM shall also be used. These logs are provided by the Department and are official prescription forms that shall be signed by the authorized prescriber and forwarded to the Department every week. Computer generated medication logs may be utilized when approved by and compatible with Department data/prescription needs.

(Source: Amended at 25 Ill. Reg. 11063, effective August 14, 2001)

Section 2060.415 Infectious Disease Control

a) Licensees shall be in compliance with:
   1) guidelines issued by the U.S. Centers for Disease Control and Prevention in "Recommendations for Prevention of HIV Transmission in Health Care Settings": and "Update: Universal Precautions for Prevention of Transmission of Human Immunodeficiency Virus, Hepatitis B Virus, and other Bloodborne Pathogens in Healthcare Settings", both known as "Universal Precautions"; and
   2) the U.S. Department of Labor rules for Occupational Exposure to Bloodborne Pathogens, 29 CRF 1910.1030 (2000).

b) Tuberculosis Control and Services
   1) Any organization providing treatment services shall have its medical director or other designated staff be responsible for developing, reviewing annually and evaluating the effectiveness of a tuberculosis infection control plan based on a tuberculosis risk assessment of the facility following the protocol for conducting a tuberculosis (TB) risk assessment in a health care facility in "Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health Care Facilities", referred to as CDC Tuberculosis Guidelines, which should, at a minimum, include:
      A) a medical screening of each patient for infectious, communicable tuberculosis as required in Section 2060.413(b) of this Part;
      B) identification of patients at increased risk of being infected with tuberculosis, using a standardized screening tool, and provision of tuberculosis services, either directly or through referral with other public, nonprofit or private entities;
      C) procedures for the immediate reporting of patients with, or suspected of having, active, infectious tuberculosis to the local tuberculosis control agency and a process for isolation of such patients from the general population until the patient is determined to be non-infectious. Provisions shall be made for respiratory isolation (by linkage with other health care providers and the local tuberculosis control agency) for substance abuse treatment if and when possible and appropriate;

D) procedures for providing prompt and appropriate curative therapy directly by the organization or by referral. Such medical care provided shall be consistent with standards specified by the Centers for Disease Control and Prevention, Treatment of Tuberculosis and Tuberculosis Infection in Adults and Children (American Thoracic Society, Medical Society of the American Lung Association and U.S. Department of Health and Human Services). Am. J. Respir. Crit. Care Med. vol. 149, pp. 1359-1374, 1994 (no later amendments or editions included);

E) procedures (by way of linkage with other health care providers and with the local health department) for isolation of patients who may have active infectious tuberculosis;

F) procedures for lessening the risk of environmental transmission within the facility; and

G) procedures for meeting State reporting requirements while adhering to confidentiality requirements specified in Section 2060.319 of this Part and in 42 CFR 2.

2) Employee Skin Testing and Management

A) All staff shall have a tuberculin skin test using the Mantoux method (5TU, PPD) when hired, annually and as indicated in the CDC Tuberculosis Guidelines (or authentic documentation of a skin test within the past three months, or of completion of previous medical treatment of the disease, or of preventive therapy). The test shall be read within 48 to 72 hours by personnel trained in accordance with guidance from the local tuberculosis agency.

B) The organization shall establish procedures requiring medical evaluation for personnel with positive skin tests or with signs and symptoms of active tuberculosis disease; requiring preventive therapy for personnel with tuberculosis infection, unless medically contraindicated; and requiring leave and/or restriction from the patient population as necessary in cases of active infectious tuberculosis.

C) Staff who have an initial negative skin test result but who have not had a documented negative skin test result during the 12 preceding months shall be retested using the Mantoux method within one to three weeks after the initial test. If the second test is positive, the person should be considered previously infected.

D) Staff with negative tests shall be retested at least every 12 months and upon a known or suspected exposure to tuberculosis.

E) The organization shall document and have available for review by the Department the results of all staff tuberculin testing.

3) Patient Skin Testing and Management

A) The medical director of any organization providing treatment

services shall develop a tuberculosis skin testing policy and procedure based on the tuberculosis risk assessment and tuberculosis infection control plan required in subsection (b)(1) of this Section.

B) Patient Testing

i) Each organization providing inpatient services (except for residential extended care) and/or providing opioid maintenance therapy shall either directly or through arrangements with other public, nonprofit or private entities, provide each patient with medical tuberculosis screening services including at a minimum a PPD skin test (5TU, PPD), placed within seven calendar days after admission and read within 48 to 72 hours after placement by personnel trained in accordance with guidance from the local tuberculosis agency. If a patient is known to be immunosuppressed, a chest x-ray, energy battery, sputum smear and/or sputum culture/sensitivity study for tuberculosis may be used instead of a PPD skin test.

ii) Patients with prior positive skin tests or diagnoses who have not completed treatment or prevention therapy shall be medically evaluated for symptoms of infectious tuberculosis.

C) The result of the Mantoux skin test in mm of induration, the date given and the date read shall be recorded in the patient's medical file.

D) Patients who have a positive reaction of 5 mm or more to the skin test or who have signs and symptoms compatible with tuberculosis disease shall be medically evaluated for tuberculosis or shall be referred for such evaluation. Admission of patients with symptoms of active tuberculosis may be delayed until there is adequate documentation that the person is not infectious.

E) Organizations shall follow the CDC Tuberculosis Guidelines regarding appropriate testing after the initial test (i.e., in determining appropriate retesting, the need for anergy testing, testing required upon exposure and additional considerations for interpreting test results). Patients with negative reactions to the initial tuberculin test shall be retested using the Mantoux method (5TU PPD) at least annually or after any known exposure to infectious tuberculosis.

F) Procedures shall be established for providing prompt and appropriate curative and preventive therapy directly by the organization or by referral. Medical care provided shall be consistent with the CDC's Treatment of Tuberculosis and

Tuberculosis Infection in Adults and Children.

4) Facility Environment-Transmission Prevention

A) An organization that provides respiratory isolation at a facility shall assure that it has consulted engineers or other professionals with expertise in ventilation engineering to ensure that its facility ventilation systems meet applicable federal, State and local standards.

B) Persons with suspected or known infectious tuberculosis shall not be allowed to enter living or work areas of a treatment facility. The process for handling persons prior to and while screening for infectious tuberculosis shall be done as to avoid environmental exposure to other patients and staff.

(Source: Amended at 25 Ill. Reg. 11063, effective August 14, 2001)

Section 2060.417 Assessment for Patient Placement

An assessment shall be conducted prior to admission to any level of care. This assessment shall be an individual face-to-face service and shall include collection of demographic data as referenced in Section 2060.325(1) of this Part and:

a) For admission to Level 0.5, Early Intervention:

1) review of any specific conditions of court supervision or probation including any prior substance abuse screenings or evaluations conducted prior to admission (i.e., DUI); and

2) sufficient assessment to screen for, or rule out, substance related disorders.

b) For admission to Levels I-IV care:

1) an evaluation of the severity of the six dimensions established in the ASAM Patient Placement Criteria;

2) a recommendation for placement in Levels I-IV care as established in the ASAM Patient Placement Criteria;

3) a diagnostic impression of substance abuse and/or dependence as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) that shall be confirmed as a diagnosis by a physician.

c) Physician confirmation of diagnosis and initial patient placement:

1) the medical director shall define protocols and authorize procedures for confirmation of diagnosis or admission without diagnosis as specified in Section 2060.403(a) of this Part and initial patient placement in Levels I-IV care.

2) confirmation of diagnosis may be made by telephone or facsimile transmission if so authorized by procedure.

3) confirmation shall occur no later than 24 hours after admission for Level IV care, no later than 72 hours after admission for Level III care, and no later than 7 working days after admission for Level I and II care.

4) confirmation of diagnosis and admission is not necessary for Level 0.5 Early Intervention.

d) Prior to admission, or in the case of an intoxicated patient, as soon as stabilization occurs, basic information about treatment services shall also be provided and shall include the following:
1) the procedures and treatment services the patient will receive;
2) if possible, an introduction to the professional staff members who serve as the primary contact with the facility for the client;
3) the hours during which services are available;
4) the risks, side effects, and benefits of all medications prescribed by the organization's medical director or physicians working under his/her supervision or direction and experimental treatment procedures to be used;
5) the cost, itemized when possible, of services to be rendered;
6) any limitations placed on duration of services; and
7) the rules and regulations of the facility applicable to the patient's conduct.

e) A written, dated, and signed informed consent form shall be obtained from the patient, or the patient's legal guardian, and from family members who also participate, for use or performance of the following activities:
1) experimental medications;
2) hazardous on experimental assessment procedures;
3) recording on audiovisual equipment;
4) participation of the patient in research projects; and
5) testing for Human Immunodeficiency Virus (HIV).

(Source: Amended at 25 Ill. Reg. 11063, effective August 14, 2001)

Section 2060.419 Assessment for Treatment Planning

Upon admission and initial placement in Levels I-IV of care, the clinical assessment of the patient shall continue in order to develop the treatment plan. Patient needs shall be determined through specific inquiry and analysis in the six dimensions established in the ASAM Patient Placement Criteria and include but not be limited to:

a) a review of the medical screening, any subsequent physician referrals or changes in the patient's health, including a determination of acute intoxication and/or withdrawal potential, the current substance use or abuse pattern and medication use, and history of prior treatment for substance abuse or dependence and number of relapses, if applicable;

b) any previous emotional or behavioral problems and treatment and the patient's current emotional and behavioral functioning, including any history of previous or on-going physical, emotional or sexual abuse, in order to detect problems that may be life threatening or indicative of severe personality disorganization or that may seriously affect the patient's progress in treatment;

c) an analysis of the patient's home and/or living environment including child care

needs, religion, childhood, military service history, education and vocational history, financial status, social or peer group, family constellation and history of substance abuse and a determination of the need for participation of any family members or significant others in the patient's treatment, information on pending criminal or misdemeanor charges or any specific conditions of court supervision, probation or parole including any prior substance abuse evaluations conducted in specific reference to an offense of DUI.

Section 2060.421 Treatment Plans

a) At a minimum, the initial patient treatment plan shall be based on the patient's presenting concerns as evidenced from the biomedical and emotional/behavioral assessment. Such treatment plan shall be developed within 24 hours after admission for any patient in Level IV care, seven calendar days after admission for any patient in Level III or II care and 14 calendar days after admission for any patient in Level I care.

b) The initial treatment plan shall be confirmed by the medical director or physician according to established protocol (i.e., in person, by telephone, facsimile transmission, standing order), in accordance with the time frames established in subsection (a) of this Section. Such confirmation shall be documented in the patient record by date and signature of the physician making such confirmation. The treatment plan shall also be signed and dated by the patient, indicating participation in the development of the plan, and by the professional staff member assigned primary responsibility for services to the patient.

c) The treatment plan shall be written, gender and culturally appropriate and individual to each patient.

d) The treatment plan shall list problems (e.g., an injury, dysfunction or loss), goals (a statement to guide resolution or reduction of the problem), objectives (observable and measurable signposts on the way to achieving the goals), methods (the treatment services to be provided, the site of those services, the intensity and duration of those services) and a time table for achieving the goals and objectives of treatment that are within the time frame of the patient's expected participation.

e) The treatment plan shall describe and include the frequency of all activities, referrals and consultations planned for the patient and/or any family members or significant others and shall designate all professional staff members assigned to provide or coordinate referrals for such services. Referrals or consultations for other needed services not directly provided may include, but not be limited to, prenatal care, other medical care, child care services or any other appropriate legal, financial, social or mental health service.

Section 2060.423 Continued Stay Review

a) Ongoing assessment of the patient's progress in treatment shall occur in order to

determine continued stay in the level of care in which the patient was placed or the need to move to another level of care or to discharge. The assessment shall be accomplished using the ASAM "continued stay" or "discharge" criteria." As the patient moves through treatment, progress shall be continually assessed and recorded in progress notes. At a minimum, a continued stay review shall include a review of the ASAM continued stay or discharge criteria, the current treatment plan, and all subsequent progress notes. Continued stay reviews shall be measured through hours or days. The type of measurement (hours or days) must be specified in the initial and each subsequent treatment plan and this measurement must remain unchanged until the next continued stay review. Continued stay review shall occur as follows:

1) upon movement to any other level of care based on any change in the level of patient functioning; or
2) every 60 calendar days or after every 10 hours of treatment for patients receiving Level I or residential extended care, every 30 calendar days or after every 27 hours of treatment for patients receiving Level II care, every 14 calendar days for patients receiving Level III care, and every 24 hours for patients receiving Level IV care;
3) prior to planned discharge;
4) every 30 days for patients in opioid maintenance therapy during the first 90 days of treatment and every 90 days thereafter for patients who demonstrate 90 days of stable participation and for whom no change has occurred in the ASAM Biomedical Conditions and Complications dimension.

b) Documentation of the continued stay review shall:
1) be by progress note in the patient record;
2) include the participation of the patient;
3) be initialed and dated by the patient;
4) be initialed and dated by the professional staff member conducting the review; and
5) be authorized as evidenced by a progress note in the patient record written and dated and initialed by the medical director or a physician working under his or her supervision if there is a change in the ASAM Biomedical Conditions and Complications dimension.

(Source: Amended at 25 Ill. Reg. 11063, effective August 14, 2001)

Section 2060.425 Progress Notes and Documentation of Service Delivery

a) Progress notes shall reflect patient progress and shall be consistent with the clinical assessment, level of care and expectation of progress. Progress notes can include a summary of services delivered prior to each continued stay review. Progress notes shall be summarized a minimum of every 14 calendar days for

patients in Level II care, daily for patients in Level III care, and upon each continued stay review for patients in Level I and Residential Extended Care. Progress notes shall be entered in the patient record and include the following:

1) chronological documentation of the patient's progress in treatment;
2) documentation of any change in the patient's behavior; and
3) descriptions of the patient's response to treatments, the outcome of treatment, and the response of significant others to events in the course of treatment.

b) Documentation of service delivery in the patient record shall specify the name and credentials of the individual who provided the service and be signed or initialed and dated in ink by the individual making the entry or in accordance with the provisions for electronic signature specified in 2060.325(c)-(e) of this Part.

c) Any entry that includes a subjective interpretation of the patient's progress shall include a description of the actual behavior observed.

d) Each service delivered shall be documented in the patient record and include the specific type of service delivered, location of service delivery, date, time and duration of each service rendered to the patient (with the exception of HIV counseling and testing). Clinical notes, clinical checklists and clinical rating scales may also be included with this documentation.

(Source: Amended at 25 Ill. Reg. 11063, effective August 14, 2001)

Section 2060.427 Continuing Recovery Planning and Discharge

a) Organizations shall develop a continuing recovery plan for patients who are no longer actively receiving treatment in, or no longer require, an ASAM level of care.

b) The continuing recovery plan shall contain the following information as appropriate for individual patients:

1) a relapse prevention plan for patients who have obtained abstinence that also identifies actions to be taken if relapse should occur;
2) actions planned by the organization to support continuing recovery or reinitiation of active treatment services;
3) specific and measurable patient involvement in the event that accountability by the patient is required for any case management or monitoring organization (i.e., circuit courts, offices of probation, Office of the Illinois Secretary of State, parole officers, employers, etc.); and
4) community recovery support services that will maintain, support and enhance progress made in treatment.

The continuing recovery plan shall be completed prior to the patient discharge from all ASAM levels of care within the organization for any patient no longer meeting the criteria for continued active treatment.

c) Organizations shall develop discharge and exclusionary criteria consistent with

customary clinical standards accepted within the community. After the patient is discharged from all treatment, a discharge summary shall be entered in the patient record within 15 days. This summary shall include:

1) the reason for discharge and the progress of the patient relative to each goal and objective in the treatment plan;
2) a prognostic statement of the patient's condition at discharge, including any continued use of prescribed medications; and
3) the patient's continuing recovery plan.

(Source: Amended at 25 Ill. Reg. 11063, effective August 14, 2001)

SUBPART E: REQUIREMENTS – INTERVENTION LICENSES

Section 2060.501 General Requirements

In addition to the provisions specified in this Subpart, all DUI evaluation, DUI risk education and designated program services shall meet all applicable provisions specified in Subparts A, B, and C of this Part. Recovery Homes shall meet all applicable provisions specified in Subparts A and B, as well as all provisions specified in Section 2060.509 of this Part.

(Source: Amended at 25 Ill. Reg. 11063, effective August 14, 2001)

Section 2060.503 DUI Evaluation

a) The purpose of a DUI evaluation is to conduct an initial screening to obtain significant and relevant information from a DUI offender about the nature and extent of the use of alcohol or other drugs in order to:
   1) identify the offender's risk to public safety for the circuit court of venue or the Office of the Secretary of State; and
   2) recommend an initial intervention to the DUI offender and to the circuit court of venue or the Office of the Secretary of State.

b) DUI evaluation services shall be provided to any offender under the same terms and conditions regardless of ability to pay.
   1) If an offender provides proof of indigence, in accordance with poverty guidelines established by the U.S. Department of Health and Human Services and contained in the Department's annual Drunk and Drugged Driving Prevention Fund (DDDPF) billing manual, the organization providing the evaluation may bill for reimbursement for the DUI evaluation from the DDDPF. All such reimbursement shall be via a rate established by the Department and in accordance with the Department's most current fiscal year DDDPF billing manual.
   2) Additionally, all reimbursement from the DDDPF is subject to availability of funds. Organizations shall have an alternative fee assessment and

collection procedure for use should DDDPF funding not be available. However, if the reimbursement from the DDDPF or any additional fee assessed to the offender, as specified in subsection (b)(3) of this Section, has not been received by the completion of services, the evaluation shall still be released to the appropriate circuit court of venue or the Office of the Secretary of State in accordance with this Section.

3) The organization may also assess a fee for the evaluation to an indigent DUI offender when the organization's standard fee charged for an evaluation to a non-indigent DUI offender exceeds the rate of reimbursement provided by the Department. In such cases, the amount assessed to the offender shall not exceed the difference between the organization's standard fee and the Department's rate.

4) Any organization choosing not to submit reimbursement claims shall still provide services to indigent offenders in accordance with this Part.

c) All evaluations shall consist of a face-to-face individual interview. The evaluation shall be conducted at the facility unless otherwise specified in this Part or by court rule.

d) Each DUI offender shall be given a copy of the Department's Informed Consent form and a copy of the Department's brochure that explains the DUI evaluation process.

1) This brochure shall be read by or to the offender prior to the provision of the evaluation.

2) The Informed Consent specifies that any information provided by the DUI offender will be released to the circuit court of venue, the Office of the Secretary of State and/or the Department and explains that the consent of the offender is not required for this disclosure.

3) The Informed Consent also requires the offender to specify where he or she underwent any previous evaluations as a result of the most current DUI offense and to provide a copy of those evaluations, if completed, to the current DUI evaluator.

4) Each DUI offender shall sign the Informed Consent form indicating his or her understanding of the DUI evaluation process and disclosure requirements or initial the Informed Consent form indicating refusal to proceed with the evaluation. A copy of this form shall be placed in the DUI offender record.

5) If the offender refuses to sign, or refuses to present copies of other evaluations completed, written notice of that refusal shall be sent to the circuit court of venue or the Office of the Secretary of State and the evaluation will be terminated.

e) Written policies and procedures shall be established that protect the non-disclosure privilege of DUI offenders that, at a minimum, shall include provisions to ensure that no evaluation information shall be released to any party other than the DUI offender, the Illinois circuit court of venue or its court officials as

specified by local court rules, the Office of the Secretary of State or the Department without the written consent of the DUI offender. Any release of information relative to alcohol and drug treatment received by the DUI offender requires the written consent of the offender.

f) The evaluation shall be structured and scheduled in order to ensure that, prior to its completion, the following occurs:

1) collection of a comprehensive chronological history of substance use from first use to present, including alcohol, prescription and non-prescription drugs, and exposure to intoxicating compounds and illegal drugs, that specifies the frequency and patterns of use, type and amount of substance used and any change in the use or abuse pattern and the reason for the change;

2) a determination of the extent to which the substance use has caused marital, family, legal, social, emotional, vocational, physical and/or economic impairment;

3) an analysis of the offender's verbal description of:

A) alcohol and drug related legal history, driving history (all offenses), and any related substance use or chemical test results (blood alcohol concentration – BAC) and all substances used that resulted in all arrests, including the most recent DUI arrest;

B) past history of substance abuse evaluations, alcohol or drug treatment and/or self-help group involvement;

C) family history of substance abuse.

4) an analysis of:

A) objective test results from either the Driver Risk Inventory (DRI) or Mortimer/Filkens test;

B) the offender's current driving record as documented on the Alcohol/Drug Related Driving Offenses summary form from the Office of the Secretary of State or a copy of the actual Court Purposes driving abstract supplied to the circuit court of venue by the Office of the Secretary of State; and

C) the Law Enforcement Sworn Report (issued to the offender at the time of the arrest for DUI) that identifies the chemical test result BAC or the refusal to submit to chemical testing relative to the most current DUI arrest.

g) All information obtained during the evaluation shall be analyzed and the offender's risk to public safety shall be determined. However, such determination shall be considered an initial finding that may be subject to change when more comprehensive and definitive information is obtained from the offender during participation in any recommended intervention. The determination of risk shall be minimal, moderate, significant, or high as follows:

1) Minimal Risk

The offender has:

A) no prior conviction or court ordered supervisions for DUI, no prior statutory summary suspensions, and no prior reckless driving conviction reduced from DUI; and

B) a BAC of less than .15 as a result of the most current arrest for DUI; and

C) no other symptoms of substance abuse or dependence.

2) Moderate Risk

The offender has:

A) no prior conviction or court ordered supervisions for DUI, no prior statutory summary suspensions, and no prior reckless driving conviction reduced from DUI; and

B) a BAC of .15 to .19 or a refusal of chemical testing as a result of the most current arrest for DUI; and

C) no other symptoms of substance abuse or dependence.

3) Significant Risk

The offender has:

A) one prior conviction or court ordered supervision for DUI, or one prior statutory summary suspension, or one prior reckless driving conviction reduced from DUI; and/or

B) a BAC of .20 or higher as a result of the most current arrest for DUI; and/or

C) other symptoms of substance abuse.

4) High Risk

The offender has:

A) symptoms of substance dependence (regardless of driving record); and/or

B) within the 10 year period prior to the date of the most current (third or subsequent) arrest, any combination of two prior convictions or court ordered supervisions for DUI, or prior statutory summary suspensions, or prior reckless driving convictions reduced from DUI, resulting from separate incidents.

h) After the determination of risk, a corresponding intervention shall be recommended. However, that recommendation shall be viewed as the minimum necessary and, as such, not the determinate intervention. Any subsequent information relevant to the offender's substance use or arrest history discovered during the offender's participation in risk education, early intervention and/or treatment shall be considered pertinent in formulating a recommendation for further services necessary to reduce the offender's risk to public safety. Initially, the following interventions for each designation of risk shall be selected and recommended:

1) Minimal Risk

Successful completion of a minimum of 10 hours of DUI risk education as defined in Section 2060.505 of this Part.

2) Moderate Risk
Successful completion of a minimum of 10 hours of DUI risk education as defined in this Part; a minimum of 12 hours of early intervention as defined in Section 2060.401(a) provided over a minimum of four weeks with no more than three hours per day in any seven consecutive days; subsequent completion of any and all necessary treatment; and, after discharge, active ongoing participation in all activities specified in the continuing care plan, if so recommended following completion of the early intervention. This early intervention and any subsequent treatment shall be as specified in the ASAM Patient Placement Criteria and shall be conducted by an organization meeting the requirements specified in subsection (j) of this Section and Section 2060.401 of this Part.

3) Significant Risk
Successful completion of a minimum of 10 hours of DUI risk education as defined in this Part; a minimum of 20 hours of substance abuse treatment; and, upon completion of any and all necessary treatment, and, after discharge, active on-going participation in all activities specified in the continuing care plan. This treatment shall be as specified in the ASAM Patient Placement Criteria and shall be conducted by an organization meeting the requirements specified in subsection (j) of this Section and Section 2060.401 of this Part.

4) High Risk
Successful completion of a minimum of 75 hours of substance abuse treatment; and upon completion of any and all necessary treatment, and, after discharge, active on-going participation in all activities specified in the continuing care plan. This treatment shall be as specified in the ASAM Patient Placement Criteria and shall be conducted by an organization meeting the requirements specified in subsection (j) of this Section and Section 2060.401 of this Part.

i) A summary of the DUI evaluation, the assigned risk and the corresponding intervention shall be documented on the Department's Alcohol and Drug Evaluation Uniform Report, which is produced by the DUI Service Reporting System (DSRS). All sections of this form shall be complete and it shall be signed by the offender at the facility.

j) Upon completion of the evaluation, all offenders:

1) who need substance abuse treatment shall be referred for appropriate services to organizations licensed pursuant to the Act or to individuals who are otherwise licensed in Illinois or any other state to provide such services.

2) who need DUI risk education as defined in this Part shall be referred to such services licensed by the Department.

3) shall verify that they have been shown, prior to referral, a listing of organizations as specified in subsection (j)(1) and (2) of this Section,

unless an alternative process is established by court rule. The verification shall be on the Department's Referral List Verification Form.

k) The evaluation is complete when all of the above referenced information is obtained and the Alcohol and Drug Evaluation Uniform Report is signed by the offender.

1) The Alcohol and Drug Evaluation Uniform Report shall be provided directly to the circuit court of venue, unless another court repository is specified by court rule. A copy shall also be given to the DUI offender upon completion of payment or as otherwise specified in subsection (b)(2) of this Section.

2) If the offender will be requesting a judicial driving permit from the circuit court of venue, an Alcohol and Drug Evaluation Report Summary shall also be completed. This form is supplied by the Office of the Secretary of State and required by Section 6-201 of the Illinois Driver Licensing Law [625 ILCS 5/6-201] and should be sent directly to the circuit court of venue, unless another court repository is specified by court rule.

l) Evaluations shall be scheduled and completed so that the Alcohol and Drug Evaluation Uniform Report can be sent directly to the circuit court of venue at least five calendar days prior to the offender's court date, unless otherwise specified by court rule.

m) The evaluator shall be available to provide testimony relative to the DUI evaluation when summoned by the circuit court of venue, the Office of the Secretary of State or the DUI offender.

n) The circuit court of venue or the Office of the Secretary of State, whichever is applicable, shall be notified, within five calendar days, when a DUI offender does not complete an evaluation or refuses to sign the evaluation. Such notification shall also be made, within five calendar days, when an offender does not return to sign the evaluation after 30 calendar days from the last face-to-face contact. The information needed to complete the evaluation shall be communicated using the Department's Notice of Incomplete/Refused DUI Evaluation form.

o) In addition to meeting the provisions specified in Section 2060.325 of this Part, the following documents shall also be contained in the DUI offender's record:

1) a copy of the offender's Alcohol and Drug Evaluation Uniform Report and narrative information to support the conclusions summarized in this report and a copy of the Alcohol and Drug Evaluation Report Summary if the offender requested judicial driving privileges;

2) a copy of the Driver Risk Inventory (DRI) report or Mortimer/Filkens test;

3) documentation to support any subsequent change in risk assignment or intervention;

4) a copy of the Informed Consent Release form;

5) documentation of the offender's driving record and chemical tests results;

6) a copy of Notification of Incomplete or Refused Evaluation form, if applicable; and

7) a copy of the Referral List Verification form.

(Source: Amended at 25 Ill. Reg. 11063, effective August 14, 2001)

Section 2060.505 DUI Risk Education

a) The purpose of DUI risk education is to provide orientation to offenders regarding the impact of alcohol and other drug use on individual behavior and driving skills and to allow offenders to further explore the personal ramifications of their own substance use and abuse.

b) DUI risk education services shall be provided to any offender under the same terms and conditions regardless of ability to pay.

1) If an offender provides proof of indigence, in accordance with poverty guidelines established by the U.S. Department of Health and Human Services and published in the Department's annual Drunk and Drugged Driving Prevention Fund (DDDPF) billing manual, the organization providing the risk education may bill for reimbursement for such evaluation from the DDDPF. All such reimbursement shall be via a rate established by the Department and in accordance with the Department's most current fiscal year DDDPF billing manual.

2) Additionally, all reimbursement from the DDDPF is subject to availability of funds. Organizations shall have an alternative fee assessment and collection procedure for use should DDDPF funding not be available. However, if the reimbursement from the DDDPF or any additional fee assessed to the offender, as specified in subsection (b)(3) of this Section, has not been received by the completion of services, documentation of successful completion of risk education shall still be released to the appropriate circuit court of venue or the Office of the Secretary of State in accordance with this Section.

3) The organization may also assess a fee for the risk education to an indigent DUI offender when the organization's standard fee charged for risk education to a non-indigent DUI offender exceeds the rate of reimbursement provided by the Department. In such cases, the amount assessed to the offender shall not exceed the difference between the organization's standard fee and the Department's rate.

4) Any organization choosing not to submit reimbursement claims shall still provide services to indigent offenders in accordance with this Part.

c) The risk education curriculum shall include:

1) information on alcohol as a drug;

2) physiological and pharmacological effects of alcohol and other drugs, including their residual impairment on normal levels of driving performance;

3) other drugs, legal and illegal, and their effects on driving when used

separately and/or in combination with alcohol;

4) substance abuse/dependence and the effect on individuals and families;

5) blood alcohol concentration (BAC) level and its effect on driving performance;

6) information about Illinois driving under the influence laws and associated penalties;

7) factors that influence the formation of patterns of alcohol and drug abuse; and

8) information about referrals for services that can address any identified problem that may increase the risk for future alcohol/drug related difficulty.

d) Risk education courses shall include a minimum of 10 hours of classroom instruction, divided into at least four sessions held on different days. No session shall exceed three hours in length.

e) A pre-test and post-test shall be designed and administered to offenders to assess the effectiveness of the service and any increase in knowledge in the curriculum areas. The pre-test and post-test shall be submitted for review by the Department at the time of application for licensure or license renewal.

f) In order to successfully complete risk education, the offender shall attend each session in its entirety and in proper sequence and achieve a score on the post-test of at least 75%.

g) Upon successful completion, a DUI Risk Education Certificate of Completion shall be issued to each offender. The certificate is produced by the DUI Service Reporting System (DSRS). All sections of this form shall be complete and it shall be signed by the DUI Risk Education Instructor.

h) Audio-visual presentations shall not comprise more than 25% of the total class time.

i) No more than 24 participants shall be permitted in any one class session.

j) Written rules shall be developed and provided to each DUI offender upon enrollment, which address the following:

1) criteria for admission;

2) criteria for disqualification;

3) responsibilities of the DUI offender;

4) sobriety and drug-free requirements during class; and

5) course outline, content and class schedule.

k) Prior to enrollment in risk education classes, the DUI offender shall provide a copy of his or her completed Alcohol and Drug Evaluation Uniform Report indicating that risk education has been recommended.

l) The organization that provided the evaluation or, if applicable, treatment service shall be notified in the event that information is discovered or disclosed while the offender is in risk education that indicates the offender was not correctly evaluated and is in need of additional services. The notification shall also be made to the circuit court of venue or the Office of the Secretary of State, if

applicable.

m) The circuit court of venue or the Office of the Secretary of State, whichever is applicable, shall be notified, within five calendar days, when a DUI offender is involuntarily terminated from risk education. This information shall be communicated by using the Department's Notice of Involuntary Termination from DUI Risk Education form.

n) Each risk education instructor shall be available to provide testimony relative to the offender's participation in risk education when summoned by the circuit court of venue, the Office of the Secretary of State or the DUI offender.

o) In addition to meeting the provisions specified in Section 2060.325 of this Part, the following documents shall also be contained in the DUI offender's record:

1) a copy of the Alcohol and Drug Evaluation Uniform Report;
2) the pre- and post-test specifying percentage scores;
3) a copy of the DUI Risk Education Certificate of Completion;
4) a copy of Notice of Involuntary Termination from DUI Risk Education form, if applicable; and
5) a copy of any notification regarding a change in the risk level assignment and intervention.

(Source: Amended at 25 Ill. Reg. 11063, effective August 14, 2001)

Section 2060.507 Designated Program

a) The Department shall designate an organization (hereafter referred to as the designated program) to provide assessment and case management services for the Illinois courts. Such services are subject to the exemptions specified in Section 40-5 of the Act and are for any substance abuser who is charged with or convicted of a crime and who may elect treatment as an alternative to incarceration under the supervision of such organization pursuant to the provisions of Article 40 of the Act.

b) The designated program shall provide the services specified in this Section in a uniform manner to districts or circuits of the Illinois courts throughout the State either directly or by subcontract or referral.

c) The designated program shall have a written agreement with the Chief Judge of each circuit court receiving services from the program that identifies such services and specifies how they will be provided in relation to the operation of that specific court.

d) Assessment

1) The designated program shall conduct an assessment, in accordance with the provisions specified in Section 2060.417 of this Part, to determine if the offender is likely to be rehabilitated through substance abuse treatment.

2) The designated program shall obtain the offender's informed consent prior

to the provision of services.

3) The assessment shall include, at a minimum, collection of demographic data as specified in Section 2060.325(l) of this Part.

A) If it is determined that the offender has had a previous sentence of probation, the designated program shall request a statement from the relevant probation department.

B) This statement shall, at a minimum, summarize the offender's probation record, including, when available, known history of substance use, the identity of any treatment program utilized by the offender and any record of compliance with court ordered conditions.

4) Upon completion of the assessment, the designated program shall make a recommendation to the court relative to the offender's substance use and/or abuse and the likelihood of the offender's rehabilitation through substance abuse treatment.

A) Such notification to the court shall be made to the probation department during the offender's pre-sentence investigation, unless otherwise ordered by the court.

B) The designated program shall send written notification to the offender regarding the result of the assessment and its subsequent recommendation.

e) Case Management

1) The designated program shall provide case management services which will assist the offender with admission to treatment, assist the court in final dispositions, and assist treatment providers in identifying any special treatment needs the offender may have. At a minimum, such services shall include:

A) written notification to the court regarding the offender's initial or subsequent admission to treatment which shall include identification of the treatment program; address and telephone number; the name of the professional treatment staff assigned to the case; the name, address and telephone number of the designated program staff assigned to the case; and the date of the admission to treatment;

B) written monthly reports to the court relative to the offender's status in treatment; and

C) a written report summarizing the offender's treatment and rehabilitation upon discharge from the designated program.

f) The designated program shall have mutual linkage agreements with any treatment program utilized for referrals that ensures communication and documentation of offender progress in treatment.

g) The designated program shall identify all criteria that the offender shall meet in order to participate in the program and how such criteria will be used to measure

the offender's progress in treatment.

h) The designated program shall specify the method that will be utilized to intervene with an offender should such offender fail to comply with the program's criteria or those specified in the offender's treatment plan.

i) The designated program shall conduct all chemical test services in accordance with the provisions specified in Section 2060.415(a) of this Part.

j) The designated program shall document all court appearances, including any status or violation hearing and all decisions of the court and any subsequent required actions. Procedures shall be established to specify the activities required before, during and after any hearing and the staff responsible for such.

k) The designated program shall maintain offender records in accordance with the provisions specified in Section 2060.325 of this Part. In addition, each offender record shall include:

1) documentation of the offender's informed consent and any other consent to release information form;

2) the document which contains the results of the assessment, including psychological evaluation reports and prior treatment information that determined the offender's substance abuse problem and readiness for treatment;

3) a copy of the notification of assessment results and recommendations to the offender and the court;

4) copies of any other correspondence, court order or record of judicial proceedings related to the assessment or any other case management service;

5) documentation of admission to treatment and a copy of the notification to the court of such admission;

6) documentation of any chemical test results;

7) documentation of all court appearances;

8) written reports from the treatment provider relative to the offender's progress in treatment;

9) copies of any warning letters and/or jeopardy meeting reports;

10) copies of any case conference meeting report; and

11) copies of all documents related to the offender's discharge from the designated program.

l) Offender Discharge

1) The designated program shall establish standardized procedures for discharge of the offender from the designated program. Such procedures shall include, at a minimum:

A) the process for review of offender progress in treatment to determine if a change in status is justified;

B) the specific instances that would lead to a change in offender status and the procedure to be followed when such determination is made;

C) the process that will be followed when there is a judicial request to reassess a discharge offender; and

D) a process to ensure that proper notice is given to the courts and the offender prior to and upon successful or unsuccessful discharge.

2) The designated program shall send written reports of successful discharge to the court within ten calendar days after discharge. Such reports shall contain the offender's intended residency, if known, summary of treatment progress, and recommendations for any further treatment.

3) The designated program shall send written reports of unsuccessful discharge to the courts within three calendar days after discharge. Such reports shall contain the offender's intended residency, if known, instructions for continued contact between the designated program and the courts, and the specific reasons for the unsuccessful discharge.

Section 2060.509 Recovery Homes

Recovery Homes are alcohol and drug free housing components whose rules, peer-led groups, staff activities and/or other structured operations are directed toward maintenance of sobriety for persons who exhibit treatment resistance, relapse potential and/or lack of suitable recovery living environments or who recently have completed substance abuse treatment services or who may be receiving such treatment services at another licensed facility. In order to be called a Recovery Home, the home shall:

a) provide a structured alcohol and drug free environment for congregate living that shall offer regularly scheduled peer-led or community gatherings (self-help groups, etc.) that are held a minimum of five days per week and provide recovery education groups weekly;

b) have written linkage agreements with substance abuse providers in accordance with the provisions specified in Section 2060.329 of this Part;

c) establish a referral network to be utilized by residents for any necessary medical, mental health, substance abuse, vocational or employment resources, and maintain the confidentiality of client identifying information in accordance with 42 CFR 2 (Confidentiality of alcohol and drug abuse patient records);

d) establish a budget that specifies monthly operating expenses and demonstrates sufficient income to meet these expenses plus emergency reserve by providing documentation of access to a minimum sum equivalent to the total of two months of operating expenses;

e) comply with all applicable zoning and local building ordinances and the provisions specified in Chapter 26 (Lodging or Rooming Houses) of the National Fire Protection Association's (NFPA) Life Safety Code of 2000 (no later amendments or editions included) for any building housing 16 or fewer residents and with the provisions specified in Chapter 29 (Existing Hotels and Dormitories) of the NFPA Life Safety Code of 2000 (no later amendments or editions included) for any building housing 17 or more residents;

f) maintain fire, hazard, liability and other insurance coverages appropriate to the administration of a recovery home;

g) employ at least one full-time Recovery Home Operator who is responsible for the daily operations at the Recovery Home (i.e., fiscal, personnel, rule compliance, etc.) who shall:

1) either:

A) hold clinical certification from IAODAPCA or receive that certification within two years after the date of employment; or

B) hold certification as a National Certified Recovery Specialist (NCRS) as specified by the Association of Halfway House Alcohol Programs (AHHAP), RR 2 Box 415, Kerhonkson NY 12446

C) have a minimum of 2000 hours of work experience or 4000 hours of volunteer experience in the field of substance abuse of which 1500 hours shall have been in direct Recovery Support Systems Services (i.e., Residential Extended Care Facility or Recovery Home); and

2) provide three letters of recommendation from substance abuse professional staff as defined in Section 2060.309 of this Part; and

3) provide a signed and dated acceptance of the Code of Ethics as established by the Illinois Association of Residential Extended Care Programs, Box 269180, Chicago, Illinois 60626, website: AHHAP.org; and

h) have on-site at least one Recovery Home Manager who oversees all Recovery Home activities under the direction of the Recovery Home Operator. Recovery Home Managers shall:

1) hold certification as a National Certified Recovery Specialist (NCRS) as specified by the Association of Halfway House Alcoholism Programs of North America, Inc. (AHHAP), RR2 Box 415 Kerhonkson NY 12446, or receive such certification within two years after the date of employment; or

2) hold certification from IAODAPCA or receive the certification within two years after the date of employment; or

3) have a minimum of 1000 hours of work experience or 2000 hours of volunteer experience in the field of substance abuse of which 750 hours shall have been in direct Recovery Support Systems Services (i.e., Residential Extended Care Facility or Recovery Home) and provide a signed and dated acceptance of the Code of Ethics as established by the Illinois Association of Residential Extended Care, Box 269180, Chicago, Illinois, 60626, website: AHHAP.org.

The Recovery Home Operator may also function as the Recovery Home Manager as long as the requirements for both positions are met.

(Source: Amended at 27 Ill. Reg. 13997, effective August 8, 2003)