Behavior Health Department

A Division of the Lawrence County Health Department
Serving the Citizens of Lawrence County and Surrounding Counties
Since 1943

11362 Country Club Rd.
Lawrenceville, IL 62439
618-943-3302, option #3

WELCOME TO BEHAVIOR HEALTH

LAWRENCE COUNTY HEALTH DEPARTMENT

We would like to share with you some information about our agency that may help make your visits more beneficial. Please take a moment to review the following information.

Your counselor's name is _____ and can be reached at (618) 943-3754.

Our office hours are as follows:

Monday, Wednesday and Friday from 8:00 am – 4:00 pm. Tuesday and Thursday from 8:00 am- 6:00 pm.

Your counselor does not necessarily keep the above schedule, however, counseling staff is available to you at this office for those time listed above. If you need a counselor after hours, you may call (618) 943-5766.

During your time with a counselor, it will be necessary to gather information from you in addition to the forms you have just completed. You will also work with your counselor on goals and a plan of treatment that will be reviewed regularly. Your session with your counselor can last up to 50 minutes. Please help your counselor with this time frame in order to better serve all clients.

During treatment, and after your case is closed, you will receive a questionnaire and/or phone call for follow up and your opinion of treatment. Please complete this and return it to our agency so we may improve on our services.

Thank you for your time. If you have a difficulty while you are at our agency, please feel free to talk to me. Also available for your convenience are grievance forms as well as a suggestion box. These will be reviewed regularly to ensure your quality of care. While you are visiting LCHD-BH, we strive to ensure the safety of all of our clients and staff. If there is a concern, please feel free to tell any staff member and we will make every attempt to correct the issue in a timely manner.

Sincerely,

Alesha Allen, LCSW
Director of Behavior Health

Lawrence County
Health Department

BEHAVIOR HEALTH

11362 Country Club Rd.
Lawrenceville, IL 62439
618-943-3302, option #3

(618) 943-5766 After Hours Crisis Line
(618) 943-2901 Ivy Center

BEHAVIOR HEALTH DEPARTMENT'S HOURS OF OPERATION

.

Monday, Wednesday, Friday 8:00 a.m. – 4:00 p.m.
Tuesday, Thursday 8:00 a.m. – 6:00 p.m.

STATEWIDE COORDINATOR OF DEAF AND HARD OF HEARING SERVICES
DEPARTMENT OF HUMAN SERVICES / OFFICE OF MENTAL HEALTH

(618) 943-5769 TTY / (800) 526-0857 Relay Services

LAWRENCE COUNTY HEALTH DEPARTMENT SERVICES

Behavior Health (618) 943-3754
Group and Individual Outpatient Counseling for Adults, Adolescents and Children
Crisis Intervention Services, Psychosocial Rehabilitation (The Ivy Center), Substance Abuse Counseling

Home Health Agency (618) 943-4663
Local Highly-Skilled Registered Nurses and C.N.A. Staff for All Your Home Healthcare Needs

Rural Health Clinic (618) 943-2609
Gary Carr, M.D. along with Certified Family Nurse Practitioner Kimothy Fulk, A.P.N.

Environmental Health (618) 943-3302
Water Testing, Food Sanitation, Private Sewage Inspection, Nuisance Abatement

WIC: Women, Infants and Children (618) 943-3302
Immunizations (Including Flu), Prenatal, Teen-Parent Services, Prevention Education, Family Planning

Other Services (618) 943-3302
Communicable Diseases Education & Prevention, Blood Pressure Screening / Smoking Cessation, Cholesterol & Blood Sugar Testing, Emergency Preparedness and More…

CANCELLATION POLICY

If you are unable to keep your appointment, please phone our office as early as possible to prevent scheduling difficulties. You have made an important step toward your goals and attending your appointment is vital to your progress. Failure to cancel appointments may affect the delivery of services and result in $5.00 fee.

Lawrence County
Health Department
Behavior Health

Consent/Authorization for Treatment

1. I hereby authorize the employees or designees of the LCHD/BH to provide the service indicated but not limited to the following:

◊ Outpatient Therapy/Counseling
◊ Case Management Services
◊ Crisis Intervention/Stabilization
◊ Psychiatric Services/Evaluation/Monitoring
◊ Referral Services
◊ Psychosocial Rehabilitation Services (PSR)
◊ Community Support Services
◊ Substance Abuse Treatment

2. I understand that this authorization for treatment is subject to revocation at any time by request and will automatically expire upon termination of treatment and will be reviewed annually.

3. I authorize the release of any information required in the process of applications for financial coverage for the services rendered. This authorization provides that information may be released related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent. Payment will be made directly to the LCHD for treatment and/or services provided.

4. I agree to pay all charges from the date of admission to the date of discharge at the time services are rendered unless special provisions have been made.

5. For cancellations, LCHD/BH may contact me at the number(s) listed in CIS to cancel my appointment. The staff (◊ may ◊ may not) identify themselves as center staff personnel. (noted in CIS if NOT).

I have read and understand the consent/authorization stated above.

Consent expires one year from signature date.

Client Signature is found in Electronic Medical Record (CIS) on Consent Form.

Lawrence County
Health Department
Behavior Health

Mental Health and Substance Abuse
Orientation Statement

This is a statement to verify I have been given written and/or oral information regarding the procedures and practices of this agency while I may be receiving services and that I understand the implications of these. The areas of information include, but may not be limited to, the following:

Statement of Rights
Confidentiality/HIPAA
Grievance Procedures
Code of Ethics
Quality of Care
Access to After Hours Services
Financial Obligations
Cancellation/No Show Policy
Emergency Exits
Safety Practices Including De-escalation Intervention, Smoking, Alcohol, Drugs, Weapons and Aggression
Restrictions
Advanced Directives
Process and Purpose for Assessment, Treatment and Discharge Planning
Consumer Empowerment Efforts
AIDS/HIV Education
Tuberculosis (TB) Education
Infectious Disease Precaution
Restrictions to Programming
Regaining Lost Rights in Programming
Achievement of Outcomes
Transition/Referrals/Completion Procedures
Client Satisfaction

Client Signature is found in Electronic Medical Record (CIS) on Consent Form.

Lawrence County
Health Department
Behavior Health

Department of Human Services
Consent for Disclosure

The Department of Human Services (DHS) may pay for some or all of the costs of your community mental health services. If DHS is to pay for these services, the Lawrence County Health Department (LCHD) must report certain personal information to the Department of Human Services. If you do not want the LCHD to report this information, you may decline to be a recipient of DHS funding. If you do not decline, the LCHD will report all of the following information to the Department of Human Services:

- Your full name (first, last, and middle initial)
- Your social security number
- Your birth date
- Your gender (male, female)
- Your county of residence
- Your household income and size of family
- All mental health services for which the LCHD expects payment

To **ACCEPT** being considered as DHS client

I **CHOOSE** to have the Lawrence County Health Department bill DHS for my services, and I understand the above information will be reported to the Illinois Department of Human Services.

To **DECLINE** being considered as a DHS client

I **DO NOT** choose to have the Lawrence County Health Department bill DHS for my services, I understand the information will **NOT** be reported to the Illinois Department of Human Services. I further understand in declining to bill DHS, I will be charged full fee for services rendered.

Client Choice & Signature is found in Electronic Medical Record (CIS) on Consent Form.

Lawrence County Health Department Financial Policies

(Rural Health Clinic, Home Health Agency, Behavior Health, & Public Health)

Thank you for choosing the Lawrence County Health Department as your healthcare provider. We are committed to providing you with quality care. The following is our Financial Policy which we require you to read and sign prior to any treatment.

Payment Policy & Delinquent Accounts

Please understand payment of your account is considered your responsibility. On an annual basis all patients must complete our registration and insurance form before services are rendered. All co-pays and/or deductibles are due at the time of service prior to treatment. Upon request, you may complete the required paperwork to determine eligibility for the Discounted Sliding Fee Schedule. A $20.00 fee will be assessed for all returned checks. Should we receive more than one returned check from you, a check will no longer be considered as a valid form of payment.

Missed Appointments

As a courtesy, we ask that you notify our office as soon as possible if you are unable to keep your scheduled appointment. A minimum 24 hour notice is preferred. In the event you have had three (3) or more missed/no show appointments you may be dismissed from our practice. A $5.00 late fee may be assessed for missed appointments without proper notification. Payment of any late fees assessed must be paid prior to being seen for future appointments.

Insurance

We may accept assignment of insurance benefits; however, the balance is your responsibility whether your insurance company pays or not. Your insurance policy is a contractual agreement between you and the insurance company. We are not a party to the contract. It is your responsibility to get the correct insurance information to us at the time of visit. If incorrect information is given or withheld, resulting in delayed payment, the balance then becomes the patient's.

Our practice is committed to providing the best treatment for our patients. We charge usual and customary fees for our area. Your signature authorizes our office to bill and receive payment directly from your insurance company for services rendered by the Lawrence County Health Department.

Divorce Decrees & Minors

The Lawrence County Health Department is not a party to your divorce decree. Adult patients are responsible for their bill. Subsequently the responsibility for minors rests with the accompanying adult at the time of service.

Collection Agency

If payment arrangements are not honored, we reserve the right to turn any balance older than 90 days over to our collection agency. If the account is assigned to a third party collection agency for collection, please understand a collection charge of 25% of the unpaid balance at the time of assignment will be added to the account to cover the cost of collection and administrative fees. I agree to pay this collections charge, plus interest, court costs and attorney fees if applicable.

I have read the financial policies and my signature indicates my understanding and awareness of these policies.

Client Signature is found in Electronic Medical Record (CIS) on Consent Form.

Lawrence County
Health Department

Behavioral Health Department
11362 Country Club Rd.
Lawrenceville, IL 62439
618-943-3302, option #3

Consumer Empowerment Efforts

To: Concerned Consumers, Family Members, and Friends

The Illinois Department of Human Services (DHS) Office of Mental Health is seeking input from the consumers or clients of the mental health system.

This means that any client, client's family members or concerned friend(s) is welcomed and encouraged to attend the planning meetings that are held regarding mental health services in our state.

If you, your family or your friend(s) are interested, there are two different groups that meet. You may attend and participate in these meetings.

1. Southern Network: Includes the 33 southern counties of Illinois and deals with mental health services for adults.
2. Consumer Council: Focuses on local mental health needs addressed by this agency.

If you are interested and would like more information regarding dates and location of the above, feel free to ask or call us at (618) 943-3754.

Sincerely,

The Clinical Staff
Lawrence County Behavior Health Department

Serving the citizens of Lawrence County and surrounding counties since 1943.

Lawrence County
Health Department
Behavior Health

Statement of Rights

1. You have the right to maintain all of your legal and civil rights. You have the right to be free from abuse, neglect and exploitation.
2. You have a right to receive all services regardless of your race, color, ethnicity, national origin, personal or social creed, disability, age, sexual orientation, religion, HIV status, marital status, financial status or criminal record related to present dangerousness.
3. You have the right to have disabilities accommodated as required by the Americans with Disabilities Act, Section 504 of the Rehabilitation Act and the Human Rights Act [775 ILCS 5].
4. You have the right to adequate and humane care and services in the least restrictive environment available and that service be provided by clinical staff operating within the framework of an accepted (e.g., NASW, or APA, CIC) code of ethics.
5. You have a right to communicate with other people in private, without obstruction or censorship by agency staff. These rights include communication by mail, telephone and visitation.
6. You have the right to have all information concerning you kept confidential in accordance with Mental Health and Developmental Disabilities Code (405 ILCS 5), the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110), and the Notice of Privacy Practices According to HIPPA, including:
   A. To be asked to sign a written consent form or give oral/verbal consent if not possible before any information is shared by the agency and to revoke any written consent by informing the agency in writing.
   B. To be informed of the exceptions to confidentiality including court order of records, duty to protect you and others form harm, and the Child Abuse and Neglect mandated reporting status of agency staff.
   C. To be aware of the limited waiver of confidentiality of records when choosing a third party payment source.
7. You have a right to withhold informed consent regarding treatment and confidential information pertaining to you.
8. You have a right to confidentiality regarding HIV/AIDS status and testing as set forth by the AIDS Confidentiality Act (410 ILCS 305).
9. You have the right to contact the public payer (IL Medicaid, Medicare) or its designee and to be informed of the public payer's process for reviewing grievances.
10. You have the right to your personal property.
11. You have the right to review your clinical record and to view or receive copies of selected policies and procedures, grievance procedures and codes of ethics.

Client ID#: _____

12. You have the right to participate in the development of your individualized treatment plan and to participate in any treatment team staffing regarding yourself.
13. Your rights shall be protected with the Illinois Administrative Code and the use of seclusion or restraint shall not be permitted.
14. You have the right to refuse treatment or any specific treatment procedure unless such services are necessary to prevent serious harm to yourself or others. You have the right to be informed of the consequences resulting for exercising any of your rights.
15. Justification for any restriction of your individual rights shall be documented in your individual record.
16. You have the right to express any grievance and to appeal adverse decisions of this agency in writing up to and including the Board of Health. The Board of Health's decision on the grievance shall constitute a final administrative decision and shall be subject to review in accordance with the Administrative Review Code.
17. You have the right to be free from physical, fiduciary and psychological abuse or neglect and to be treated with dignity and respect. Any incidents of abuse or neglect should be reported to the Illinois Department Office of Inspector General for investigation.
18. You have the right to report any infringements of your rights to the following agencies:

Department of Human Services Division of Mental Health
319 East Madison, Suite 3B
Springfield, IL 62701
(217) 782-6470

or

100 W. Randolph Street, Suite 6-400
Chicago, IL 60601
(312) 814-3785

Equip for Equality, Inc.
20 N. Michigan Ave.
Chicago, IL 60602
(312) 341-0022

Guardianship and Advocacy Commission (GAC)
Egyptian Regional Authority
#7 Cottage Drive
Anna, IL 62906-1669

Division of Alcohol and Substance Abuse
100 West Randolph St., Suite 5-600
Chicago, IL 60601
(312) 814-3840

Office of Inspector General
(800) 368-1463

19. You have the right to require agency staff assistance in contacting the above agencies.
20. You shall not be denied, suspended or terminated form services or have services reduced for exercising any of your rights.
21. You shall receive a copy of the "*Notice of Privacy Practices"* in accordance with the Health Insurance Portability and Accountability Act.
22. You have the right to participate in the alcohol/drug evaluation/education process.
23. You have the right to notification of termination for cause from the DUI Risk Education Program.
24. You have the right to contact our office for Crisis Services. When our office is closed you may reach our After-Hours Crisis Line services by calling 911. Give your first name and phone number and a counselor will call you back.

25. Clients are expected to attend scheduled sessions. If you are unable or unwilling to attend your session, you are expected to notify our agency at least 24 hours in advance**. <u>You will be charged a $5.00 fee for failure to show or late cancellation (less than 24-hour notice).</u>** No future appointments will be made until all no-show fees are paid. Advance notice helps our staff use their time better to accommodate the many people who desire appointments. Failure to participate regularly may result in termination of services.
26. The Firearm Concealed Carry Act (PA 98-063) mandates clinicians, mental health facilities and qualified examiners to report persons who they believe pose a "clear and present danger" to themselves or others. If a client is assessed to pose a “clear and present danger, the clinicians will first call 911 to report the assessed danger to local emergency services. The clinician will follow any instructions given by local authorities. The clinician will follow standard crisis procedures as outlined in Section III.H. Finally, a report will be made to the Firearm Owner Identification (FOID) Mental Health Reporting System.

Note: *Services may be discontinued for a recipient in cases where 1) the recipient’s conduct poses a risk to the well-being of agency personnel and/or agency clientele and 2) the recipient refuses to pay for service (this does not include inability to pay due to lack of financial means). Lastly 3) the agency reserves the right to refuse services for reasons that the Administrator or Director of Behavior Health deems necessary.*

Should you be restricted from services, your service provider, along with the Director of Behavior Health will devise a plan for you to follow in order to begin receiving services again with this agency. This plan will be based on each individual.

This information was explained to the client by means of ( ) verbal ( ) written ( ) American Sign Language) expression.

I have read this Statement of Rights or have had it read and explained to me and understand the content. A copy of these rights and the “Notice of Privacy Practices” have been provided to me*.*
Client Signature is found in Electronic Medical Record (CIS) on Consent Form.

Lawrence County
Health Department
Policy and Procedure

Client Grievance

Policy:

It is the policy of the LCHD to provide all clients with the right to present grievances to the LCHD about their treatment and to have their grievances acted upon. The client and the Health Department staff shall go through all of the procedure steps in the event of a client grievance.

Procedure:

1. The client's written grievance will be presented to the Service Provider. The Service Provider shall meet with the client within 10 working days of the grievance in an effort to come to a resolution.
2. If there is no agreeable resolution, the client may present his/her written grievance to the Program Director. The Program Director will meet with the client within 10 working days in an effort to come to a resolution.
3. If there is no resolution, the client may present his/her written grievance to the Administrator. The Administrator will meet with the client within 30 calendar days in an effort to resolve the grievance.
4. If the Administrator is unable to resolve the grievance, the Administrator shall present the written grievance to the Board of Health at their next scheduled meeting. The decision of the Board of Health shall be final.
5. Every step in the grievance process is documented by the appropriate staff member, up to and including, grievances that are sent to the Board of Health for resolution.
6. The Board of Health shall be informed of all alleged human rights violations and all alleged incidents of abuse or neglect.
7. The administration will use all client grievances, whether resolved or unresolved, as information for potential modifications in programming services.
8. Client grievance will be maintained in a grievance file including all actions or decisions taken the final resolution.
9. All grievances will be held confidential and no negative consequences may be placed against the client or significant others for exercising their client rights.
10. A review of grievances on file shall be conducted and utilized for identifying trends and/or performance improvement.

Lawrence County
Health Department
Behavior Health

Grievance Form

Name(s) of Grievant: _____

Address: _____

Phone: _____ Date of Form Completion: _____

Nature of the Grievance:

_____

_____

_____

_____

_____

_____

Requested Resolution:

_____

_____

_____

Signature of Grievant: _____

Grievant's Representative (If Applicable) _____

Address: _____ Phone: _____

Client ID#: _____

Lawrence County
Health Department
Behavior Health

4 Stage Grievance Process

Stage 1

To:_____
(Grievance Filed With)

Date Filed:_____

Received By: _____

Stage 2

To: _____
(Department Supervisor)

Date:_____

Resolution:_____

_____

_____

_____

Stage 3

To: _____
(Administrator)

Date:_____

Resolution: _____

_____

_____

_____

Stage 4

To: _____
(Board of Health)

Date: _____

Resolution: _____

_____

_____

_____

Client ID#: _____

(Version 9-1-13)

The Lawrence County Health Department

Notice of Privacy Practices

This Notice of Privacy Practices describes how medical information about you may be used and disclosed; and how you can get access to this information. Please review it carefully.

If you have questions about this Notice, please contact our office.

Who Will Follow This Notice

This "Notice of Privacy Practices" (aka Notice) describes the privacy practices of the Lawrence County Health Department (aka Department) and those of:

- Any health care professional authorized to enter information into your medical chart.
- All divisions and units of the Department, and the operations the Department outsources to certain of our business partners, as well as their Business Associates.
- All of our workforce, employed or otherwise.

All these entities, sites and locations follow the terms of this Notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment or operations purposes described in this Notice.

Our Pledge Regarding Medical Information

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at our facilities. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by us. Your hospital or other physicians may have different policies or notices regarding the use and disclosure of medical information they create.

This Notice will tell you about the ways in which we may use and disclose medical information about you. It also describes your rights, and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept private;
- Make available to you this Notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the Notice that is currently in effect. This Notice may change, in the manner described below under "Changes to This Notice."

The following categories describe different ways that we use and disclose your medical information (also known as Individually Identifiable Health Information (IIHI) and/or Protected Health Information (PHI)). For each category of use or disclosure, we provide examples, but not every use or disclosure in a category is listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- **For Treatment**
  We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you. For example, we may forward your records to another specialist to assure that you receive proper care. Also, if you were referred to us by another health care provider, it is likely that we will report back to that provider with information about our diagnosis and plan for treatment.

  We may disclose medical information about you to people outside the Department who may be involved in your medical care, such as family members, close friends, clergy or others we use to provide services that are a part of your care. For instance, from time-to-time we may receive calls from concerned family members or close friends to determine if a patient has completed his or her appointment. Unless you have advised us otherwise, in writing, we will let them know your current status with our office. In addition, at some time, it may be necessary for our staff to reach you by telephone in regard to your appointment. Unless otherwise notified by you in writing, we will contact you using numbers you have provided and we may have to leave a voicemail message for you. In certain circumstances, care givers from nursing homes, assisted living centers, etc. will bring a patient to our facility. Often these care givers are exposed to that patient's personal health information.

- **For Payment**
  We may use and disclose medical information about you so that the treatment and services you receive from us may be billed to and collected from you, an insurance company or health plan or other third party. For example, we may need to give your health plan specific information about treatment you received at our office so your health plan will pay us or reimburse you for the treatment. In addition, we, or our representatives, may discuss payment issues with family members or others involved in the process of paying for medical treatment you have received. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. We may have our bills and payment arrangements outsourced to one or more third-party service providers who issue, process and collect bills on our behalf. Each of these is governed by the same health care information disclosure and confidentiality laws that we must follow.

- **For Health Care Operations**
  We may use and disclose medical information about you for our Department operations. These uses and disclosures are necessary to run our Department and make sure that all our patients receive quality care. For example, we may use medical information to review our treatment and services, and to evaluate the performance of our staff in caring for you. We may also combine medical information about many of our patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technologists, medical students, and other members of our staff for review and learning purposes.

- **Treatment Alternatives**
  We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

- **Business Associates**
  On occasion the Department may use outside organizations to provide business services. Business Associates that will be exposed to your health information are required to comply with

all the same HIPAA administrative, physical and technical safeguard requirements that apply to the Department. Also, if the business associate contracts with a third party, they too must comply with all HIPAA rules.

- **As Required By Law**
  We will disclose medical information about you when required to do so by federal, state or local law.

- **To Avert A Serious Threat To Health Or Safety**
  We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety, or the health and safety of the public, or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

- **Special Situations**
  We may also use and disclose medical information about you in the situations described under "Special Situations," below.

Other Uses Of Medical Information

Other uses and disclosures of medical information not covered by this Notice, or the laws that apply to us, will be made only with your written authorization. A form for such authorizations, both those that you request and those that we request, is available from our office. If you give us an authorization, you may later revoke that permission in writing at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. In that case, however, we will be unable to take back any disclosures we have already made with your permission, and we will still be required to retain our records of the care that we provided to you.

Special Situations *(Including but not limited to…)*

Military and Veterans

If you are a member of the armed forces, we may release medical information about you as required by military command authorities, or in some cases, if needed to determine benefits to the Department of Veterans Affairs.

Public Health Risks

We may disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability;
- To report births and deaths;
- To report child abuse or neglect;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and/or
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure when required or authorized by law.

Health Oversight Activities

We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Immunization Reporting

The Department may disclose proof of immunization to a school where law requires a school to have such information. Written authorization for this disclosure is not required, however, the Department will obtain agreement to this release, which may be oral, from a parent, guardian or other person acting in *loco parentis* for the individual, or from the individual himself or herself, if the individual is an adult or emancipated minor.

Outside Use

It is a violation of Department Policy to use patient PHI for Marketing, Research or to sell PHI in any way. Under no circumstances will the Department engage in these activities.

Fundraising

It is a violation of Department Policy to use patient PHI for fundraising purposes. The Department will not contact patients to conduct fundraising activities using PHI as a source of identification.

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement

We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at our practice; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors

We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

Decedents

A decedent's PHI is protected for 50 years after the individual's death. After that point, the information is no longer considered PHI.

National Security, Intelligence and Federal Protective Service Activities

We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law, and to authorized federal officials where required to provide protection to the President of the United States, other authorized persons or foreign heads of state or conduct special investigations.

Inmates

If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official where necessary for the institution to provide you with health care; to protect your health and safety or the health and safety of others; or for the safety and security of the correctional institution.

Your Rights Regarding Medical Information About You

You have the following rights regarding medical information we maintain about you:

- **Right to Inspect and Copy**

  You have the right to inspect and request a copy of medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes.

  You may request an electronic copy of your PHI that is maintained electronically. The Department will provide an electronic copy in the form requested, if readily producible, or if not, in a readable electronic form and format as agreed by you and the Department.

  You must submit any request to inspect and copy your medical records to our staff, in writing. (A form for that request is available from our office.) If you request a copy of your information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

  We may deny your request in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another health care professional chosen by our staff will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of that review.

- **Right to Amend**

  If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our Department. You must submit any request for an amendment to our staff, in writing. (A form for that request is available from our office.) Your written request must provide a reason that supports your request.

  We may deny your request for an amendment if it is not in writing, or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

  - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the medical information kept by or for our Department.
  - Is not part of the information which you are permitted to inspect and copy; or
  - Is accurate and complete.

- **Right to an Accounting of Disclosures**

  You have the right to request an "accounting of disclosures." This is a list of the disclosures we have made of medical information about you, with some exceptions. The exceptions are governed by federal health privacy law, and may include:

  - Many routine disclosures for treatment, payment and operations; and
  - Disclosures to you.

  You must submit any request for an accounting of disclosures to our office, in writing. (A form for that request is available from our office.) Your written request must state a time period, which may not be longer than six years. The first report you request within a 12-month period will be free. For additional reports, we may charge you for the costs of providing the report. We will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions**

  You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right

to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a medical service you received. Also, you have the right to designate a personal representative who will then have the ability to access your personal health information, just as you do. You may also ask us to be selective in the way we communicate personal health information to you. For example, you may request that we not contact you by telephone at your office or you may designate a mailing address other than your home. Such requests must be made in writing. (A form for such requests is available from our office.) Please note that we are not required to agree to your requests. However, if we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

You have the right to restrict the disclosure of PHI (for payment or health care operations) to a health plan when you pay out-of-pocket, in full, and request such a restriction. The Department must honor such a request unless otherwise required by law. This restriction does not apply to follow-up visits if they are not paid for in full out of pocket.

You must submit any request for restrictions to our staff, in writing. (A form for each request is available from our office.) Your written request must tell us:

- What information you want to limit;
- Whether you want to limit our use, disclosure or both; and
- To whom you want the limits to apply, for example, disclosures to your spouse.

- **Right to a Paper Copy of This Notice**
  You may ask us to give you a paper copy of this "Notice of Privacy Practices" at any time by contacting our office.

- **Right to Receive a Breach Notice**
  Should the Department experience an impermissible use or disclosure of PHI and that exposure poses a significant risk of financial, reputational, or other harm to an individual, the Department will provide individual notice to all persons affected by the breach.

- **Complaints**
  If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our office. (A form for this purpose is available from our office.) You will not be penalized for filing a complaint.

The Lawrence County Health Department's Right to Make Changes to This Notice

The Department reserves the right to change this Notice. When we do, we may make the changed Notice effective for medical information we already have about you, as well as information we receive in the future. We will post a copy of the current Notice in our facilities. Each Notice will contain on the first page, in the top right-hand corner, its effective date. Also, each time you register at our office for medical services, a copy of the current Notice in effect will be available to you in the waiting area.

State of Illinois
Department of Human Services

Authorization to Disclose/Obtain Information

(1) I authorize _____ to ☐ disclose ☐ obtain ☐ disclose and obtain
(Hospital/Agency/Individual)

(2) ☐ Discharge Summary ☐ Discharge Staffing ☐ Psychiatric Evaluation ☐ Social History ☐ History and Physical
☐ Treatment/Hab Plans ☐ Assessments (Specify Type) _____ ☐ Physicians Orders
☐ Med. Administration Records ☐ Progress Notes ☐ Behavioral Plans ☐ Consultations ☐ Lab/X-Ray
☐ Photos ☐ Record Abstract ☐ Patient Review ☐ Other (specify) _____

Concerning the care of the below named person from DATE (or RANGE OF DATES): _____

(3) About (Name) _____ Social Security Number: _____
Date of Birth: _____ Alias: _____

(4) For purposes of: ☐ Personal Use ☐ Continuity of Care ☐ Placement Transfer ☐ Financial/Benefits
☐ Attorney ☐ State Law/Court ☐ Death ☐ Other (specify) _____

(5) Information may be disclosed/obtained: Mail, In-Person, Phone, E-Mail or by Fax (For Urgent/Emergency Needs).
Restrictions if any: _____

(6) ☐ Disclose To	☐ Obtain From
Name:	Name:
Address:	Address:
City/State/Zip:	City/State/Zip:

(7) This authorization is valid until calendar date: _____ (Month) _____ (Day) _____ (Year)

(8) It is my full understanding that the records and communications to be disclosed WILL include sensitive information such as evaluation, habilitation/treatment information for mental health, developmental disabilities, alcohol or substance use/abuse or HIV/AIDs. **CHECK BELOW FOR EXCLUSION ONLY.**
☐ Alcohol/Substance Abuse ☐ Mental Health ☐ Developmental Disabilities
☐ HIV/AID's ☐ Other (specify) _____

(9) I understand that the above-named agency/facility/person authorized to receive this information has the right to inspect and copy the information disclosed. I further understand that if the entity receiving this information is not a healthcare provider/ plan covered by HIPAA privacy regulations, the information described above may be re-disclosed and no longer protected by the HIPAA Regulations.

(10) I understand that I may revoke this authorization; however, the revocation must be in writing and must be sent/given to the facility record's department. I understand that no revocation of this authorization shall be effective to prevent disclosure of records and communications until it is received by the person otherwise authorized to disclose records and communications.

(11) Refusal to sign this form will result in the following consequences: INFORMATION WILL NOT BE DISCLOSED/OBTAINED.

(12) _____ _____
Signature of individual (age 12 or older) Date/Time

(13) _____ _____
Signature of parent/guardian (Under 18 or Disabled) Date/Time

(14) _____ _____
Witness OR (2nd parent/guardian, if co-custodial, may sign here) Date/Time

(15) _____ _____
Signature of staff person disclosing/obtaining information Date/Time:

Specific information about disclosures and dates shall be documented in the individual's clinical record or Disclosure Tracking System.
A facsimile of this original shall have the same force and effect as the original.

The Standards for Privacy of Personally identifiable Health Information, 45 CFR Parts 160 and 164, states that information used or disclosed pursuant to this authorization may be subject to a re disclosure by the recipient of the information. The federal confidentiality Rules 42 CFR Part 2 prohibit making any further disclosure of drug or alcohol information unless further disclosure of this information is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 1. A general authorization for the release of medical or other information DOES NOT restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient (52FR21809, June 9, 1987; 52 FR4 1997, November 2, 1987)

NOTE: Your refusal to sign an Authorization to Disclose/Obtain Information will not prevent treatment, payment, or enrollment in a health plan or eligibility for benefits

State of Illinois
Department of Human Services

Authorization to Disclose/Obtain Information

INSTRUCTIONS: Authorizations to Disclose/Obtain Information

(1) Identify whether the form will be used to disclose, to obtain or to disclose/obtain (share) information and whom you are authorizing to perform this function.

(2) Check the specific information you wish to disclose/obtain. Check only what is the minimum necessary to fulfill the purpose of disclosure. Enter a service date - if unknown, indicate "last service date" and only checked information from last service dates will be released or obtained.

(3) Complete the individual's name, date of birth, social security number and aliases or a maiden name to help correctly identify the individual.

(4) Check the purpose or reason why the information needs to be disclosed/obtained.

(5) Circle all manners which the information may be disclosed/obtained. If you wish to restrict any of these, please specify. If nothing is specified, all manners of release will be considered authorized. (Information will only be faxed if URGENT.)

(6) Complete the name and address of the agency, facility or person to whom you will disclose the information or complete the name and address of the agency, facility or person from whom you are obtaining the information. If you wish it to be phoned or faxed, include area code and numbers.

(7) Complete the calendar date (month, day and year) on which this authorization will expire. Information cannot be disclosed/obtained without a specific date of expiration.

(8) Sensitive information will be released/obtained unless you specifically check an exclusion. **If no items are checked all information within the patient record is subject to disclosure.**

(9) Self-explanatory.

(10) Self-explanatory.

(11) Self-explanatory.

NOTE: In accordance with federal and state privacy laws only the following persons shall be entitled to consent in writing to the inspection, copying and/or the release of the individual's protected health information.

- The individual if they are 12 years of age or older.
- The parent or guardian of an individual less than 12 years of age **(If both parents have co-custody, both individuals must sign - one on line 13, the other on line 14.)**
- The parent or guardian of an individual between the ages of 12 and 17, provided the individual does not object and has signed the authorization.
- The guardian of a person 18 years of age or older.
- An attorney or guardian ad litem who represents a minor 12 or older provided the court has entered an order granting this right.

(12) Individual to sign and date here if - age 12 or older.

(13) Parent to sign and date here if -

- Individual is less than 12 years of age or
- If individual is between 12 and 18 and has signed on line 12 or Guardian to sign here if -
- If individual is 18 years of age or older but is legally disabled. **You must provide a copy of the Guardianship court order granting you this right.**

Guardian to sign here if -

- If you are a guardian ad litem or attorney representing a minor 12 or older in any judicial or administrative proceeding. **You must provide a copy of the court order granting you this right.**

(14) Witness to sign and date here. **All authorizations require a witness signature to attest to the identity of the person entitled to give consent** (person signing line 12/13)
Line may be used by a co-custodial parent.

(15) Staff person disclosing/obtaining information signs here. Specific dates when disclosed/obtained shall be documented in the individual's clinical record and/or the Disclosure Tracking system.

State of Illinois
Department of Human Services-OFFICES OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES

REVOCATION OF AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

The Health Insurance and Portability Act of 1996 (HIPAA), and the Mental Health and Developmental Disabilities (MHDD) Confidentiality Act provides an individual the right to revoke a previous authorization to disclose information at any time. By completing this form you are requesting a restriction to any further disclosures of your personal health information.

I, _____

(Print your name, address and phone number)

_____

hereby revoke any previous authorizations to disclose my protected health information.

I understand that by signing below, revokes previous authorizations to disclose my protected information.

I understand that no revocation of this consent shall be effective to prevent disclosure of records and/or communications until it is received by the person otherwise authorized to disclose records and communications.

I further understand that the revocation will only apply to further disclosures or actions regarding my personal health information and cannot cancel actions or disclosures made while the disclosure was previously in effect and valid.

I will retain a copy of the revocation form for personal reference, and the original will be kept on file in the medical record for the period of time designated for such retention.

_____ _____

Signature of Individual Date

_____ _____

Signature of Witness Date

Office Use Only

_____ _____

Designee/Privacy Officer Date

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

HEALTH BEAT

TUBERCULOSIS

Tuberculosis Cases by Illinois County

What is tuberculosis?

Tuberculosis (TB) is a contagious and potentially life-threatening disease transmitted through the air. While it can affect any part of the body (such as the brain, the kidneys or the spine), TB usually affects the lungs. When first infected with the TB germ, people usually do not feel sick or have any symptoms. However, they may develop active TB disease in the future.

Although both preventable and curable, tuberculosis once was the leading cause of death in the United States. Today in Illinois, less than 30 deaths a year are attributed to tuberculosis and the number of cases in the state has fallen more than 40 percent in the past 10 years, reaching an all-time low of 633 in 2003.

What is the difference between TB infection and TB disease?

People with TB infection have the TB germ in their bodies but are not sick because the germs are inactive and, therefore, cannot be spread to others. Because these people may develop the disease in the future, they often are given preventive treatment.

People with TB disease are sick from the germs that are active in their bodies. They exhibit symptoms of the disease and, if they have TB of the lungs or throat, can spread the disease to others. Physicians can prescribe drugs to cure TB.

Are some people at greater risk of getting TB?

Although anyone may get TB, the following people are at higher risk:

- Persons who have been in close contact with an active TB case
- Persons who are infected with or at risk for human immunodeficiency virus (HIV)
- Foreign-born persons from countries where TB is common
- Persons with other medical conditions, such as diabetes, silicosis, end-stage renal disease and some forms of cancer, that increase the risk of TB once infection has occurred
- Persons 65 years of age or older
- Residents of long-term care facilities, such as nursing homes or prisons

- Persons who abuse alcohol or use intravenous drugs
- Persons in occupations that serve groups at high risk for TB
- Minority and other medically underserved populations

How serious is the problem among minorities?

TB disproportionately affects racial and ethnic minority groups. This is particularly true among children. In the U.S., more than 80 percent of childhood cases of TB occur in minority groups. Overall, from 1985 through 1993, TB cases increased among non-Hispanic blacks by 18 percent, among Asians and Pacific Islanders by 48 percent and among Hispanics by 67 percent. In contrast, cases among non-Hispanic whites decreased by 18 percent.

What are the symptoms of TB disease?

The general symptoms of TB disease include feeling sick or weak, weight loss, fever and night sweats. TB of the lungs causes the general symptoms plus coughing, sometimes producing blood, and chest pain. Other symptoms depend on the part of the body that is affected.

How is TB spread?

TB is spread from person to person through the air. When people with TB disease of the lungs or throat cough or sneeze, they can put TB germs into the air. Then other people who breathe in the air containing these germs can become infected. People with TB disease are most likely to spread it to people with whom they spend time with every day, such as family members or coworkers. (Remember, though, a person must have active TB disease to spread it; persons who are infected but do not have the disease **cannot** spread TB to others.) If a person thinks he or she has been in close contact with someone with TB disease, it is important to go to a clinic or health department for a TB skin test.

How is a person tested for TB?

The tuberculin skin test is used to find out whether a person is infected with the TB germ. It does not tell whether the person has TB disease. For the skin test, a small amount of fluid--called tuberculin--is injected under the skin in the lower part of the arm. Two or three days later, a health care worker checks the site of the injection to see if there has been a reaction.

What does a positive reaction mean?

A positive reaction to the tuberculin skin test usually means that the person has been infected with the TB germ. It does not necessarily mean that the person has TB disease. Other tests, such as a chest X-ray and a sample of sputum, are needed to see whether the person has TB disease.

How is TB disease treated?

TB disease can be cured by taking several drugs for six to nine months. It is very important that people who have TB disease take the drugs exactly as prescribed. If a person stops taking the drugs too soon or if the drugs are not taken correctly, the germs that are still alive may become resistant to the drugs. This makes the disease

much harder to treat. Generally, after the first several weeks of drug therapy, most TB patients become non-infectious.

How is TB infection treated?

The drug used to prevent TB infection from developing into TB disease is isoniazid. It must be taken for six to 12 months. The drug may cause liver problems in certain people, especially older individuals and people with liver disease. Therefore, people who are taking isoniazid should be monitored carefully for signs of adverse reactions.

idph online home
health fact sheets

Illinois Department of Public Health
535 West Jefferson Street
Springfield, Illinois 62761
Phone 217-782-4977
Fax 217-782-3987
TTY 800-547-0466
Questions or Comments

HIV

What you need to know

Learn about HIV/AIDS
and how to protect yourself.

Illinois Department of Public Health

No matter what you've heard, HIV, the virus that causes AIDS, has not gone away. You cannot tell who is infected by how they look or by their lifestyle. They may look fine and healthy, but they can still pass the virus to you.

HIV/AIDS Basics

- HIV stands for human immunodeficiency virus. This is the virus that causes AIDS (acquired immunodeficiency syndrome).
- HIV attacks the body's immune system. People infected with HIV are more likely to become ill from infections and diseases that healthy persons usually can fight off.
- Once you are infected with HIV, you are infected for life.
- There is no cure or vaccine for HIV. But, there are medications that can help people with HIV stay healthy longer.
- A person infected with HIV may have no symptoms but can still infect others.

HIV **cannot** be spread by –

- Giving blood
- Toilet seats
- Hot tubs
- Working with or being around someone with HIV
- Hugging
- Coughs or sneezes
- Shaking hands
- Sweat or tears
- Mosquitoes
- Simple (closed-mouth) kissing
- Eating food prepared or handled by an HIV-infected person

How do you get infected with HIV?

HIV is found in the blood, semen and vaginal secretions of infected persons. It can be spread in the following ways:

- Having unprotected sex — vaginal, anal or oral — with an HIV-infected person (male or female)
- Sharing needles or injection equipment with an HIV-infected person to inject drugs (including hormones, insulin or steroids)
- From an HIV-infected woman to her baby during pregnancy, birth or breastfeeding

Before 1985, some people were infected with HIV through blood transfusions or use of blood products. Since 1985, blood products have been screened for HIV, so infection through a blood transfusion is extremely rare.

You can protect yourself!

- To avoid infection through sex, the only sure way is not to have sex — vaginal, anal or oral — or to have sex only with someone who is not infected and who only has sex with you.
- If you do have sex, correctly using a latex condom every time you have sex (anal, vaginal or oral) can greatly lower your risk of infection.
- For many people, using a condom can be tricky the first few times. Read instructions carefully and practice. Here are a few tips:
  - Check the expiration date on the condom. Don't keep a condom in your wallet or pocket for more than a few days. Your body heat can weaken it.
  - Put the condom on as soon as the penis is hard.
  - If you use a lubricant, be sure it is water-based.
  - After you come, hold the condom on the penis at the base and pull slowly out of your partner.

- Unprotected anal or vaginal sex puts you at much more risk for HIV than oral sex. However, some STDs are spread through oral sex. Use condoms or dental dams if you engage in oral sex.
- Avoid drugs and alcohol because they can increase your chances of infection and can lead to risky behaviors.
- Never share needles or injection equipment. Sharing needles or equipment to inject drugs, hormones, insulin or steroids even once can transmit HIV. This is because HIV from an infected person's blood can remain in a needle or injection equipment and can then be injected into the bloodstream of the next person using the equipment.

You should seriously consider taking an HIV test if –

- you are a man who has had sex with other men;
- you have shared injection needles or equipment;
- you have had sex with one or more partners whose sex and drug-using behaviors are unknown to you;
- you have had sex with someone who is infected with HIV or who falls into one of the above groups; or
- you (or your partner) are pregnant or considering pregnancy (early treatment can help to protect babies of HIV-infected mothers from being born with HIV).

If you are infected, knowing lets you make choices about how to protect your health, as well as the health of others. New treatments, too, can help you stay healthy longer.

If your HIV test is negative, you can live longer and healthier by taking steps now to avoid becoming infected with HIV and other STDs.

You can avoid HIV and STDs.

- Talk to your partner about HIV.
- Take the lead; be the one to suggest condoms. It shows that you're smart and in control.
- Don't accept the pressure. If someone really cares about you, he or she will respect your choice to use condoms or not to have sex.
- Explore other ways to have fun, stay in control and be safe.
- Plan ahead to be safe. That way you'll have what you need when you need it.

Got more questions? We've got answers!

You can always call the Illinois AIDS/HIV & STD Hotline at 1-800-243-2437 or TTY (hearing impaired use only) 1-800-782-0423. It's free and anonymous (no names). Trained counselors can help to answer your questions and help you to find a testing site that's right for you. They are available seven days a week (9 a.m. to 9 p.m. on weekdays and 10 a.m. to 6 p.m. on weekends).

"Is a baby in my future?"

HIV/AIDS Facts for Life

- AIDS is a disease caused by HIV (human immunodeficiency virus).
- Testing is the only sure way to know if you are infected with HIV.
- A person infected with HIV may have no symptoms but can still infect others.
- HIV is spread through unprotected sex with an infected person. Both men and women can spread HIV.
- To avoid HIV infection through sex, don't have sex, or have sex only with a partner who isn't infected and who only has sex with you.
- Using condoms correctly every time you have sex reduces the risk of HIV infection.
- HIV also is spread by sharing needles and injection equipment.
- An infected woman can pass HIV to her baby during pregnancy, birth or breastfeeding.
- Donating blood is safe.
- HIV is not spread by hugs, handshakes or kisses.
- HIV is not spread by mosquitoes.
- There is no cure or vaccine for HIV. However, current treatments can keep you healthier longer.

AIDS/HIV & STD
1.800.243.2437
HOTLINE
Illinois Department of Public Health

Printed by the Authority of the State of Illinois PO#513678 10M 8/02

COST

The cost of the alcohol and drug evaluation is established by the provider. It is the responsibility of the defendant to pay for the evaluation. However, providers must offer alcohol and drug evaluations at a reduced fee to defendants who can prove inability to pay the full cost according to established program standards.

REGULATIONS

Providers that conduct DUI evaluations for the Court or the Office of the Secretary of State are licensed and regulated by the Illinois Department of Human Services, Division of Alcoholism and Substance Abuse. Professional evaluators working in these programs must meet standards prescribed by the Department. Programs are inspected and must conform to applicable Department Rules and Regulations in order to maintain licensure.

COMPLAINTS

The Department has statutory authority to investigate providers who conduct alcohol and drug evaluations for DUI defendants. Questions or complaints regarding DUI services rendered should be directed to:

Illinois Department of Human Services
Division of Alcoholism and Substance Abuse
Licensing and Certification
401 South Clinton Street, Second Floor
Chicago, Illinois 60607
312-814-3840

If you have any questions about alcohol or other drugs, call:

Illinois Department of Human Services
Division of Alcoholism and Substance Abuse

1-866-213-0548 (toll-free Voice)
1-866-843-7344 (toll-free TTY)

If you have questions about Illinois Department of Human Services (IDHS) programs or services please call or visit your local Family Community Resource Center (FCRC). We will answer your questions.
If you do not know where your FCRC is or if you are unable to go there, you may call the automated helpline 24 hours a day at:

1-800-843-6154
1-800-447-6404 (TTY)

You may speak to a representative between:
8:00 a.m. - 5:30 p.m.
Monday - Friday (except state holidays)

Visit our website at:
www.dhs.state.il.us

IDHS
Illinois Department of Human Services

DHS 4499 (R-02-14) DHS/DASA DUI Processes and Evaluations
Printed by the Authority of the State of Illinois.
200 copies P.O.#14-1086

State of Illinois
Department of Human Services

DUI Processes and Evaluations

IDHS
Illinois Department of Human Services

INTRODUCTION

In Illinois, anyone arrested for driving under the influence of alcohol and/or other drugs (DUI) must undergo an alcohol and drug evaluation before sentencing can occur for the DUI offense, or restricted or full driving privileges can be granted by the Office of the Secretary of State.

The purpose of the evaluation is to determine the extent of the defendant's alcohol and/or drug use and its associated risk to current or future public safety. The following areas are reviewed: the defendant's driving history, chemical test results (blood alcohol content), Objective Test score and category, and the interview with an evaluator.

The focus of the interview is past and current alcohol and drug use, specifically as it relates to driving history. Defendant responses are checked against the driving record, the Objective Test score, the results of the chemical testing, and possibly other corroborative sources. Inconsistencies must be reconciled between the defendant and the evaluator. If not, the evaluation will have no validity and could result in the following consequences:

- Denial of driving privileges by the Office of the Secretary of State.
- A request by the Court or the Office of the Secretary of State to undergo another evaluation at the defendant's expense.
- Delay of sentencing for the DUI or consideration for restricted or full driving privileges.

When the evaluation is completed, a classification and a recommendation will be determined by the evaluator and recorded on the Alcohol and Drug Uniform Report form for the Court or the Office of the Secretary of State. This form will then be sent to the Court or given to the defendant to take to the Office of the Secretary of State for the driver's license hearing.

The classification will be one of the following:

- Minimal Risk
- Moderate Risk
- Significant Risk
- High Risk

RECOMMENDATIONS

The minimum recommendation to the Court or the Office of the Secretary of State related to each classification is as follows:

Minimal Risk

Completion of a minimum of ten hours of DUI Risk Education.

Moderate Risk

Completion of a minimum of ten hours of DUI Risk Education and a minimum of 12 hours of early intervention 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.

Significant Risk

Completion of a minimum of ten hours of DUI Risk Education and a minimum of 20 hours of substance abuse treatment and, after discharge, active ongoing participation in all activities specified in the continuing care plan.

High Risk

Completion of a minimum of 75 hours of substance abuse treatment and, after discharge, active ongoing participation in all activities specified in the continuing care plan.

In all cases, it is at the discretion of the Court to determine what type of recommendation, if any, will ultimately become a part of the sanction for the DUI offense. However, if the alcohol and drug evaluation is for the Office of the Secretary of State in relation to the return of full or limited driving privileges, the defendant will be required to complete any recommendations contained in the alcohol and drug evaluation.

The defendant has the right to reject the completed alcohol and drug evaluation, to withdraw from the process at any time, or to seek a second opinion by obtaining another evaluation. However, any information provided may be released to the Court or the Office of the Secretary of State, upon request. If the evaluation procedure is not completed, notice will be sent to the Court or the Office of the Secretary of State.